Dr Anthony Christopher

Quality Report

Heath Town Medical Centre
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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this service	Inadequate
Are services safe?	Inadequate
Are services effective?	Inadequate
Are services caring?	Requires improvement
Are services responsive to people's needs?	Requires improvement
Are services well-led?	Inadequate

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Dr Christopher practice on Wednesday 13 January 2016. Overall the practice is rated as inadequate.

Our key findings across all the areas we inspected were as follows:

- Staff understood their responsibilities to raise concerns and to report incidents and near misses, however the practice did not have a formal system in place for recording and monitoring significant events, incidents and accidents.
- The practice did not have a programme of continuous clinical and internal audit in order to monitor quality and make improvements.
- There was insufficient monitoring of performance to demonstrate people received effective care and treatment.
- Patients were positive about their interactions with staff and said they were treated with compassion and dignity.
- Urgent appointments were available on the day they were requested. Patients said that they sometimes had to wait a long time to be seen at their appointment but accepted this as they were more than happy with the level of care provided by the GP.
- The practice had limited formal governance arrangements in place.
- There was a clear leadership structure and staff felt supported by the management. The practice did not proactively seek feedback from patients to ensure patients were involved in the delivery of the service.

The areas where the provider must make improvements are:

- Implement effective systems for the management of risks to patients and others against inappropriate or unsafe care. This should include arrangements for recording, analysing and acting upon significant events and improving the monitoring and recording of staff training.
- Ensure that staff who undertake the role of a chaperone have a Disclosure and Barring (DBS) check

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or an appropriate risk assessment carried out to demonstrate why a DBS check is not in place and how patients are protected from the risk of abuse during an examination.
- Implement robust governance arrangements to ensure appropriate systems are in place for assessing and monitoring the quality of services provided. This should include undertaking audits of practice, including completed clinical audit cycles.
- Implement systems for the management and monitoring of performance to demonstrate people received effective care and treatment. This should include patients with long term conditions such as diabetes and asthma and patients with dementia.

The areas where the provider should make improvement are:

- Consider repeating the risk assessment for legionella as recommended in the report and ensure a copy of the outcome and a policy is available at the practice to provide guidance for staff.
- Have a system in place to record, investigate and demonstrate the outcome of written and verbal complaints received.
- Ensure all staff receive training in the protection of vulnerable adults.
- Ensure that fire drill training/practice sessions take place for all staff.

I am placing this practice in special measures. Practices placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate for any population group, key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The practice will be kept under review and if needed could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration. Special measures will give people who use the practice the reassurance that the care they get should improve.

Professor Steve Field (CBE FRCP FFPH FRCGP)
Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Inadequate

The practice is rated as inadequate for providing safe services and improvements must be made. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. However, reviews and investigations were not thorough enough. Risk assessments were carried out by an external company. Although risks to patients who used services were assessed, the practice did not have systems and processes to address these risks themselves and ensure patients were kept safe. Most pre-employment checks had been completed however non-clinical staff had not had a Disclosure and Barring Service check (DBS check) completed to confirm that they were suitable and safe to undertake their role or had a risk assessment in place to justify the lack of a DBS check. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable). Although staff had not received training in safeguarding adults staff were aware of the signs of abuse of older people, vulnerable adults and children and were aware of their responsibilities.

Are services effective?

Inadequate

The practice is rated as inadequate for providing effective services and improvements must be made. The GP referred to guidance from the National Institute for Health and Care Excellence although changes were not always implemented. Data from the Quality and Outcomes Framework showed patient outcomes were mostly at or below average for the locality and six clinical areas were significantly below the local and national average. There was no evidence of completed clinical audit cycles or that audits were driving improvement in performance to improve patient outcomes. Formal meetings did not take place with the wider multidisciplinary teams to understand and meet the range and complexity of patients' needs. However, contact was maintained through telephone conversations and one to one discussions. There was evidence of appraisals for all staff.

Are services caring?

Requires improvement

The practice is rated as requires improvement for providing caring services as there are areas where improvements should be made. Data from the National GP Patient Survey showed patients rated the practice overall comparable with or higher than others for several aspects of care. Patients said they were treated with compassion,

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dignity and respect and they were involved in decisions about their care and treatment. Information for patients about the services available was easy to understand and accessible. We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.

Are services responsive to people's needs?

Requires improvement

The practice is rated as requires improvement for providing responsive services as there are areas where improvements should be made. The practice engaged with the Clinical Commissioning Group to review the needs of its local population and to secure improvements to services where these were identified. The practice opening times were less than the contracted hours the GP practice was required to be open. The practice was equipped to treat patients and meet their needs. Patients could get information about how to complain in a format they could understand. However, there was no evidence that complaints were monitored or that learning from complaints had been shared with staff and other stakeholders. Feedback from the national patient survey published in July 2015 reported that 49.8% of patients said they could not always see or speak to a preferred GP. The accuracy of this feedback was questioned as there was only one GP at the practice. Patients said they found it easy to make an appointment with the GP and there was continuity of care, with urgent appointments available the same day.

Are services well-led?

Inadequate

The practice is rated as inadequate for being well-led. The practice had a number of policies and procedures to lead and govern safe activity. However there was a limited governance framework in place to support the delivery of good quality care and identify risk. The minutes of meetings did not show that governance issues to drive improvement were discussed. The practice did not have a programme of continuous clinical or internal audit in place to monitor quality and make improvements. The practice did not have a clear or consistent system in place for reporting, recording and monitoring significant events, incidents and accidents.

The practice had not proactively sought feedback from patients. The practice had a suggestion box in place however there was no evidence to show that staff had monitored the use of the box. The practice did not have a patient participation group (PPG). PPGs are a way for patients to work in partnership with a GP practice to encourage the continuous improvement of services. The practice manager told us that the location of the practice and the changing

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transient population made it difficult to gain interest from patients to form a PPG. There was a clear leadership structure and staff felt supported by the management. Staff were clear about the vision and their responsibilities in relation to this.	

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The six population groups and what we found

We always inspect the quality of care for these six population groups.

Older people

Inadequate

The practice is rated as inadequate for the care of older people. The practice is rated as inadequate for the domains of safe, effective and well led and rated as requires improvement in responsive and caring. The concerns that led to these ratings apply to everybody using this practice including this population group. The practice had fewer older patients at the practice when compared to other local practices. Care and treatment of older people reflected current evidence-based practice, and older people had care plans where necessary. The practice offered home visits and urgent appointments for those older patients with enhanced needs. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. Performance for the number of patients aged 65 and older who had received a seasonal flu vaccination was comparable to the national average. (76.23% as compared to the national average of 73.24%).

People with long term conditions

Inadequate

The practice is rated as inadequate for the care of people with long-term conditions. The practice is rated as inadequate for the domains of safe, effective and well led and rated as requires improvement in responsive and caring. The concerns that led to these ratings apply to everybody using this practice including this population group. Performance for diabetes assessment and care 54.7% was much lower compared to the local average of 82.3% and the national average of 89.2%. Longer appointments and home visits were available when needed. The GP offered some suggestions as to the reasons for the low level of performance one of which was due to the transient population. The GP worked with relevant health care professionals to support the needs of patients with the most complex needs on an individual basis or by telephone.

Families, children and young people

Inadequate

The practice is rated as inadequate for the care of families, children and young people. The practice is rated as inadequate for the domains of safe, effective and well led and rated as requires improvement in responsive and caring. The concerns that led to these ratings apply to everybody using this practice including this population group. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. Immunisation rates were relatively high

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for all standard childhood immunisations. Data showed that 48.78% of patients on the practice asthma register had had an asthma review in the last 12 months this was significantly below the national average. The GP presented similar reasons for this level of performance as with the diabetes data but had not reviewed this information to see whether improvements could be made. Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this. Appointments were available outside of school hours and the premises were suitable for children and babies. The practice's uptake for the cervical screening programme was 77.72%, which was comparable to the national average of 81.83%.

Working age people (including those recently retired and students)

Inadequate

The practice is rated as inadequate for the care of working-age people (including those recently retired and students). The practice is rated as inadequate for the domains of safe, effective and well led and rated as requires improvement in responsive and caring. The concerns that led to these ratings apply to everybody using this practice including this population group. The age profile of patients at the practice is mainly those of working age, students and the recently retired and the practice had adjusted its services to ensure these were accessible, flexible and offered continuity of care to this group of patients. The practice offered extended opening hours for appointments two evenings per week. However patients did not have access to book appointments or order repeat prescriptions online because the practice did not have a website. Health promotion advice was offered and health promotion material was available to patients in the waiting area. Patients were supported to access local healthy lifestyle programmes.

People whose circumstances may make them vulnerable

Inadequate

The practice is rated as inadequate for the care of people whose circumstances may make them vulnerable. The practice is rated as inadequate for the domains of safe, effective and well led and rated as requires improvement in responsive and caring. The concerns that led to these ratings apply to everybody using this practice including this population group. The practice had a register for patients with a learning disability and all had received an annual review. The practice was not aware of any patients living in vulnerable circumstances including homeless people or travellers. The practice was aware of the need to allow people with no fixed address to register or be seen at the practice. It had told vulnerable patients about how to access various support groups and voluntary organisations. Staff knew how to recognise signs of abuse in

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vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies and how to access various support groups and voluntary organisations. However staff had not received training in safeguarding vulnerable adults to support them in the identification of possible signs of abuse and the procedures they should follow to act on their concerns.

People experiencing poor mental health (including people with dementia)

Inadequate

The practice is rated as inadequate for the care of people experiencing poor mental health (including people with dementia). The practice is rated as inadequate for the domains of safe, effective and well led and rated as requires improvement in responsive and caring. The concerns that led to these ratings apply to everybody using this practice including this population group. The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations. The data showed that 100% of patients on the practice register who experienced poor mental health had been offered an annual health check. Although higher than the national average, 84.01% the practice had an exception rate of 40%. The dementia diagnosis rate for 2014/2015 was much lower than the national average (28.57% as compared to the national average of 84.01%).

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What people who use the service say

The national GP patient survey results published in July 2015 showed the practice was performing in line with local and national averages. A total of 439 surveys (8.2% of patient list) were sent out and 87 (19.8%) responses, which is equivalent to 2.1% of the patient list, were returned. Results indicated the practice performed comparable to other practices in most aspects of care, which included for example:

- 68% found it easy to get through to this surgery by phone compared to the local Clinical Commissioning Group (CCG) average of 73% and a national average of 73%.
- 86% were able to get an appointment to see or speak to someone the last time they tried (CCG average 82%, national average 85%).
- 89% described the overall experience of their GP surgery as fairly good or very good (CCG average 82%, national average 85%).
- 74% said they would definitely or probably recommend their GP surgery to someone who has just moved to the local area (CCG average 71%, national average 78%).

As part of our inspection we also asked for Care Quality Commission (CQC) comment cards to be completed by patients prior to our inspection. We received six comment cards which were all extremely positive. Patients told us that staff were attentive and caring. They felt they received a good service, that staff were always respectful and that they had a good attitude.

We also spoke with two patients on the day of our inspection their comments were in line with the comments made in the cards we received. All patients said they were happy with the care they received and thought staff were approachable, committed and caring.

Areas for improvement

Action the service MUST take to improve

- Implement effective systems for the management of risks to patients and others against inappropriate or unsafe care. This should include arrangements for recording, analysing and acting upon significant events and improving the monitoring and recording of staff training.
- Ensure that staff who undertake the role of a chaperone have a Disclosure and Barring (DBS) check or an appropriate risk assessment carried out to demonstrate why a DBS check is not in place and how patients are protected from the risk of abuse during an examination.
- Implement robust governance arrangements to ensure appropriate systems are in place for assessing and monitoring the quality of services provided. This should include undertaking audits of practice, including completed clinical audit cycles.
- Implement systems for the management and monitoring of performance to demonstrate people received effective care and treatment. This should include patients with long term conditions such as diabetes and asthma and patients with dementia.

Action the service SHOULD take to improve

- Consider repeating the risk assessment for legionella as recommended in the report and ensure a copy of the outcome and a policy is available at the practice to provide guidance for staff.
- Have a system in place to record, investigate and demonstrate the outcome of written and verbal complaints received.
- Ensure all staff receive training in the protection of vulnerable adults.
- Ensure that fire drill training/practice sessions take place for all staff.

Dr Anthony Christopher

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a Care Quality Commission (CQC) lead Inspector**.** The team included a GP specialist advisor and a practice manager specialist advisor.

Background to Dr Anthony Christopher

Dr Anthony Christopher is located near the city of Wolverhampton in the West Midlands and operates from a single location. There are approximately 2445 patients registered at the practice. The practice has a larger than local average number of patients between the ages of four to 18 and 25 to 40 years. The percentage of patients between the ages of 65 and 85 plus is significantly lower than the practice average across England 7.1% compared to 26.5%. There is a significantly higher than national average representation of income deprivation affecting children and older people. The practice population is culturally diverse with approximately 77% of patients from Asian, African or East European backgrounds.

The practice is situated behind other properties within premises that used to also be occupied by other health professionals. The practice is now the only service that occupies the building. There is a lift situated at road level providing access to the practice for patients who use a wheelchair, patients with mobility problems and parents with pushchairs. The practice can also be accessed from the road by a flight of stairs.

The practice clinical team consists of a single male full time GP. The GP is supported by a practice manager and four receptionist/administration staff who work either full or part time hours. The GP told us that attempts to retain the services of a practice nurse had not been successful.

The practice is open between 8.30am and 6.30pm Monday, Tuesday, Thursday, Friday and Wednesday 8.30am to 1pm. Appointments are from 9am to 1pm Monday to Friday and afternoon appointments Monday, Tuesday, Thursday and Friday 2.50pm to 5.50pm. Extended surgery hours are available from 6pm to 7pm on Monday and Tuesday. The practice does not provide an out-of-hours service to its patients but has alternative arrangements for patients to be seen when the practice is closed. Patients are directed to the out of hours services, Primecare. Patients are also given details about the NHS 111 service and the local Walk-in Centres.

The practice has a contract to provide General Medical Services (GMS) for patients. This is a contract for the practice to deliver general medical services to the local community. It provides Directed Enhanced Services, such as the childhood vaccination and immunisation scheme and minor surgery. The practice provides a number of clinics for example long-term condition management including asthma, diabetes and high blood pressure.

Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The inspection was planned to check whether the provider is meeting the legal

requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

How we carried out this inspection

Before visiting, we reviewed a range of information we held about the practice and asked other organisations to share what they knew. We carried out an announced inspection on 13 January 2015.

During our visit we:

- Spoke with the GP, the practice manager, reception staff, and spoke with patients who used the service.
- Observed how patients were being cared for and spoke with carers and/or family members
- Reviewed the personal care and treatment of patients.
- Reviewed comment cards where patients and members of the public shared their views and experiences of the service.
- Prior to and after the inspection we reviewed a range of information that we held about the practice and asked other organisations to share what they knew about the practice. This included NHS Wolverhampton CCG, NHS England Area Team and Wolverhampton City Council.

To get to the heart of patients' experiences of care and treatment, we always ask the following five questions:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

We also looked at how well services were provided for specific groups of people and what good care looked like for them. The population groups are:

- Older people
- People with long-term conditions
- Families, children and young people
- Working age people (including those recently retired and students)
- People whose circumstances may make them vulnerable
- People experiencing poor mental health (including people with dementia)

Please note that when referring to information throughout this report, for example any reference to the Quality and Outcomes Framework data, this relates to the most recent information available to the CQC at that time.

Inadequate

Are services safe?

Our findings

Safe track record and learning

There were no formal systems for reporting significant events but staff we spoke with were aware of their responsibilities to raise concerns. Staff told us they would inform the practice manager or GP of any incidents and these were then discussed at the monthly practice meetings. We found that the practice could demonstrate an effective system for recording significant events for the period 2007 to 2012. After these dates, significant events had not been formally recorded. There was a lack of information in the minutes of practice meetings to demonstrate that lessons were shared to improve safety at the practice. The GP received medicine and safety alerts from the practice manager. Records available confirmed that action had been taken to address recent alerts.

Information we received from the practice before the inspection said that there had been no significant events over the past 12 months. We examined minutes of practice meetings and other records and although not easy to follow there was evidence that incidents had occurred which the practice termed as 'lessons of the week'. We found reference to a significant event in a book titled 'Action Book'. The book contained a daily log of messages and other information. The GP also told us about a further incident related to an abnormal test result that had not been followed up. We were able to track both incidents and confirm that patients were followed up and both incidents were discussed as a 'lesson of the week' at practice meetings. We found that the details for both incidents were not comprehensive and lacked detail. However we were able to confirm that changes had been made to prevent re-occurrence. There was no evidence to demonstrate that learning from events had been shared with external stakeholders. We were told that patients affected by any incidents received an apology and were told about actions taken to improve care. We were told that this was carried out on an informal basis and therefore there were no records to confirm that this took place.

Overview of safety systems and processes

The practice had systems in place to keep patients safe and safeguarded from the risk of abuse. The GP was the lead for safeguarding vulnerable adults and children and had received training to enable them to fulfil their role. Staff were aware of who the lead was and who they should speak to if they had a safeguarding concern. Training records we examined showed that the practice manager and receptionists had received training in safeguarding children but not vulnerable adult safeguarding. Although staff had not received training in vulnerable adult safeguarding they knew how to recognise signs of abuse in older people and vulnerable adults. Staff knew how they would raise their concerns and where to find contact details for the relevant agencies. Policies were in place that reflected relevant legislation and local requirements and policies were accessible to all staff. The GP had not attended multidisciplinary safeguarding meetings but always spoke on the telephone and provided reports where necessary for other agencies.

There was a chaperone policy, which was visible in the consulting room and a notice in the waiting room advised patients that chaperones were available if required. A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure. We found that all of the reception staff acted as chaperones and were trained for the role. However none of the staff had had a Disclosure and Barring Service check (DBS check) completed to confirm that they were suitable and safe to undertake this role or had a risk assessment in place to explain why a DBS was not necessary. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable). Following the inspection the practice manager provided evidence to show that the outcome of DBS checks had been received for three of the reception staff and they were awaiting the other two. The practice manager told us that only those staff with completed DBS checks would be used to undertake a chaperone role.

The practice maintained appropriate standards of cleanliness and hygiene. We observed the premises to be clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. Patients we spoke with told us that they always found the practice clean and had no concerns about cleanliness and infection control. The practice manager was the infection control lead and the GP was the infection control clinical lead. We looked at

the most recent infection control audit completed in September 2015 by the local infection control team. The practice audit had achieved 93% compliance and an action plan was in place to address recommendations.

Most of the arrangements for managing medicines, including emergency medicines and vaccines, in the practice kept patients safe (including obtaining, prescribing, recording and handling). However we noted that a case used to store the emergency medicines was not securely stored. Following the inspection the practice told us about the arrangements put in place to address this. We were told that the case was now lockable and it had been locked and stored in a lockable area. However we were not able to evidence this. All prescriptions were computer generated and patient prescription requests were kept secure prior to collection by patients and a system was in place for their safe disposal if not collected. Staff were able to explain the cold chain policy especially in relation to vaccines and were aware of the importance of ensuring medicines were kept at a regular temperature. We saw that daily records of the minimum, maximum and actual temperature of the medicine refrigerator was maintained. Staff were aware of the action to take in the event that the refrigerator failed to work correctly.

There was no evidence that regular medicine audits had been carried out at the practice. The GP told us that a prescribing advisor from the local clinical commissioning group (CCG) should make monthly visits to support the review of policies, effective prescribing practices and performance data. However the GP told us that they had only received two visits last year (2015) and had not pursued the reason for this. This initiative aimed to ensure cost effective prescribing whilst maintaining and improving quality. The 2014/2015 data showed the prescribing of antibiotics at the practice was comparable to other local practices.

We reviewed staff personnel files and found that full pre-employment checks had not been completed for all staff prior to employment. We saw that proof of identification and references were sought but appropriate checks through the Disclosure and Barring Service had not been carried out for the five reception staff. The practice manager told us that this would be actioned and following the inspection sent us evidence to confirm that requests for DBS checks for all staff had been carried out and a satisfactory outcome for three of the five staff had been received. Information forwarded to the CQC by the practice manager showed details of the DBS numbers from the certificate.

Monitoring risks to patients

The practice had limited systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. There was a contract in place with an external company who had completed risk assessments and health and safety audits at the practice. These included assessments of the safety of the premises, fire and legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings). The legionella assessment was completed in December 2013 and identified an overall risk rating of very high. The practice manager told us that the recommendations made had been actioned, however information orvisual evidence was not available to confirm this. Training records we looked at showed that staff had received infection control training, and other records showed that water outlets were flushed and a log of water temperatures was recorded. It was also recommended that the legionella assessment be repeated by 19 December 2015, NHS property services had told the practice that this would be completed early March 2016. The practice did not have a risk log in place and apart from an assessment of the control of substances hazardous to health had not completed any other risk assessments of their own.

There was a rota system in place for the receptionist staff to ensure that there were sufficient administration staff to meet the needs of patients and provide non-clinical support to the GP. The practice had identified the need for a practice nurse. The GP had trained the receptionists and administration staff to assist in areas such as safely accepting and packaging specimens and chaperoning. It was evident at the inspection that reception and administration staff did not undertake nursing or other clinically related roles.

Arrangements to deal with emergencies and major incidents

The practice had some arrangements in place to respond to emergencies and major incidents. There was an instant messaging system on the computers in all areas which alerted staff to any emergency. All staff had received recent annual update training in basic life support and the

practice had equipment available for staff to use if required. Emergency equipment available on the premises included a defibrillator (which provides an electric shock to stabilise a life threatening heart rhythm) and oxygen with adult and children's masks. We saw that the pads needed to use the defibrillator safely were out of date. Following the inspection the practice provided information to confirm that these had been replaced. We saw that the practice had a large oxygen cylinder which would not be easily transportable by staff in the event of an emergency. The GP and practice manager told us that they would address this, confirmation that this has been addressed had not been received.

The practice had most of the emergency medicines available within the practice to treat emergencies that may be faced in general practice. These were medicines to treat allergic reactions, severe infections, worsening asthma and prolonged seizures (fitting). There were no medicines to treat emergency conditions such as unresponsive patients due to hypoglycaemia (low blood sugar). We spoke with the GP about this; they told us they would review the addition of this medicine based on current best practice guidance. We found that emergency equipment and medicines were kept in different rooms within the practice, hindering quick access in the event of an emergency. We noted that emergency medicines were not securely stored. Following the inspection the practice had put arrangements in place to address this.

The practice had a business continuity plan in place. We found, however that this needed to be reviewed to ensure that staff had appropriate information available to them in the event of an unplanned occurrence that affected services. This included for example, contact numbers for contractors and alternative premises arrangements.

A fire risk assessment, weekly fire alarm and emergency lights checks had been completed by an external company. Staff confirmed that these checks were carried out however they had not attended fire drills. The practice manager told us that they would arrange for unplanned fire drills to be carried out. Staff had attended fire training. Electrical equipment checks were up to date to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly.

Inadequate

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice was operated by a single handed GP who had the sole responsibility for the assessment, treatment and care of patients registered at the practice. The GP was therefore the lead in all clinical areas such as diabetes, heart disease and chronic lung disease and was responsible for reviewing guidance and implementing changes as required. The GP could outline the rationale for their approaches to treatment and was familiar with current best practice guidance. However systems were not in place to show how they kept up to date or that the practice monitored these guidelines through risk assessments, audits and random sample checks of patient records.

Management, monitoring and improving outcomes for people

There was no information to show that the practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. QOF is a system intended to improve the quality of general practice and reward good practice. The most recent published results showed that it had achieved 84.9% of the total number of points available. The practice QOF results were lower than the national average of 94.2%. Further practice QOF data from 2014 to 2015 showed:

- The practice clinical exception rate of 5.9% was lower than the Clinical Commissioning Group (CCG) average of 7.5% and national average of 9.2%. Clinical exception rates relate to the number of patients who did not attend a review. A lower clinical exception rate indicated that more patients had attended a review or received treatment than the local and national averages.
- The practice did not have regular (at least 3 monthly) multidisciplinary case review meetings to discuss patients on the palliative care register.
- The percentage of patients with hypertension in whom the last blood pressure reading measured in the preceding 12 months is 150/90mmHg or less showed a very large variation from the national average (62.02% compared to 83.65%).
- The percentage of patients with asthma, on the register, who have had an asthma review in the preceding 12 months that includes an assessment of asthma control using the 3 RCP questions showed a very large variation from the national average (48.78% compared to 75.35%).
- The percentage of patients with Chronic Obstructive Pulmonary Disease (COPD) who had a review undertaken including an assessment of breathlessness using the Medical Research Council dyspnoea scale in the preceding 12 months showed a very large variation from the national average (55.56% compared to 89.9%).
- The percentage of patients diagnosed with dementia whose care had been reviewed in a face-to-face review in the preceding 12 months showed a very large variation from the national average from the national average (28.57% compared to 84.01%).
- The percentage of patients who experienced poor mental health who had a comprehensive, agreed care plan documented in the preceding 12 months showed that 100% of patients on the practice register who experienced poor mental health had been offered an annual health check. This was higher than the national average of 84.01%, however the practice had an exception rate of 40%.
- The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less showed a very large variation from the national average (41.84% compared to 78.03%).

We saw that the CCG bench marked the practice against other practices in the locality. This information was provided to the practice as part of their Practice Support Visit carried out by the CCG on 29 October 2015. Areas identified as requiring improvement had been discussed and an action plan developed. For example, the 2014/15 CCG supplied data showed the practice:

- had a high referral rate for first outpatient appointments per 1000 patients.
- needed to ensure that all patients with a lung disease had a review undertaken including an assessment of breathlessness.
- needed to ensure that patients with a high cholesterol were on the appropriate medicine based on clinical evidence.

Information received at this inspection did not demonstrate that the practice had worked to ensure that appropriate action was taken to improve the outcomes for

Inadequate

Are services effective?

(for example, treatment is effective)

patients in the areas mentioned above. The GP told us that they planned to have daily meetings to discuss QOF data and identify plans to ensure improvements are made. This has not been evidenced. Some of the reasons provided for this was due to the practice being a single handed practice with no practice nurse or health care assistant. Further contributing factors were felt to be due to the practice location, the transient population, high levels of deprivation and the cultural diversity of its patients. The practice was unable to provide evidence of action taken to address this.

The practice was a single handed GP practice with no other clinical staff therefore clinical meetings were not held. The GP could not demonstrate whether they were involved in clinical meetings with their peers to enable them to discuss clinical issues they had come across. There was no evidence of quality improvement activity at the practice, clinical audits and systems to meet their QOF requirements. Information provided by the practice showed that a list of the number of patients in certain groups had been counted but it was not an audit. There was no information to show lessons learnt and if improvements had been made.

Effective staffing

The GP could demonstrate role-specific training and updating of their skills. There were no other permanent clinical staff at the practice. The practice occasionally used the services of another GP (female) and ensured they had the necessary skills to meet the needs of patients registered at the practice. The GP had trained the receptionists and administration staff to assist in areas such as safely accepting and packaging specimens and chaperoning. Reception and administration staff had had appraisals completed within the last 12 months. Staff had also received training that included: safeguarding children, fire procedures, chaperoning, infection control and basic life support.

Coordinating patient care and information sharing

Staff told us that they maintained contact with other health and social care services to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. QOF data identified that the practice did not have regular (at least 3 monthly) multidisciplinary case review meetings where all the patients on the palliative care register were discussed. The GP told us that they visited patients on the list and had informal one to one and telephone discussions with relevant professionals. The outcome of these discussions had not been recorded. A community midwife visited the practice weekly to support the care of pregnant women.

The practice had identified problems with patients not receiving their first outpatient appointment. To monitor this the practice kept information that confirmed they had sent referrals together with the name of the person who had confirmed receipt of the referral. However the booking centre stated that appointment letters had not been issued as they had not received the referral letters. The practice had not investigated this any further with the hospital involved. This concern had also been highlighted by the local Clinical Commisssioning Group (CCG) and discussed at the practice support visit (PSV) meeting. The PSV programme is a local CCG initiative to support and enable practices to make quality improvements.

Consent to care and treatment

We found that staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005. When providing care and treatment for children and young people, assessments of capacity to consent were also carried out in line with relevant guidance. Where a patient's mental capacity to consent to care or treatment was unclear the GP assessed the patient's capacity and where appropriate, recorded the outcome of the assessment. We saw that patients' consent had been recorded for example, when consenting to certain tests and treatments such as vaccinations.

Supporting patients to live healthier lives

The practice offered a full range of immunisations for children, travel vaccines and influenza vaccinations in line with current national guidance. The flu vaccination rates in the defined clinical at risk groups was 58.7% this was comparable to the national average of 50.68%. Data collected by NHS England for 2014 -2015 showed that the performance for all childhood immunisations was comparable or higher than the local CCG average. For example, childhood immunisation rates for the vaccination of children under two years of age ranged from 83.3% to 100%, children aged two to five 80.4% to 100% and five

Inadequate

Are services effective?

(for example, treatment is effective)

year olds from 83.6% to 96.7%. Flu vaccination rates for patients aged over 65 were 76.23%, this was comparable to the national average of 73.24% for the year 01/04/2013 to 31/03/2014.

Although the practice told us that they encouraged patients to attend national screening programmes for bowel and breast cancer screening, data published in March 2015 showed that there was a low attendance rate by patients from this practice. Screening rates for breast and bowel cancer were below local and national averages. For example:

- 56.3% of females aged 50 to 70 were screened for breast cancer in the last three years compared to a CCG average of 68.4% and national average of 72.2%.
- 36.6% of patients aged 60 to 69 were screened for bowel cancer in the last 2.5years compared to a CCG average of 52.3% and 58.3%.

The practice was aware of the factors that contributed to the low cancer screening uptake and had tried to promote screening through posters and leaflets. The practice's uptake for the cervical screening programme was 71.9%, which was comparable to the local average of 70.8% and the national average of 74.3%. The practice demonstrated how they encouraged uptake of the screening programme by using information in different languages. A female clinician was available on some occasions to carry out the test.

The practice promoted the healthy lifestyle programme to its patients. This included referring or signposting patients requiring advice on their diet, smoking and or alcohol cessation to the appropriate service. For example, smoking cessation advice was available from a local support group. We saw that information was displayed in the waiting area. Patients had access to appropriate health assessments and checks.

Requires improvement

Are services caring?

Our findings

Kindness, dignity, respect and compassion

We observed members of staff were courteous and very helpful to patients and treated them with dignity and respect. Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments. We noted that consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard. Reception staff knew when patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.

Patients completed Care Quality Commission (CQC) comment cards to tell us what they thought about the practice. We received six completed cards. The cards contained positive comments about the practice and staff. Patients commented that the service was excellent, they were treated with respect and dignity and that the GP and staff were professional and caring. We also spoke with three patients on the day of our inspection. Their comments were in line with the comments made in the cards we received.

Results from the national GP patient survey showed patients felt they were treated with compassion, dignity and respect. The practice was above average for its satisfaction scores on consultations with the GP. For example:

- 94.2% said the GP was good at listening to them compared to the local Clinical Commissioning Group (CCG) average of 84.5% and national average of 88.6%.
- 89% said the GP gave them enough time (CCG average 83.7%, national average 86.6%).
- 89.9% said they had confidence and trust in the last GP they saw (CCG average 93.5%, national average 95.2%).
- 90% said the last GP they spoke to was good at treating them with care and concern (CCG average 80.3%, national average 85.1%).
- 87.8% said they found the receptionists at the practice helpful (CCG average 86.5%, national average 86.8%).

Care planning and involvement in decisions about care and treatment

Patients told us they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them. Patient feedback on the comment cards we received was also positive and aligned with these views.

Results from the national GP patient survey showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. Results were significantly higher than the local and national averages. For example:

- 92.1% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 82.6% and national average of 86%.
- 91.1% said the last GP they saw was good at involving them in decisions about their care (CCG average 76.8%, national average 81.4%).

We saw how patients were supported to be involved in decisions about their care. The patients told us that the GP gave them the time needed to discuss their treatment, answered their questions and discussed the choices available to them. Translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patients this service was available and information for patients was displayed in the waiting area in different languages that met the needs of patients registered at the practice.

Patient and carer support to cope emotionally with care and treatment

The practice maintained a carers register and had systems in place to ensure they were offered support to meet their health needs. There were notices and leaflets displayed in the waiting room that provided patients with information on health promotion. Information was available for patients on how to access a number of support groups and organisations. Written information was available for carers to ensure they understood the various avenues of support available to them. There were 8 carers on the practice carers register. This represented 0.33% of the practice population. This was less than the expected 2% for the practice population size. The practice identified some of the reasons for this as being due to the relatively low

Requires improvement

Are services caring?

number of elderly patients registered at the practice 7.1% compared to the average across England of 26.5%. Staff told us that if families had suffered bereavement, the GP contacted them. Patients we spoke with confirmed this.

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

Although services were planned to take into account the needs of different patient groups and to help provide flexibility, choice and continuity of care, there were insufficient clinical staff to ensure these needs were met. For example:

- The practice was a single handed practice with no practice nurse or health care assistant to provide additional clinical support.
- The absence of a female clinician meant that female patients could not express a preference to have a female GP or nurse to provide their care an treatment.
- There were longer appointments available for patients with a learning disability, older people and patients with long-term conditions.
- The practice opening times were less than the contracted hours the GP practice was required to be open.
- Home visits were available for older patients and patients who would benefit from these, which included patients with long term conditions or receiving end of life care.
- Urgent access appointments were available for children and those with serious medical conditions.
- Telephone consultations were available every day after morning clinics and extended hours appointments were available on Monday and Tuesday evenings.
- There were disabled toilet facilities and the practice was wheelchair accessible. A lift was available from the road for access to the practice
- Translation services were available and access to this service was advertised.

Access to the service

The practice was open between 8.30am to 6pm Monday, Tuesday, Thursday and Friday, Wednesday 8.30am to 1pm. Appointments were from 9am to 1pm Monday to Friday and afternoon appointments Monday, Tuesday, Thursday and Friday 2.50pm to 5.50pm. Extended surgery hours were offered on Monday and Tuesday from 6pm to 7pm. The practice did not provide an out-of-hours service to its patients but had alternative arrangements for patients to be seen when the practice was closed. Patients were directed to the out of hours services. Pre-bookable appointments could be booked up to two weeks in advance; urgent appointments were also available for patients that needed them.

Results from the national GP patient survey showed that patient's satisfaction with how they could access care and treatment was comparable to local and national averages.

- 79.2% of patients were satisfied with the practice's opening hours compared to the local Commissioning Group (CCG) average of 76.7% and national average of 74.9%.
- 79% patients said they could get through easily to the surgery by phone (CCG average 72.8%, national average 73.3%).

Patients told us on the day of the inspection that they were able to get appointments when they needed them.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. The practice manager was the designated responsible person who handled all complaints at the practice. We saw that information was available to help patients understand the complaints system including leaflets available in the reception area. This information was also available in different languages to meet the needs of patients registered at the practice. Patients we spoke with were aware of the process to follow if they wished to make a complaint.

The practice manager told us that they had not received any formal complaints, however they told us that they had received verbal complaints which were dealt with immediately. The practice had not recorded the verbal complaints and so there was no evidence to show what action was taken or if lessons were learnt and improvements made where appropriate.

Are services well-led?

Inadequate

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action)

Our findings

Vision and strategy

The practice had a vision to deliver high quality care and promote good outcomes for patients through the recruitment of appropriate staff, working with other agencies and from suitable premises. However a strategy or detailed supporting business plan to address issues in a timely and effective way were not in place. The GP told us that they would like to recruit additional clinical staff to improve access for patients to care and treatment. This would include a practice nurse and a GP preferably female which would improve access for women. The practice had identified issues with the premises and were working with NHS England and the local council to relocate to more suitable premises in approximately two to three years.

Governance arrangements

The practice had a limited governance framework in place to support the delivery of good quality care. We found that:

- The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop on any computer and in folders within the practice.
- There was a clear leadership structure and named reception staff were responsible for the administration work related to allocated groups of patients. All members of staff were all clear about their own roles and responsibilities. Staff felt valued, well supported and knew who to go to in the practice with any concerns.
- The practice did not have a clear or consistent system in place for reporting, recording and monitoring significant events, incidents and accidents.
- The practice did not have a programme of continuous clinical and internal audit in order to monitor quality and make improvements.
- Staff had received training in safeguarding children but not in safeguarding vulnerable adults. However staff were aware of the procedures to follow if they had concerns about the safety of both adults and children.
- We found that the systems in place to review and maintain the premises were not sufficiently robust to mitigate risks associated with the safety of people accessing the premises and/or using the service.
- The practice held monthly staff meetings but we were unable to see in minutes we looked at where governance issues, for example, performance, quality and risks were discussed.

Leadership and culture

There was a clear leadership structure in place and staff felt supported by the management. The staff team were clear about their roles and responsibilities, and that of the GP. Staff we spoke with were positive about working at the practice. Staff told us that monthly staff meetings were held and changes to the day to day running of the practice were communicated.

The GP and the practice manager were the lead in all aspects of practice management. We found that there was a lack of leadership in relation to having robust governance procedures related to the overall management of the practice. For example the practice was unclear as to the role of the external property services organisations and their responsibilities related to risk assessments at the premises. Formal systems were not in place to demonstrate improved outcomes for patients or learning from significant events and complaints.

Seeking and acting on feedback from patients, the public and staff

The practice told us that patients were encouraged to give feedback. Patients we spoke with and comments made in comment cards we received from patients confirmed this. However this was carried out on an informal basis. The practice did not carry out their own patient surveys and had not acted on the feedback they received from patients' surveys, such as the national GP patient survey and the friends and family test (FFT).

The practice had not had a patient participation group (PPG) since 2006 and had not proactively attempted to form another. PPGs are a way for patients to work in partnership with a GP practice to encourage the continuous improvement of services. The practice manager told us that the location of the practice and the changing transient population made it difficult to gain interest from

Are services well-led?

Inadequate

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action)

patients. The practice did not have a website to promote and encourage patient feedback. The practice had a suggestion box in place but could not evidence that this was monitored or that it had been used by patients.

The practice had gathered feedback from staff through staff meetings, appraisals and discussions. Administrative staff told us they had monthly meetings which were minuted. We found that the minutes were not structured which made it difficult to identify staff contribution and feedback. Staff told us they had opportunities to get involved and engaged in providing feedback, and contributing to decisions about practice improvements however they could not give us an example of this.

Continuous improvement

The practice did not have a formal system in place for recording and monitoring incidents. The minutes of meetings we saw did not demonstrate the detail of the discussions or of learning that had taken place. This meant that staff who were not in attendance were not able to update themselves. The practice was unable to provide evidence of any robust and structured clinical audits carried out. There were no systems in place to demonstrate that outcomes for patients were monitored.

The practice was a single handed GP practice with no other clinical staff therefore clinical meetings were not held. The GP could not demonstrate whether they were involved in clinical meetings with their peers to enable them to discuss clinical issues they had come across, new guidance and improvements for patients. The local Clinical Commissioning Group (CCG) told us that the GP had not attended the locality meetings for GPs for sometime. However, they were aware that the locality lead would ensure that the GP was kept up to date by forwarding the minutes and contacting the GP. The practice manager told us that the GP was made aware of the dates of these meetings.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **How the regulation was not being met:** The registered person did not do all that was reasonably practicable to assess, monitor, manage and mitigate risks to the health and safety of service users. They had not actively engaged with other professionals external to the practice or taken part in multidisciplinary meetings to ensure that care and treatment remained safe for people using the service. 12(1)(2)(a)(b)(i)

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **How the regulation was not being met:** The provider did not ensure systems and processes were in place to assess monitor and: • improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services). • mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity. • improve the quality and safety of the services provided and to seek and act on feedback from relevant persons and other persons on the services provided in the carrying on of the regulated activity, for the purposes of continually evaluating and improving such services.

This section is primarily information for the provider

Requirement notices

- maintain securely such other records as are necessary to be kept in relation to; the management of the regulated activity.

Regulation 17(1)(2)(a)(b)(d)(e)

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed **How the regulation was not being met:** The provider had not ensured that they had gathered all available information to confirm that they had made all appropriate checks on persons employed for the purposes of carrying on a regulated activity before they are employed. Reg. 19(1)(a)(2)(a)(3)(b) Schedule 3