Aston Healthcare Limited

Inspection report

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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 location	Inadequate
Are services safe?	Inadequate
Are services effective?	Requires improvement
Are services caring?	Requires improvement
Are services responsive?	Inadequate
Are services well-led?	Inadequate

Overall summary

This practice is rated as inadequate overall. (Previous rating 24 November 2016– Good)

The key questions are rated as:

Are services safe? – Inadequate

Are services effective? – Inadequate

Are services caring? – Requires Improvement

Are services responsive? – Requires Improvement

Are services well-led? - Inadequate

We carried out an announced comprehensive inspection at Aston Healthcare Ltd on 2, 3 and 4 October 2018 as part of our risk assessed inspection programme.

At this inspection we found:

- The registered provider had not developed an infrastructure that was sufficient enough to effectively manage a GP practice that provided a service for 27,317 patients spread across six branch surgeries.
- Governance arrangements for recognising and managing risks across branch surgeries were not well established or effective.
- There provider did not have systems in place to mentor or have oversight of the competencies and practice of the nurse clinicians.
- Periodical health and safety checks were not always completed and when these were in place, the registered provider had not responded to the recommendations in the reports. We noted that there were serious issues concerned with fire safety at three of the branch surgeries.
- The registered provider had not ensured premises in use were fit for purpose and we found that one of the branch surgeries was unfit for use due to the condition of the premises.
- Systems and processes in place to protect children and adults from abuse needed to be strengthened.
- The registered provider's recruitment practices did not always promote the employment of staff suitable for working with vulnerable people.
- Processes for reporting, managing and learning from incidents were not well developed.
- Medicines management needed to improve to ensure medicines were safe to use, and administered and prescribed in keeping with the legal requirements.
- Equipment and arrangements for dealing with medical emergencies did not promote the wellbeing of patients.
- Medicines for managing medical emergencies were not always well managed.
- The registered provider did not have oversight of the care and treatment offered to patients; there was no effective central control over the management, deployment or supervision of staff.
- There was no evidence of formal performance management of GPs at the practice and adequate system of consultation, referral and prescribing audits for GPs and nurse clinicians was not in place.
- The systems to manage complaints required improvement. There was limited evidence to show the practice encouraged and welcomed complaints so that their processes could be improved.
- The practice acted on and learned from external safety events as well as patient and medicine safety alerts however this was not always timely and the provider did not have an oversight of how well alerts were responded to.
- Patient feedback we reviewed indicated that staff treated patients with compassion, kindness, dignity and respect, however processes and systems in place did not always support this.

The areas where the provider **must** make improvements as they are in breach of regulations are:

- Ensure care and treatment is provided in a safe way to patients.
- Ensure there is an effective system for identifying, receiving, recording, handling and responding to complaints by patients and other persons in relation to the carrying on of the regulated activity.
- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.
- Ensure staff receive training and supervision to enable them to competently carry out their roles.
- Ensure systems are in place to ensure fit and proper persons are employed to work for the service and recruitment checks are completed before new recruits commence working at the practice. Ensure all premises and equipment used by the service provider is fit for use.

The areas where the provider **should** make improvements are:

Overall summary

- Review the management infrastructure to ensure all aspects of running the service are covered by appropriately skilled and experienced staff.
- Review the system for safety alerts received by the practice to ensure action taken is documented.
- Provide clear and detailed incident reporting policies and procedures which includes periodical auditing.
- Provide instruction and training to staff so that they understand what incidents need to be reported.
- Develop clear and overarching systems for staff to report incidents to make sure these are responded to appropriately, learnt from and monitored.
- Review the security of clinical waste bins that are stored outside the surgery premises.
- Review systems for testing for commonly undiagnosed conditions.
- Develop ways to improve uptake of cervical smears.

I am placing this service in special measures. Services 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 service 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 remove this location or cancel the provider's registration.

Special measures will give people who use the service the reassurance that the care they get should improve.

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

Population group ratings

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

Our inspection team

Our inspection team was led by a CQC lead inspector**.** The team also included: three additional CQC inspectors, two GP specialist advisers, two practice manager advisers and two members of the CQC medicines team.

Background to Aston Healthcare Limited

The practice has a Primary Medical Services (PMS) contract with a registered list size of approximately 27,317 patients. The practice list is shared between the main practice and five other branches which are managed and overseen from the main office at Manor Farm Primary Care Resource Centre, Manor Farm Road, Huyton, L36 0UB.

Most patients did not attend the main practice and attended one or other of the branch surgeries. Each branch surgery produced a list of patients 'registered' with it.

The five branch surgeries are:

- Camberley Medical Centre, Camberley Drive, Halewood, Liverpool L25 9PS
- Gresford Medical Centre, Pilch Lane, Liverpool, L14 0JE
- Knowsley Medical Centre, Frederick Lunt Avenue, Knowsley, L34 0HF
- Halewood Resource Centre, Roseheath Drive, Halewood, Liverpool, L26 9UH
- Whiston Primary Resource Centre, Old Colliery Road, Liverpool, L35 3SX

As part of this inspection we visited the main site and all the branch surgeries.

Aston Healthcare Limited is located in Knowsley and is registered with the Care Quality Commission (CQC) to provide the following regulated activities:

- Diagnostic and screening procedures
- Maternity and midwifery services
- Surgical procedures
- Treatment of disease, disorder or injury

Inadequate

Are services safe?

We rated the practice as inadequate for providing safe services.

The practice was rated as inadequate for providing safe services because:

- **There were no systems in place to make sure that premises used for the branch surgeries were well managed so that the health and safety of patients and staff were promoted. One of the branches was in an extremely poor state of repair; essential fire safety equipment was not in place; fire safety instructions were misleading; the recommendations from fire safety checks had not been carried out and significant infection control risks had not been reviewed by the registered provider. These issues made Gresford medical centre unfit for use and we told the provider not to use the premises with immediate effect.**
- There were gaps in systems to keep people safe and safeguarded from abuse and the recruitment and selection processes were not robust.
- The management of medicines did not always promote the wellbeing of patients and the systems in place to monitor patient safety and medicines safety alerts needed to be formalised.
- Arrangements for medical emergencies were not well managed and emergency medicines and equipment were not readily accessible in all branches.

Safety systems and processes

- The registered provider did not ensure the system in place to keep people safe and safeguarded from abuse were effective and used consistently throughout the service.
- Policies and procedures concerning child protection and safeguarding vulnerable adults from abuse were in place and a safeguarding lead with responsibility for the main and branch surgeries had been identified. Staff had completed up-to-date safeguarding training appropriate to their role. Information about how to raise child and adult safeguarding concerns were posted in clinic rooms and the administration offices in each practice. We found however, that potential child protection and adult safeguarding concerns had not been raised with the safeguarding lead or reported to the local authority as required which may have resulted in delays in appropriate intervention. This issue had been reviewed by the practice at the time of the inspection however learning from the incident had not been shared with all staff.
- The registered provider did not have a standard method for raising safeguarding issues with the safeguarding lead and there were no checks to ensure that these methods were efficient.
- Although multiagency working was facilitated, records demonstrated examples of significant delays in responding to multiagency requests for information. The processes for flagging safeguarding concerns to the safeguarding lead were not robust or fully understood by staff. Reports and learning from safeguarding concerns were not shared with staff.
- DBS checks had not been completed for staff who acted as chaperones. (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.) It was also noted that staff whose roles required DBS checks had commenced working at the practice prior to completion of these checks. The provider had not ensured that all staff had the required medical indemnity insurance. Other checks however, such as confirmation of identity and references had been completed.
- There was no infection control lead with overarching responsibility to ensure each practice was compliant with the infection prevention and control code of practice. An infection prevention and control policy was in place but this was not well established and embedded into the service. There was a designated infection control lead at each practice however, at the time of inspection this was a newly designated role and no one had completed additional infection control and prevention training to ensure they could carry out these duties competently. Frontline staff had not completed training for recognising or considering the early stages of sepsis, however medical and nursing staff had equipment available to diagnose sepsis. The provider had not satisfied themselves of the immunisation status of nursing and medical staff to ensure patients were appropriately protected from the risk of cross infection.
- Legionella risk assessments and confirmation of water safety checks were not available for all branches.
- The practice did not have arrangements to ensure that facilities and equipment were safe and in good working

order in all the branch surgeries. One branch surgery was unfit for use due the poor state of the fabric of the building. There was evidence of possible rodent infestation and no evidence that previous or current electrical wiring tests had been completed.

- There were serious issues with regards to the fire safety in three of the branch surgeries. Fire-safety checks had been completed. However, the provider had not acted on the recommendations from these checks. Recommendations in the reports had included making sure escape routes were clear to prevent entrapment and installation of systems to alert staff and patients to a fire. The fire exit signage in one branch surgery would have diverted patients into an unsafe part of the building if a fire had broken out.
- Security in all the practices was insufficient as the public could access all areas of each surgery we visited, unimpeded. Clinic and storage rooms were not kept locked. The rooms containing the medicine fridges were unlocked and the keys left in the fridges. Arrangements for managing waste and clinical specimens kept people safe. However, the large bins stored outside were not always anchored for added security. The minor surgery unit at Halewood Medical Centre was well managed and met all the required infection control and prevention standards.
- Processes were in place to ensure that samples taken during minor surgery were handled safely, laboratory test results were promptly received and reviewed so that patients received timely appropriate care and treatment.

Risks to patients

The systems to assess, monitor and manage risks to patient safety were insufficient.

- Long established GPs and nurses were aware of how they were expected to respond to medical emergencies. However, defibrillators and medicines for responding to medical emergencies were inaccessible or poorly managed at four of the practices and the wellbeing of patients in an emergency were not promoted at these practices.
- No formal induction programmes had been developed to support new staff in becoming familiar with the workings of the organisation or their new place of work. There were no formalised competency checks to ensure staff understood their new responsibilities and were performing as competently as required.
- The provider had not ensured newly appointed doctors had completed an effective induction to enable them to work safely and effectively in the service. Newly appointed doctors were unaware of how important procedures operated such as access to emergency equipment and medicines at the different branch surgeries.
- The provider rarely used temporary or locum staff who were unknown to the practice. However, this meant that on occasion there were only nurse clinicians available to provide clinical care and treatment and formal systems for these nurses to access additional medical support during those periods was not in place. GPs knew how to identify and manage patients with severe infections including sepsis and equipment was available to assist with diagnosing sepsis. Practice nurses, nurse clinicians and front of house staff however, had not completed recognising sepsis training relevant to their roles.
- Arrangements were in place for planning and monitoring the number and mix of staff needed to meet patients' needs, including planning for holidays, sickness, busy periods and epidemics. However, these plans were not suitable because GP's were not always available at all the branch surgeries and this situation was not risk assessed.

Information to deliver safe care and treatment

Staff had the information they needed to deliver safe care and treatment to patients.

- The care records we saw showed that information needed to deliver safe care and treatment was available to staff. There was a documented approach to managing test results.
- The practice had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment. However, these were not the same throughout the service and were not always used effectively.
- Clinicians made timely referrals in line with protocols. However, the safety netting systems for two-week

referrals varied across the branch surgeries. Some had monitoring systems to check patients received appointments and monitor the outcome; in others it was not clear how this was managed.

Appropriate and safe use of medicines

The practice did not have reliable systems for the appropriate and safe handling of medicines.

- Medicines management needed to improve to ensure medicines were safe to use, administered safely and prescribed in keeping with the legal requirements. Out of date medicines were found at two of the branch surgeries.
- The patient group directions (PGDs) documents were inaccurate and incomplete, they did not provide the legal framework to allow named registered healthcare professionals to supply and, or, administer medicines. (PGDs are written instructions for the supply or administration of medicines such as vaccines, approved by the NHS, to groups of patients who may not be individually identified before presentation for treatment. These PGDs act as a direction to a nurse to supply and administer prescription only medicines to patients using their own assessment of patient need, without referring to a doctor for an individual prescription.) The provider had not assured themselves and evidence was not presented to confirm that practice nurses and nurse clinicians were competent at administering the medicines listed. Practice nurses and nurse clinicians had also administered vaccines which were not included in the PGDs available at the practice.
- PGDs for vaccinations were not always signed by a GP who needed to confirm witness that nurse who were to administer the medicines were competent. Some PGD's had been signed by nurses months after they had already administered the medicines.
- Patients' health was not always monitored in relation to the use of medicines and followed up on appropriately.
- Systems in place did not ensure that action was always taken when fridge temperatures were outside the ranges required for the medicines stored.
- Blank printer prescription forms were not kept secure and their use was not monitored.
- The registered provider, however, had systems in place to adhere to the local antibiotic prescribing protocols and had acted to support good antimicrobial stewardship in line with local guidance.

Track record on safety

- There were processes in place for receiving and complying with safety alerts. This was not fully understood by all staff, so some nurses developed their own system for receiving and responding to alerts.
- There were no periodical checks to assess how well the system for cascading alerts worked. However, the provider had commissioned a specialist pharmacist to review the system in relation to medicines alerts.
- Alerts reviewed had been actioned however, the response was not always timely.

Lessons learned and improvements made

- The practice had a newly implemented policy for reporting incidents. Staff did not understand their duty to raise concerns and report incidents and near misses and very few incidents had been recorded given the patient list size. Staff did not routinely receive feedback about the incidents raised. The processes for reporting and dealing with an incident differed at each practice. Staff did not have a universally clear understanding of the processes involved and the importance of reporting incidents. Staff had not received training in sufficient detail to help them understand what needed to be reported.
- Systems for reviewing and investigating when things went wrong were not adequate. The practice did not always learn from incidents and lessons learnt were not always shared. There were no systems in place for identifying themes and subsequent action to improve safety.
- There was insufficient clinical oversight which meant incidents and near misses could be overlooked. Four near miss incidents were identified by the inspection team and brought to the attention of the registered provider during the inspection.

Inadequate

Are services effective?

We rated the practice as inadequate providing effective services overall and across all population groups.

The practice was rated as inadequate for providing effective services because:

- The provider did not provide assurance that staff routinely followed clear clinical pathways for assessing and treating all patients.
- The provider did not have effective processes in place to ensure staff had the correct skills and competencies to provide effective care and treatment.
- Systems for sharing patient information with other organisations and between clinicians were not used consistently and the processes did not ensure important information was always shared as appropriate.

Effective needs assessment, care and treatment

- Systems were not in place to keep clinicians up to date with current evidence-based practice. Not all clinicians routinely used best practice templates and care plans to assess needs and ensure their care and treatment was delivered in line with current legislation, standards and guidance. There were no other formal systems in place to ensure staff, particularly newly employed GPs and nurse clinicians, provided care and treatment in line with best practice or could justify through a considered risk assessment when care deviated from best practice.
- There was no expectation from the provider that staff followed clear clinical pathways and protocols.
- Patients' immediate and ongoing needs were assessed. However there was no assurance that assessments were always based on best practice guidelines. Assessments included clinical needs and mental and physical wellbeing.
- We saw no evidence of discrimination when making care and treatment decisions.
- Staff advised patients what to do if their condition got worse and where to seek further help.

Older people:

- Older patients who were frail or could be vulnerable were not routinely offered full assessments of their physical, mental and social needs.
- The practice had systems in place to ensure all older patients discharged from hospital were followed up to ensure that their prescriptions were updated to reflect any extra or changed needs.

People with long-term conditions:

- Patients with long-term conditions were offered a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the practice nurses worked with other health and care professionals to deliver a coordinated package of care.
- Staff who were responsible for reviews of patients with long term conditions had received specific training for example, diabetic care training.
- There were no standard systems in place to prompt GPs to follow-up patients who had received treatment in hospital or through out-of-hours services for an acute exacerbation of asthma.
- Adults with newly diagnosed cardiovascular disease were offered statins for secondary prevention. People with suspected hypertension were offered ambulatory blood pressure monitoring and patients with atrial fibrillation were assessed for stroke risk and treated as appropriate.
- The practice did not have a policy or protocol relating to tests for commonly undiagnosed conditions; for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension). However, several staff stated that they completed the relevant tests opportunistically.
- The practice's performance on quality indicators for long-term conditions was in line with national averages. However, we noted that the numbers of patients included in the data the practice sent for national audits was unverified.

Families, children and young people:

- Childhood immunisation uptake rates were above the target percentage of 90%.
- The practice had arrangements for following up failed attendance of children's appointments following an appointment in secondary care or for immunisation.

Working age people (including those recently retired and students):

- The practice's uptake for cervical screening was 69.1%, which was in line with local and national averages but below the 80% coverage target for the national screening programme. Practice nurses and clinicians

were not aware of any specific steps that had been taken to try and improve the uptake of cervical smears. Staff felt this was a national initiative and they could do little to influence uptake.
- All sample takers had up-to-date cervical smear training. Sample takers were sent information about the quality of samples they sent. However, they did not all monitor and review their results to identify areas for improvement.
- The practice's uptake for breast and bowel cancer screening was in line with the national average.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40-74. However, follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified was not always appropriate.

People whose circumstances make them vulnerable:

- End of life care was not well organised or delivered in a coordinated way which considered the needs of those whose circumstances may make them vulnerable. The medical records of end of life patients were not routinely updated following multidisciplinary meetings between the practice nurse and Macmillan nurse or health visitor. This meant that GPs did not have access to up to date information about the choices made by these patients about their care and treatment.
- The practice held a register of patients living in vulnerable circumstances such as those with a learning disability.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.

People experiencing poor mental health (including people with dementia):

- The practice's assessment and monitoring of the physical health of people with mental illness, severe mental illness, and personality disorder was inconsistent. Health checks were completed but systems for identifying when tests were due and sending reminders had not been introduced in all the branch surgeries. Health checks for patients with more than one condition were not co-ordinated to make compliance easier. The provider had however, introduced longer appointments times for patients attending for health checks.
- A structured process was not in place for following up patients who failed to attend for the administration of long-term medication.
- There were no examples given of patients assessed to be at the risk of suicide or self-harm.
- The random check of patient's records indicated that patients with dementia did not always receive care and treatment based on an up-to-date care and treatment plan.
- The practice offered annual health checks to patients with a learning disability.
- The practice's performance on quality indicators for mental health was in line with local and national averages. However, the figures presented were unverified and during the inspection we noted a number of high-risk medicines checks were overdue and action had not been taken when prescriptions for a high-risk medicine was not collected by the patient or their carer.

Monitoring care and treatment

- A credible programme of quality improvement activity was not in place for the service as a whole. Some audits had been completed, mostly at branch level. However, for different reasons, the outcomes were not always informative. For example, in one study only a small number of patients were reviewed; in others only, a single cycle of checks had been completed. Where a change had been introduced and outcomes rechecked, no additional steps were put in place if the outcome worsened. Clinical staff were unaware of the audits which had taken place throughout the service.
- Detailed and appropriate audits, however, had been completed in the minor surgery unit, to ensure treatment and recovery was as expected.

Effective staffing

- Up to date training records for staff working for Aston Healthcare limited were not available. Some staff could demonstrate that they had appropriate knowledge for their role, for example, to carry out reviews for people with long term conditions, older people or contraceptive reviews.
- There was no formal program of supervision, mentoring or continual competency checks for Nurse Clinicians, also known as Advanced Nurse Practitioners. These nurses must have completed a specialist degree course

and demonstrated specific competencies to allow them to take carry out some of the tasks usually completed by GPs; for example diagnosing and treating an illness independently without referring to a GP.

- The registered provider could not confirm all staff had achieved the specialist degree- level of education expected before treating patients. Qualified nurses who were new to the role of a practice nurse were not supported to achieve and demonstrate the competencies relevant to the role of a practice nurse.
- Staff indicated that they had not received job descriptions. The job description available for nurse practitioners had been newly developed and was not well established in the practice.
- Formal systems were not in place to ensure that the nurse clinicians practiced within their remit and to review the outcomes for patients on the nurse practitioner's caseload.
- Staff whose role included immunisation and taking samples for the cervical screening programme had received specific training and could demonstrate how they stayed up to date.
- The practice did not provide protected time for training. An up to date central record of skills, qualifications and training was not maintained. Staff took responsibility for their own training. We noted that a significant amount of training had been completed immediately after the CQC inspection was announced.
- We requested evidence of appraisals and one to one supervision for staff but this was not provided. We saw no evidence of an effective induction programme for new staff.
- The approach for supporting and managing staff when their performance was poor or variable was unclear and a policy was not in place, however we noted that action had been taken when staff performance was consistently below expectations.

Coordinating care and treatment

Staff did not always work together and with other health and social care professionals to deliver effective care and treatment.

- Records indicated that appropriate staff and those in different teams and organisations, were not always involved in assessing, planning and delivering care and treatment.
- Systems for sharing information with relevant professionals when discussing care delivery for people with long term conditions and when coordinating healthcare for care home residents were not always robust and there were gaps in communication between different professionals and parts of the organisation.
- Systems were in place to share information with, and liaise, with community services, social services and carers for housebound patients and also with health visitors and community services for children who have relocated into the local area. However, these differed between branch surgeries.
- Patients did not always receive coordinated and person-centred care. Communication between services in relation to end-of-life care communication was poor and did not ensure care was delivered in a coordinated way. Information about end of life patients in the community was not uploaded into the person's medical records which meant GPs and out-of-hours services would not always have the most up to date information about these patients. GPs were not always up-to-date with information about anticipatory medicines or preferred place of death.

Helping patients to live healthier lives

Staff were proactive in helping patients to live healthier lives.

- The practice identified patients who may need extra support, such as carers and people with learning disabilities. However, there was no cancer lead at the practice to ensure appropriate support and guidance was available for patients in the last 12 months of their lives.
- Staff at some branch surgeries encouraged and supported patients to be involved in monitoring and managing their own health, for example through social prescribing schemes.
- Staff discussed changes to care or treatment with patients and their carers as necessary.
- The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns and tackling obesity.

Consent to care and treatment

The provider had not ensured that consent to care and treatment was always in line with legislation and guidance.

Inadequate

Are services effective?

- GPs and nurse clinicians understood the requirements of legislation and guidance when considering consent and decision making.
- GPs supported patients to make decisions and where appropriate, assessed and recorded a patient's mental capacity to make a decision. The nurse clinicians spoken with however did not have sufficient knowledge and understanding of the Mental Capacity Act 2005 (MCA) or the Deprivation of Liberty Safeguards (DoLs) to uphold people's legal rights when providing or offering care and treatment. There was no evidence that GPs and nurse clinicians responsible for diagnosing, treating and admitting patients to hospital had completed appropriate Mental Capacity Act (MCA) 2005 and Deprivation of Liberty safeguard (DoLs) training.
- The processes for seeking consent were not monitored.

Please refer to the evidence tables for further information.

Requires improvement

Are services caring?

We rated the practice as requires improvement for caring.

The practice was rated as requires improvement for caring because the privacy and dignity of patients was not always preserved and some processes in place did not support the dignity and respect of patients.

Kindness, respect and compassion

On an individual basis staff treated patients with kindness, respect and compassion.

- All of 104 CQC feedback comment cards and patient questionnaire sheets returned were positive about the attitude of the administrative staff, nurses and GP partners.
- The practice's national GP patient survey results were in line with local and national averages for questions relating to kindness, respect and compassion.

Involvement in decisions about care and treatment

Staff were aware of the Accessible Information Standard (a requirement to make sure that patients and their carers can access and understand the information that they are given.)

- Staff communicated with people in a way that they could understand, for example, translation services were available.
- Staff helped patients and their carers find further information and access community and advocacy services. They helped them ask questions about their care and treatment. The practice proactively identified carers and supported them.
- The practice's national GP patient survey results were in line with local and national averages for questions relating to involvement in decisions about care and treatment. However, the percentage of respondents to the national GP patient survey who stated that during their last GP appointment they had confidence and trust in the healthcare professional they saw or spoke to (01/01/2018 to 31/03/2018) was lower than local and national averages.
- Patients also commented to the CQC that sometimes they could only see a nurse at short notice when they would have preferred to see a GP.

Privacy and dignity

- There were instances when the privacy and dignity of patients were compromised because of the layout of the buildings. We noted that the provider had acted to prevent private conversations being overheard in the waiting areas however this was still a significant issue and concern in two out of the six branch surgeries. We were advised that the provider was working towards a solution to this matter in the two remaining practices.
- Privacy curtains were available in all consulting rooms and patients told us they could access a chaperone or request a female nurse clinician if they preferred.
- When patients wanted to discuss sensitive issues, or appeared distressed reception staff offered them a private room to discuss their needs. Staff recognised the importance of people's dignity and respect.

Requires improvement

Are services responsive to people's needs?

We rated the practice, and all of the population groups, as requires improvement for providing responsive services .

The practice was rated as requires improvement for providing a responsive service because complaints and concerns were not dealt with in keeping with legislation and not all clinical staff understood their responsibilities in relation to the Mental Capacity Act 2005.

Responding to and meeting people's needs

Systems in place did not ensure that patient needs and preferences were routinely considered.

- Processes were in place to enable the practice to understand the needs of its population who used the different branch surgeries. However, this information was not routinely used to compare outcomes between branches, identify or respond to local needs and monitior variability in care delivery.
- The provider had not ensured the facilities and premises were appropriate for the services delivered at all branch surgeries. At one branch surgery, for example, disabled access was difficult as the front door was heavy to open. There was an intercom system in place but this was not working. We were advised that the practice was aware of these issues and had plans in place to make improvements.
- The provider considered the care and treatment for patients with multiple long-term conditions by agreeing to longer appointments for these patients. However, care and treatment for patients approaching the end-of-life was not always well coordinated.
- Telephone GP consultations were available which supported patients who were unable to attend the practice during normal working hours.
- Staff throughout the service were aware of how to access translation services for patients who did not speak English.

Older people:

- All patients had a named GP who supported them in whatever setting they lived, whether it was at home or in a care home or supported living scheme.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those identified as having enhanced needs.

People with long-term conditions:

- Patients with a long-term condition did not always receive an annual review to check their health and medicines needs were being appropriately met and multiple conditions were not reviewed at one appointment. Consultation times, however, were flexible to meet each patient's specific needs. Some services, however, such as a GP run service which prioritised older patients, were only available at one of the practices. Patients were not all provided with the same self-help information, for example, not all patients with diabetes were aware that they could request repeat prescriptions online.
- The practice nurses and nurse clinicians held meetings with the local district nursing teams to discuss and manage the needs of patients with complex medical issues however this information was not always communicated to the GPs.
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Families, children and young people:

- We found there were systems 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 accident and emergency (A&E) attendances. However, a single process was not in use and staff were not always certain of how this was achieved.
- We were advised that all parents or guardians calling with concerns about a child were offered a same day appointment when necessary. However, a comment from a patient indicated this was not always the case.

Working age people (including those recently retired and students):

- The needs of this population group had been identified and clinics were run between 8am and 8pm. There were also nurse-led clinics available from 7am at two of the branch surgeries. The provider also indicated that patients could move between branch surgeries to see any doctor. The frequency of this happening was not reviewed.
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People whose circumstances make them vulnerable:

- The practice had systems in place that could record and develop a register of patients living in vulnerable

Are services responsive to people's needs?

circumstances including homeless people, travellers and those with a learning disability. Information was gathered about the number of people with a learning disability. The provider stated that there were no travellers or people with no fixed abode registered with practice.

People experiencing poor mental health (including people with dementia):

- Some nursing staff and clinicians interviewed understood how to support patients with mental health needs and those patients living with dementia.
- GP led dedicated monthly mental health and dementia clinics were held at some but not all branch surgeries. Patients who failed to attend were proactively followed up by a phone call from a GP.

Timely access to care and treatment

Patients were able to access most care and treatment from the practice within an acceptable timescale for their needs.

- Patients had timely access to initial assessment, test results, diagnosis and treatment and emergency appointments.
- Waiting times, delays and cancellations were minimal and managed appropriately.
- Patients with the most urgent needs had their care and treatment prioritised, many reported that the appointment on the day system was frustrating as by the time the phone was answered, all appointments for the day were taken.
- The practice's national GP patient survey results were in line with local and national averages for questions relating to access to care and treatment.
- Out of the patients who completed CQC questionnaires and comment cards 37 out of 104 felt they had to wait too long to see a GP of their choice. It was also noted that on occasion patients were expecting to see a GP but were treated by a nurse instead.

Listening and learning from concerns and complaints

- There was no overarching and established system to receive, manage or review verbal or written complaints or comments from all the branches. The provider reported that only five complaints had been made by the 27,317 patients who used the service. Posters about how to make a complaint lacked detail and were not available at all practices. Patient information leaflets about the complaints procedure or what to expect when a complaint was made were not readily available. The complaint policy however, had been recently updated and was in line with recognised guidance.
- The provider had not ensured all staff had a common understanding of what constituted a complaint and how to deal with and escalate verbal and written complaints or comments.
- Complaints records indicated these were fully investigated, the outcomes and learning were shared with the complainant, the staff involved and partner agencies as required.

Please refer to the evidence tables for further information.

Inadequate

Are services well-led?

We rated the practice as inadequate for providing a well-led service.

The practice was rated as inadequate for providing a well-led service because findings did not demonstrate sufficient and credible processes in place to ensure high quality leadership, management and governance of the service overall and the branch surgeries at a local level.

Leadership capacity and capability

- Leaders were not knowledgeable about issues and priorities relating to the quality and future of the services. Leaders did not understand the challenges of providing services to 27,317 patients spread over one main and five branch surgeries and so were not addressing them.
- Leaders did not attend the branch surgeries on a regular basis.

Vision and strategy

The service did not have a clear vision and credible strategy to deliver high quality, sustainable care.

- There was a mission statement and some staff understood this, however they did not know how this would be achieved or the role they and their colleagues would play.
- A business plan had been recently developed, the information was rudimentary and was not in line with health and social care priorities for the region. Strategies and plans to deliver the business plan were not in place.

Culture

The practice did not have a culture of high-quality sustainable care.

- All staff stated they felt respected, supported and valued in their day to day roles, places of work and individual practices. Some staff also stated they were not always listened to by the leaders of the practice in relation to improving the quality of care for patients. Some staff stated there was an emphasis on activities suggested by commissioners only but not concerns specific to the needs of the population in a particular area.
- Some administrative and nursing staff who worked in the branch surgeries, felt isolated from the head-office, they felt unsupported in relation to ensuring and maintaining good outcomes for patients, support for the general running of the service and accessing training and opportunities for personal development.
- Staff stated, however, that they were proud to work in the practice and it was evident that staff focused on the needs of patients.
- Insufficient processes were in place for providing staff with the development opportunities they needed. Nursing staff interviewed confirmed they were given protected time to attend training provided by the commissioning agency and the practice nurses met however they also stated they had to complete several additional courses in their own time. Formal systems were not in place to ensure nurse clinicians and newly employed GPs received the supervision and additional mentoring they may require.
- Staff had received equality and diversity training and some staff stated they felt able to raise concerns but did not always feel listened to when they did so.
- The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour, and evidence indicated that this was upheld as appropriate.

Governance arrangements

The provider had not established individuals and teams with clearly defined and appropriate responsibilities, roles and systems of accountability to support good governance and management for the service.

- The structures, processes and systems did not have the breadth to support good governance and management of the service and were not sufficient to promote a safe and effective service for 27,317 patients. The leadership team did not know or have oversight of how the services were running day to day.
- Staff were not clear on their roles and accountabilities for example in respect of infection prevention and control and responding to medical emergencies.
- Practice leaders had introduced policies, procedures and activities to promote safety but they did not assure themselves that they were operating as intended in all branch surgeries.

Managing risks, issues and performance

Inadequate

Are services well-led?

Processes for managing risks, issues and performance were unclear and processes to ensure and monitor how well the branch surgeries linked in with the leadership at head office were not established.

- Process to identify, understand, monitor and address current and future risks including risks to patient safety were not well developed.
- Practice leaders did not have oversight of safety alerts, incidents, and complaints.
- There was minimal evidence of action taken to change practice as a result of audits completed by the practice. Incidents and complaints had not been reviewed to identify possible trends and there had been a minimal number of complaints and concerns reported.
- The practice had business contingency plans in place but had not trained staff for major incidents. The plans we viewed did not contain contact details for leaders, utilities of organisations associated with running the service or the contact details of the head office, branches practices, other local practices or the local commissioning body who may assist in such circumstances.

Appropriate and accurate information

The practice did not collect sufficient information.

- The practice did not collect information about how the practice performed in relation to the daily running of the service. Compliance with policies and procedures was not monitored.
- There was no evidence that newly introduced policies and procedures were shared with and understood by staff.
- Meeting notes indicated that local team meetings took place, however these occurred sporadically and information was not shared between the branch surgeries.
- The practice submitted clinical data to external organisations as required.
- The arrangements were in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

Engagement with patients, the public, staff and external partners

The practice involved external partners to try to support high-quality sustainable services. The involvement of patients was limited considering the number of patients.

- There was an active patient participation group (PPG) at the main practice however patients who used the branch surgeries were not well represented. The practice had responded to suggestions made by PPG members.

Continuous improvement and innovation

There was limited evidence of systems and processes for learning, continuous improvement and innovation.

- The provider did not always demonstrate the skills to ensure established improvement methods were used, for example staff were not expected to use best practice guidance for the care and treatment of patients; policies and procedures such as the induction process were not always robust, and the provider had not developed audits to support staff compliance with policies and procedures.
- Processes to ensure effective communication between branch surgeries and the head office had not been established.
- Leaders and managers did not routinely provide information to staff about individual and team objectives, processes and performance.

Please refer to the evidence tables for further information.

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 the service provider was not meeting. The provider must send CQC a report that says what action it is 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 10 HSCA (RA) Regulations 2014 Dignity and respect How the regulation was not being metThe provider had not taken sufficient action to ensure the privacy of patients was maintained at all times.Patients told us that administration staff at time were not mindful of privacy issues.Inspectors observed instances when confidential information could be heard in public areas.The provider had not acted promptly to resolve all the privacy issues identified.Regulation 10 (1)(2)(a)

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment How the regulation was not being metThe nurse clinicians spoken with did not have a clear and detailed understanding of the mental capacity act 2005 and the deprivation of liberty safeguards.Nurse clinicians had not completed training or been supervised or mentored when working with patients who may need additional assessments and consideration to ensure care and treatment is provided lawfully.Systems were not in place to ensure nurse clinicians did not admit patients who lived in the local care home into hospital without first reviewing the patients' legal or mental status.Consent to care and treatment was not monitored.Regulation 13 (5)

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints

This section is primarily information for the provider

Requirement notices

Treatment of disease, disorder or injury	How the regulation was not being metThe provider did not have an effective system for identifying, receiving, recording, handling and responding to complaints by people who used the service.Regulation 16 (2)

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing How the regulation was not being metSystems were not in place to ensure all staff receivedspecialist and induction training to prepare them for their roles.appropriate mentoring and supervision to carry out continually carry out their role effectively.Regulation 18 (2)

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 metDisclosure and barring checks had not been completed for staff worked as chaperones.The provider had not ensured all the information specified in Schedule 3 was held and readily accessible.Regulation 19 (2)(a) (3)(a)

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

The table below shows the legal requirements that the service provider was not meeting. The provider must send CQC a report that says what action it is going to take to meet these. We took enforcement action because the quality of healthcare required significant improvement.

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 **Notice of decisionRegulation 12**

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment **Notices of DecisionRegulation 15**

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 **Warning NoticeRegulation 17 (1) (2) (a)(b)**