Droylsden Road Family Practice

Quality 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 service	Inadequate
Are services safe?	Requires improvement
Are services effective?	Inadequate
Are services caring?	Inadequate
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 Droylsden Road Family Practice on 21 October 2016. Overall the practice is now rated as inadequate.

The practice had previously been inspected on 8 March 2016. Following this inspection the practice was rated inadequate with the following domain ratings:

Safe – Inadequate

Effective – Inadequate

Caring – Inadequate

Responsive – Inadequate

Well-led – Inadequate

The practice provided us with an action plan detailing how they were going to make the required improvements. In addition, they wrote to us with updates on progression and actions that had been addressed.

A focused inspection took place on the 5th & 7th July 2016, to check that the practice had followed their submitted plan and to confirm that they now met legal requirements with the premises.

Following this re-inspection on 21 October 2016, our key findings across all the areas we inspected were as follows:

- Systems were still at a very early stage of development and had not been fully embedded throughout the practice. A large number of policies had been introduced or were at final review stage awaiting sign off; therefore the impact of their effectiveness could not be fully assessed.
- Patients were at risk of harm because clinical systems and processes were not fully embedded to keep them safe. For example no care plans were in place, this had been previously identified in the March 2016 inspection.
- Patients test results and hospital admissions follow ups were not actioned by clinicians in a consistent way

Summary of findings

with no clear process to ensure patient safety. We identified patients who had not received information regarding the outcome of their test results from several weeks previously.

- Patients were at risk of harm because of serious inconsistencies in the quality of recordings of consultations between clinicians. For example, a significant long term condition had not been documented in the record of one patient.
- Patient's referrals were not being processed in a timely manner after consultation.
- Repeat prescriptions, medication reviews and re authorisation checks were not always actioned appropriately by the clinical staff. Administrative staff were given permission to issue prescriptions even if the review dates were overdue.
- The practice did not have a system in place to ensure that all clinical staff, including locum GP'S were kept up to date. The practice did not disseminate NICE guidelines or monitor that they were being followed. Medical alerts were not disseminated and there was no record that they had been actioned appropriately.
- Improvements to cleanliness and hygiene of the premises had been made in that, patient areas were visibly clean and tidy.
- Information for patients was more readily available on the new website. This now provided patients with the opportunity to access services online.
- The practice had a newly formed patient participation group (PPG) and a notice board in the reception area which provided feedback to patients about how the practice had responded to patient concerns and the improvements made.
- The provider was aware of and complied with the requirements of the duty of candour.

The practice did not provide safe or effective care to patients, we found clinical areas where the provider must make improvements, these areas are:

- The provider must ensure that all clinicians undertake care planning for all at risk patients.
- The provider must develop a process to ensure that all clinicians respond in a timely manner to patients changing needs, including clinical reviews on hospital admissions, hospital discharges and patients with a long term condition.
- The provider must ensure all patients' referrals are actioned within a timely manner.
- The provider must introduce a procedure to ensure all patients test results are followed up and actioned in a timely manner and in a consistent and timely way to ensure patient safety.
- The provider must ensure patient's consultations notes are up to date, with consultation notes containing adequate patient information to be clear and precise relevant medical information to protect the patient from future risk of harm.
- The provider must follow the prescribing policy and procedure for reviewing and re-authorising repeat medication in a safe and timely manner.
- The provider must have a process to disseminate NICE guidelines and medical alerts to all clinical staff, including locums and keep an auditable trail of any actions taken.

The areas where the provider should make improvement are:

- Follow practice policy when recruitment checks are carried for all new staff.
- Add the full address of the Parliamentary and Health Service Ombudsman(PHSO) in the complaints policy and the patients information leaflet.
- Maintain the new governance systems to ensure integrated fully into the practice**.**
- Provide all staff with an annual review and appraisal**.**
- Review and increase the numbers of carers on the practices carers register.
- Continually monitor and maintain the appointment system.

Enforcement action was taken against the provider on the 8th November 2016, when we issued an urgent notice of decision to immediately suspend their registration as a service provider (in respect of all regulated activities for which they are registered) for a period of three months. We took this action because we believed that a person would or might be exposed to the risk of harm if we did not take this action.

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?

Requires improvement

When we inspected Droylsden Road Family Practice in March 2016 we found the practice did not have systems in place to keep patients safe. At this follow up inspection we found the practice had made improvements to the cleanliness of the premises and removed all risk hazards.

However, the practice is rated as requires improvement for providing safe services, as there remained some concerns.

- Repeat prescription medication reviews and re authorisation checks were not always actioned fully by clinicians. Staff were given permission to issue the prescription including when the patient had not attended for a medication review which was overdue.

We saw some examples of improving practice:

- There was a new system in place for reporting and recording significant events.
- Previous concerns relating to fire safety had been addressed and the practice now complied with current fire regulations.
- Previous concerns relating to arrangements to deal with infection control and health and safety had been improved. Clear records of checks were recorded.
- Previous concerns relating to arrangements to high risk medicines had improved with all high risk medicines being monitored by the clinicians.

Are services effective?

Inadequate

When we inspected Droylsden Road Family Practice in March 2016 we found the practice did not have effective systems in place. At this follow up inspection we found the practice had made improvements to the following areas:

- Staff were working through all outstanding patient records that needed to be summarised.
- Staff had received multiple formal training and clinical staff had completed safeguarding level three.
- Clinicians had started a programme of clinical audit cycles.

However there were major safety concerns identified within the clinical aspect in the delivery of patient care, which had still not been addressed. For example,

Summary of findings

- The practice did not complete personalised care plans for patients. Clinicians did not understanding the importance of recording patient's individual needs and preferences. We were told this was an enhanced service they did not want to provide.
- Patients test results and hospital admissions follow ups were not actioned by clinicians in a consistent way with no clear process to ensure patient safety.
- There were serious inconsistent in the quality of patients consultations recorded by clinicians.
- There was an inconsistence response from clinicians on the review of relevant and current evidence based clinical guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines.

Are services caring?

Inadequate

The practice is rated as inadequate for providing caring services.

- Data from the national GP patient survey showed patients rated the practice below others for several aspects of care.
- Patients we spoke with during the inspection gave mixed responses to questions about the care they received.
- 72% of patients said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 83% and the national average of 85%.
- Information for patients about the services available was easy to understand and accessible.
- Some of the GPs were bi-lingual and were able to communicate with patients in several languages.
- The patient participation group (PPG) spoke highly of the care and support given by the practice.

Are services responsive to people's needs?

Requires improvement

When we inspected Droylsden Road Family Practice in March 2016 we found the practice did not respond to people's needs. At this follow up inspection we found the practice had made improvements to the standards of cleanliness and hygiene of the practice had improved. Multiple hazards in the patients waiting area and treatment rooms had been addressed.

- Most patients said they found it easy to make routine appointments.
- There was a new practice website offering online services and text reminders services for patients.

Summary of findings

- The practice had updated their facilities and was equipped to treat patients and meet their needs, for example there had been improvements to the access into the building for disabled patients.
- Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.

Are services well-led?

Inadequate

When we inspected Droylsden Road Family Practice in March 2016 we found the practice did not have well led systems in place. At this follow up inspection we found the practice had made improvements. The practice employed a locum practice manager to develop and introduce a new governance system. A mission statement and values had been developed and a newly formed patient participation group (PPG) had been set up.

However, we identified major safety concerns in the clinical aspect of the practice.

- The practice had a number of new policies and procedures to govern activity and had started to hold governance meetings; this structure was still too new to establish the full effectiveness throughout the practice.
- We found clinicians were not competent in accessing the new administration system where the clinical protocols were stored.
- Arrangements for monitoring clinical risks were not in place, both GP partners showed inadequate surveillance of their own workflows of patients test results. We identified serious concerns where patients had not been informed of the outcomes of test results and actions had not been taken on abnormal results that had been taken several weeks before.
- Staff had not received an annual review or appraisal. We were told all staff recently had their job descriptions and contract of employment updated; therefore no appraisals would be done until these had been signed.
- The provider was aware of and complied with the requirements of the duty of candour. The partners encouraged a culture of openness and honesty.
- The practice had systems in place for notifiable safety incidents and ensured this information was shared with staff to ensure appropriate action was taken
- The practice proactively sought feedback from staff and patients, which it acted on. The newly patient participation group (PPG) were active.

Summary of findings

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.

This is because the concerns identified in relation to how effective, caring and well led the practice was impacted on all population groups.

- It was responsive to the needs of older people, and offered home visits and urgent appointments for those with enhanced needs.
- Longer appointments and home visits were available for older people when needed.
- The percentage of patients with COPD who had a review undertaken including an assessment of breathlessness using the Medical Research Council dyspnoea scale in the preceding 12 months (01/04/2014 to 31/03/2015) was 64% which was lower than the national average of 89.9%.

People with long term conditions

Inadequate

The practice is rated as inadequate for the care of people with long-term conditions.

This is because the concerns identified in relation to how effective, caring and well led the practice was impacted on all population groups.

- Longer appointments and home visits were available when needed.
- The practice nurse was responsible for the management of patients with long term conditions.
- 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(01/04/2014 to 31/03/2015) was 63% which was lower than the national average of 78%.

Families, children and young people

Inadequate

The practice is rated as inadequate for the care of families, children and young people. This is because the concerns identified in relation to how effective, caring and well led the practice was impacted on all population groups.

- Appointments were available outside of school hours and the premises were suitable for children and babies.

Summary of findings

- The premises were suitable for pushchairs to access.
- 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 three routine clinical practice (RCP) questions. (01/04/2014 to 31/03/2015) was 74% compared to the national average of 75%.

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). This is because the concerns identified in relation to how effective, caring and well led the practice was impacted on all population groups.

- The surgery was part of the GP Access scheme offering extended hours and weekend appointments to patients.
- Telephone consultations were available for patients that required them.
- NHS Health checks were available to this population group.

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. This is because the concerns identified in relation to how effective, caring and well led the practice was impacted on all population groups.

- The practice held a register of patients living in vulnerable circumstances including those with a learning disability.
- Staff knew how to recognise signs of abuse in vulnerable adults and children.

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). This is because the concerns identified in relation to how effective, caring and well led the practice was impacted on all population groups.

- The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive, agreed care plan documented in the record, in the preceding 12 months (01/04/2014 to 31/03/2015) was 59% which was lower than national average of 88.4%.

Summary of findings

- There was no system in place to follow up patients who had attended accident and emergency (A&E) where they may have been experiencing poor mental health.
- The percentage of patients diagnosed with dementia whose care had been reviewed in a face-to-face review in the preceding 12 months (01/04/2014 to31/03/2015) was 77% which was lower than national average of 84%.

Summary of findings

What people who use the service say

The national GP patient survey results were published in July 2016. The results showed the practice was performing in line with local and national averages. 284 survey forms were distributed and 100 were returned. This represented 2% of the practice's patient list.

- 75% of patients found it easy to get through to this practice by phone compared to the national average of 73%.
- 72% of patients were able to get an appointment to see or speak to someone the last time they tried compared to the national average of 76%.
- 70% of patients described the overall experience of this GP practice as good compared to the national average of 85%. This had decreased by 10 % from March 2016.
- 56% of patients said they would recommend this GP practice to someone who has just moved to the local area compared to the national average of 79%. This had decreased by 20 % from March 2016.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection.

We received 22 comment cards which were all positive about the standard of care received and had a common theme relating to the cleanliness of the practice. One card stated that one doctor in the practice did not listen to what you have to say. Another stated the staff had now become more friendly towards them. One patient was not happy due to some services being removed from the practice and now having to travel to have a blood test or injection.

We spoke with six patients during the inspection. Two patients we spoke to were happy with the care they had received. Two patients felt worried to talk to us and told us they felt they would be treated differently if they were seen discussing the practice with the inspection team. Another patient told us they were going to seek another practice until the practice appointed a long term locum doctor. One patient felt one certain GP was rude and felt it was a waste of time attending. All patients stated they had seen an improvement in the cleanliness and hygiene of the practice.

The practice took part in the friends and families test.

Areas for improvement

Action the service MUST take to improve

The practice did not provide safe or effective care to patients, we found clinical areas where the provider must make improvements, these areas are:

- The provider must ensure that all clinicians undertake care planning for all at risk patients.
- The provider must develop a process to ensure that all clinicians respond in a timely manner to patients changing needs, including clinical reviews on hospital admissions, hospital discharges and patients with a long term condition.
- The provider must ensure all patients' referrals are actioned within a timely manner.
- The provider must introduce a procedure to ensure all patients test results are followed up and actioned in a timely manner and in a consistent and timely way to ensure patient safety.
- The provider must ensure patient's consultations notes are up to date, with consultation notes containing adequate patient information to be clear and precise relevant medical information to protect the patient from future risk of harm.
- The provider must follow the prescribing policy and procedure for reviewing and re-authorising repeat medication in a safe and timely manner.
- The provider must have a process to disseminate NICE guidelines and medical alerts to all clinical staff, including locums and keep an auditable trail of any actions taken.

Action the service SHOULD take to improve

The areas where the provider should make improvement are:

- Follow practice policy when recruitment checks are carried for all new staff.

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- Add the full address of the Parliamentary and Health Service Ombudsman(PHSO) in the complaints policy and the patients information leaflet.
- Maintain the new governance systems to ensure integrated fully into the practice.
- Provide all staff with an annual review and appraisal.
- Review and increase the numbers of carers on the practices carers register.
- Continually monitor and maintain the appointment system.

Droylsden Road Family Practice

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector**.** The team included a GP specialist adviser, and a practice manager specialist adviser.

Background to Droylsden Road Family Practice

Droylsden Road Family Practice is located on the outskirts of Manchester and is part of North Manchester Clinical Commissioning Group (CCG).

The practice is in a highly deprived area which sees higher than average health problems in chronic obstructive pulmonary disease (COPD- name for a collection of lung diseases), drug and alcohol addiction and a range of mental health issues.

The male life expectancy for the area is 73 years compared with the CCG averages of 73 years and the national average of 79 years. The female life expectancy for the area is 79 years compared with the CCG averages of 78 years and the national average of 83 years. The practice is in the most deprived decile.

The practice is based in a large two storey house. On the ground floor there was an entrance and reception area with a large waiting area. All the consulting rooms are located on the ground floor with two further smaller waiting areas.

The practice has two GP partners (one male and one female), with one practice nurse. Members of clinical staff are supported by one practice manager and administrative staff.

The practice is open from 8am until 6:30pm Monday, Tuesday, Thursday and Friday and Wednesday 8am until1pm. Appointments times are between 9am and 6pm.

The practice has a General Medical Service (GMS) contract with NHS England. At the time of our inspection 4715 patients were registered.

Patients requiring a GP outside of normal working hours are advised to call " Go-to- Doc" using the usual surgery number and the call is re-directed to the out-of-hours service. The surgery were part of the GP Access scheme offering extended hours and weekend appointments to patients.

Why we carried out this inspection

We first carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008, on 8 March 2016, as part of our regulatory functions. That inspection found that the practice was not meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

We also attended the practice to monitor conditions imposed in July 2016, to check regulation 15 relating to the premises and cleanliness had been implemented.

Detailed findings

This most recent inspection was a comprehensive inspection, carried out on 21 October 2016, and was undertaken to assess the progress the practice had made to meet the regulations and to provide an updated rating for the service under the Care Act 2014.

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 21 October 2016.

During our visit we:

- Spoke with a range of staff including two GPs, a practice nurse and reception staff.
- Also spoke with six patients who used the service and members of the patient participation group (PPG).
- Reviewed comment cards where patients and members of the public shared their views and experiences of the service.
- Reviewed a number of policies and processes.

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.

Requires improvement

Are services safe?

Our findings

When we inspected the practice on 8 March 2016 there were a significant number of issues affecting the delivery of safe services to patients. At that time we rated the practice as inadequate.

There was no system in place for reporting and recording significant events. Staff had not been trained in safeguarding. There were no systems or processes in place to ensure patient safety regarding all high risk medicines, infection control and health and safety, COSHH and fire safety. The premises standard of cleanliness and hygiene were not maintained, we found the premises were dirty and cluttered with risks and hazards throughout.

The practice had hired a consultant who worked alongside the existing practice manager to support in the development and implementation of the new systems and policies.

During this inspection we found that improvements had been made in all these areas, but we identified new concerns.

Safe track record and learning

There was a new system in place for reporting and recording significant events.

- All the staff were aware of how to report a significant event and there was a recording form available on the practice's computer system.
- The incident process and reporting form supported the recording of notifiable incidents under the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).
- Initial incidents were discussed at practice meetings and were documented. We saw evidence of significant events being a standard agenda item at all practice meetings.
- The practice carried out an analysis of the significant events and we saw documented evidence of shared learning outcomes which enabled the practice to monitor any improvements made.
- One significant event reported by the clinicians raised serious safety concerns with the inspection team. Potential lifesaving treatment had not been identified and given to a child. This was due to a misunderstanding of commissioning restrictions imposed on the practice, not to provide invasive procedures in the practice. An invasive procedure is the use of an instrument or other objects into the body or body cavities.

We reviewed patient safety alerts and minutes of meetings where these were discussed. We saw evidence that lessons were shared and action was taken to improve safety in the practice.

Overview of safety systems and processes

The practice had recently implemented new systems, processes and practices to keep patients safe and safeguarded from abuse, which included:

- Arrangements were in place to safeguard children and vulnerable adults from abuse. These arrangements reflected relevant legislation and local requirements. Policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. There was a lead member of staff for safeguarding. The GPs attended safeguarding meetings when possible and reports where necessary for other agencies. Staff demonstrated they understood their responsibilities and all had received training on safeguarding children and vulnerable adults relevant to their role. GPs were trained to child protection or child safeguarding level three. One clinician had not completed training in the mental capacity act (MCA) and deprivation of liberty training (DoLS- which relate to people who are placed in care homes or hospitals for their care or treatment and who lack mental capacity.) We did receive the completed training certification where the GP had completed the online training after the inspection. The safeguarding lead was unaware they had completed the training in MCA and DoLS, on the day of the inspection we were told the attendance to complete this training was in November 2016; however this training was attended in January 2016.
- A notice in the waiting room advised patients that chaperones were available if required. All staff who acted as chaperones were trained for the role and had received a Disclosure and Barring Service (DBS) check. (DBS
- The practice maintained appropriate standards of cleanliness and hygiene. We observed the premises to be clean and tidy. A GP partner was the infection control

clinical lead and the practice nurse acted as the deputy. There was an infection control protocol in place and staff had received up to date training. There had been three infection control audits undertaken and we saw evidence that action was taken to address any improvements identified as a result. For example, all sharps bins were mounted on the wall. Staff had received training on infection control including hand hygiene training.

- The arrangements for managing medicines, including emergency medicines and vaccines, in the practice had been improved since the last inspection. New processes were in place for handling repeat prescriptions of high risk medicines. The practice carried out regular medicines audits, with the support of the local CCG pharmacy teams. Blank prescription forms and pads were securely stored and there were systems in place to monitor their use. Patient Group Directions (PGD) had been adopted by the practice to allow nurses to administer medicines in line with legislation.
- Processes for medical equipment ordering and storage had been developed and implemented. This included weekly treatment room checks and a full stock ordering check list. There was a nominated staff member with other staff trained to ensure continuity in the practice.
- The practice had newly introduced electronic prescribing for prescriptions. There were still a number of paper repeat prescriptions being issued. Staff told us if the medication review or reauthorisation checks were out of date on any prescription, they would not issue any prescriptions before highlighting this with a clinician. Staff were then given instructions from the clinician on the issuing of the prescription. We reviewed a sample of the repeat prescriptions awaiting collection; we identified six patients whose medication reviews were overdue, with dates ranging from one month to 2006 with no evidence that these had been reviewed by a clinician.
- Since the last inspection a new recruitment policy had been developed and adopted into the practice. We found this was not followed fully in the recent employment of two new members of staff. For example, we found no interview notes had been used and only one reference had been sourced. There was no record of proof of identity held in in the new members of staff records. We also identified that one long term locum had no DBS (Disclosure and Barring Service) check in place.
- The provider was aware of and complied with the requirements of the Duty of Candour. The partners encouraged a culture of openness and honesty. The practice had systems in place about notifiable safety incidents.

Monitoring risks to patients

- Regular risk assessments and fire drills were carried out by the practice manager.All electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly. The practice had a variety of other risk assessments in place to monitor safety of the premises such as control of substances hazardous to health (COSHH) and legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings).
- We found new fire safety arrangements had been implemented by the practice manager. For example, the practice had new fire alarm control panel with fire checks taking place at different locations in the building as suggested by the fire brigade. New fire alarms and smoke detectors had been fitted and new fire signs were visible throughout the practice. There were fire wardens nominated within the practice and a record of a fire drill completed in the last six months.
- The practice manager had performed multiple risk assessments to monitor the safety of the premises such as cross infection, lone worker and exposure to hazards.
- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system in place for all the different staffing groups to ensure enough staff were on duty.

Arrangements to deal with emergencies and major incidents

The practice had adequate arrangements in place to respond to emergencies and major incidents.

- There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency.
- All staff received annual basic life support training and there were emergency medicines available in the treatment room.

Requires improvement

Are services safe?

- The practice had oxygen with adult and children's masks. A first aid kit and accident book were available. The practice had no defibrillator but had an adequate risk assessment in place.
- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and stored securely.

The practice had a comprehensive business continuity plan in place for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff.

Inadequate

Are services effective?

(for example, treatment is effective)

Our findings

When we inspected the practice on 8 March 2016 there were a significant number of issues affecting the delivery of effective services to patients. During this follow up inspection we found some improvements had been made in these areas such the practice implemented a plan and started to summarise all the outstanding patient records. Staff had received formal training, for example in infection control, health and safety and safeguarding. The clinical staff had completed safeguarding level three training. Clinicians had carried out the first of two stage clinical audit cycles.

However there were major safety concerns within the clinical areas which had still not been addressed. For example, there was still no patient care planning or patient profiling taking place for patients. There was no clear process for managing and actioning patient test results. No formal system for dealing with the receipt of NICE guidance and medical alerts between clinicians.

Effective needs assessment

We received an inconsistent response from clinicians on the review of relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines. One clinician told us they had not received any updates by emails or any other source and were not aware of any recent updates or actions taken.

- The practice had no system in place to keep all clinical staff up to date. One clinician told us they would access the guidelines from NICE via google internet and they used this information to deliver care and treatment that met peoples' needs.
- There was no system to disseminate medical alerts to clinicians, including regular locums.
- The practice had no monitored process that these guidelines were followed through risk assessments, audits and random sample checks of patient records.

Management, monitoring and improving outcomes for people

We reviewed five anonymised patient records to corroborate the improvements the practice told us they had made we found serious inconsistencies between clinicians in the quality of recordings of consultations. For example :

- In one record there was no record of a significant long term condition documented.
- Medical coding was limited or missing in some of the records.
- Records of examinations were not detailed enough.
- We identified one patient where there was an inappropriate referral to secondary care and medication stopped and restarted without clear documented methodology of reasoning.

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 were 75% of the total number of points available, with 3.7% exception reporting. (Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects).

Data from 2015/16 published after the inspection shows the practice has increased the Quality and Outcomes Framework (QOF) from 2014/15 figures.

This practice was not an outlier for any QOF (or other national) clinical targets. Data from 2014/15 showed:

- The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 64% mmol/mol or less in the preceding 12 months (01/04/2014 to 31/03/2015) was 58% lower than CCG average of 72% and national average of 78% % with an exception rate of 3%.
- The percentage of patients with hypertension in whom the last blood pressure reading measured in the preceding 12 months is 150/90mmHg was 62% lower than CCG average of 81% and national average of 84 % with an exception rate of 1%.

There was evidence of clinical audits that had been initiated by the practice.

- There had been one full clinical audit completed in the last seven months. This was to review clinicians who

were not acting on the Quality Outcome Framework (QoF) clinical action prompts in the clinical IT system. The first audit identified no locums were actioning the prompts during consultations. The second audit showed 100% improvement in locum's actioning these prompts, but also showed a 33% decrease from one of the GP partners.

- There were three audits in progress. One we were shown was to identify patients who had Atrial fibrillation (AF) – which is a common heart rhythm disorder associated with debilitating consequences including heart failure and stroke. This was not written up but we were shown by the clinician the process to start reviewing 14 patients identified from the audit.
- One clinician told us they had completed a Vitamin B12 audit, vitamin B12 is given when your body is deficient in this vitamin. We asked to see a copy of the audit and we were told by the clinician they could not find it, then the clinician told us they had not undertaken this audit.

Effective staffing

Staff had the skills and experience to deliver effective care and treatment.

- The practice had an induction programme for all newly appointed staff. This covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality.
- Staff administering vaccines and taking samples for the cervical screening programme had received specific training which had included an assessment of competence.Staff who administered vaccines could demonstrate how they stayed up to date with changes to the immunisation programmes, for example by access to on line resources and discussion at practice meetings.
- Staff received training that included: safeguarding, fire safety awareness, basic life support and information governance. Staff had access to and made use of e-learning training modules and in-house training.
- No staff had received an annual appraisal. We were told this was due to the practice issuing new contracts of employment and new job descriptions to all staff. Once these were signed and in place the practice would set objectives and appraise the staff accordingly.

Coordinating patient care and information sharing.

We found multiple safety concerns in the delivery of effective care and treatment to patients. The full information needed to plan and deliver care and treatment was not always completed fully or actioned in patient records.

Documented care plans had not been developed for patients in any areas of care. This was also identified in the inspection which took place in March 2016. For example :

- There was no care planning taking place around planned and unplanned hospital admission and long term conditions such as Dementia or Asthma. Both GP partners told us they do provide formalised care plans for patients. One GP further stated that care plans were not a part normal care but more an enhanced service, which they do not provide.
- No clinical reviews were taking place of patients who have been discharged from hospital or who had attended accident and emergency.
- No documented care plans had been developed by the practice for patients who were at end of life. We did see meetings had taken place with external organisations however these were not documented formerly.

The practice were unable to ensure patient safety as there were no clear system in place to action hospital discharge letters or patients test results appropriately or in a timely manner and referrals were not being actioned. We reviewed the clinician's workflow system, which is where any test results are filed electronically for a clinician to action, file and code appropriately, we found;

- 77 reports were outstanding and awaiting action, 34 of which had an abnormal result.
- One clinician's workflow showed 23 results were outstanding with 17 showing as abnormal dating back to September 2016.
- We saw one patient's results that were abnormal, the patient had recently been seen by a clinician and the abnormal result had not addressed in the consultation.
- We identified where a patient significant abnormality on an x-ray carried out in September 2016 which related to an injury and the patient had not been informed of the outcome of these results.
- We identified 30 test results dating back to August 2016, which had been filed under the name of a clinician, who previous worked at the practice. None of these results had been reviewed or actioned, with some files showing abnormal results.

Inadequate

Are services effective?

(for example, treatment is effective)

- Although clinical meetings were in place, they were not yet fully embedded into the practice.
- Patient's referrals were not being processed in a timely manner after consultation with the GPs.

Consent to care and treatment

Staff sought patients' consent to care and treatment in line with legislation and guidance.

- 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, staff carried out assessments of capacity to consent in line with relevant guidance.
- Where a patient's mental capacity to consent to care or treatment was unclear the GP or practice nurse assessed the patient's capacity and, recorded the outcome of the assessment.
- The process for seeking consent was monitored through patient records audits.

Supporting patients to live healthier lives

The practice nurse identified patients who may be in need of extra support. For example:

- Those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation. Patients were signposted to the relevant service.

The practice's uptake for the cervical screening programme was 69%, which was lower than the CCG average of 77% and the national average of 82%. There was a policy to offer telephone reminders for patients who did not attend for their cervical screening test.

Since April 2016 the practice no longer offered invasive services such as cervical screening or immunisations along with any intra-muscular injection, implants and phlebotomy services to patients. These services were removed by the clinical commissioning group (CCG). Patients attend an alternative clinic.

The practice uptake for national screening programmes for bowel and breast cancer screening showed that during 2014/15 the take up of breast screening by practice patients in the preceding three years had been lower than average at 52% (CCG 57% and national average 72%). The take up by patients eligible for bowel cancer screening in last 30 months was 45% which was better than the CCG average of 44% and below the national average of 58%.

Childhood immunisation rates for the vaccinations given were comparable to CCG and national averages For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 87% to 95% and five year olds from 74% to 98%.

Patients had access to appropriate health assessments and checks. These included health checks for new patients and NHS health checks for patients aged 40–74. Appropriate follow-ups for the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.

Inadequate

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.
- Reception staff knew when patients wanted to discuss sensitive issues or appeared distressed.

We received 22 comment cards which were mainly positive; however there were some negative comments, about the standard of care received. A common theme related to the cleanliness and improved hygiene within the practice. One card stated one of the doctors in did not listen to what you have to say but overall felt the practice was fine. Another stated the staff had now become more friendly towards them. One patient had not been happy due to services being removed from the practice and having to travel to have a blood test or injection but had no problem previously.

We spoke with six patients during the inspection. Two patients we spoke to were happy with the care they had received. Two patients felt worried to talk to us and told us they felt they would be treated differently if they were seen discussing the practice with the inspection team. Another patient told us the only reason they had not left the practice, was because of the newly appointed long term locum doctor. One patient felt one certain GP had been rude and felt it was a waste of time attending.

We spoke with three members of the newly established patient participation group (PPG). They also told us they were satisfied with the care provided by the practice.

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

- 88% of patients said they had confidence and trust in the last GP they saw compared to the clinical commissioning group (CCG) average of 94% and the national average of 95%.
- 72% of patients said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 83% and the national average of 85%.
- 75% of patients said the GP gave them enough time compared to the CCG average of 84% and the national average of 87%.
- 78% of patients said the GP was good at listening to them compared to the CCG average of 87% and the national average of 89%.
- 81% of patients said they found the receptionists at the practice helpful compared to the CCG average of 87% and the national average of 89%.

Care planning and involvement in decisions about care and treatment

Most patients told us they felt involved in decision making about the care and treatment they received. However not all patients felt listened to by clinical staff. They did feel they 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 had mixed responses.

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

- 74% of patients said the last GP they saw was good at explaining tests and treatments compared to the national average of 86%.
- 66% of patients said the last GP they saw was good at involving them in decisions about their care compared to the national average of 82%.
- The practice provided facilities to help patients be involved in decisions about their care:
- Staff told us that 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.

Patient and carer support to cope emotionally with care and treatment

Inadequate

Are services caring?

Patient information leaflets and notices were available in the patient waiting area which told patients how to access a number of support groups and organisations.

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 43 patients as carers (less than 1% of the practice list).Written information was available to direct carers as a notice in the reception area.

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

When we inspected the practice on 8 March 2016 there were a significant number of issues affecting the delivery of responsive services to patients. During this inspection we found improvements had been made in these areas such as the standards of cleanliness and hygiene of the practice had improved. Multiple hazards in the patients waiting area and treatment rooms had been addressed.

Responding to and meeting people's needs

The practice engaged with the Clinical Commissioning Group (CCG) to work on identified improvements to patient services and also:

- Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice.
- Same day appointments were available for children and those patients with medical problems that require same day consultation.
- There were disabled facilities, a hearing loop and translation services available.
- There was a website and online services and text reminders services for patients
- The practice was also part of GP access scheme offering extended hours and weekend appointments to patients. In conjunction with other practices it offered extended opening times for patients.

Access to the service

The practice was open from 8am until 6:30 pm Monday, Tuesday, Thursday and Friday. On Wednesdays they opened from 8am until 1pm. Appointments times were between 9am and 6pm. The surgery were part of the GP Access scheme offering extended hours and weekend appointments to patients. In addition to pre-bookable appointments that could be booked up to four weeks in advance, urgent appointments were also available for people that needed them.

We did review one complaint in relation to patient's access to clinical services raised concerns with the inspection team. The complaint related to the lack of appointments after 4.40pm during the month of June 2016 .This was due to all the clinicians finishing clinics early for personal reasons. The practice identified in the future they must find suitable cover.

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.

- 67% of patients were satisfied with the practice's opening hours compared to the national average of 79%.
- 75% of patients said they could get through easily to the practice by phone compared to the national average of 73%.

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

The practice had a system in place to assess:

- whether a home visit was clinically necessary; and
- the urgency of the need for medical attention.

In cases where the urgency of need was so great that it would be inappropriate for the patient to wait for a GP home visit, alternative emergency care arrangements were made. Clinical and non-clinical staff were aware of their responsibilities when managing requests for home visits.

Listening and learning from concerns and complaints

The practice had an effective 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 full address of the Parliamentary and Health Service Ombudsman (PHSO) was not included in the policy or on the practice leaflet.
- There was a designated responsible person who handled all complaints in the practice.
- We saw that information was available to help patients understand the complaints system.

We looked at ten complaints received in the last seven months and found these were satisfactorily handled and dealt with in a timely way with openness and transparency.

Are services well-led?

Inadequate

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

Our findings

When we inspected the practice on 8 March there were a significant number of issues affecting the delivery of effective services to patients. At this latest inspection we found that although some improvements had been made there remained significant concerns about how the practice was being led. We identified major concerns with the overall clinical governance processes which meant that patients were not receiving a safe and effective service and their care was not being well managed. We found major concerns with the overall clinical accountability at the practice.

Vision and strategy

The practice had developed a mission statement which stated "we aim to ensure delivery of high quality, safe and effective general medical services".

- The practice displayed its new mission statement in the waiting areas and on the practice website.
- Staff understood the values and told the inspection team that it had been discussed as a practice.

Governance arrangements

The practice had recently introduced a new clinical governance framework; the practice had developed a large number of new policies and procedures to govern activity. Since the last inspection the practice had commissioned a consultant who worked alongside the existing practice manager, to introduce a non-clinical process and implement the new clinical governance system.

These systems were at a very early stage of development and had not been fully embedded throughout the practice. On the day of the inspection there was a number of policies newly introduced or at final review stage still awaiting sign off by the GP partners.

Arrangements for monitoring clinical risks were not in place, both GP partners showed inadequate monitoring of their own workflows of patients test results. We identified serious concerns where appropriate action had not been taken and patients test results had not been actioned, with patients not informed of the outcomes of these test results.

We found GP partners were not competent in accessing clinical protocols using the new system where all clinical protocols were filed. This had been introduced six weeks prior to our inspection. For example :

- We were told by the Diabetes lead they had been working on updating the Diabetes policy. We asked to see a copy of the policy, which could not be found in the new system. We asked to see the policy in the place prior to the new system being introduced but this request was declined.
- We asked one doctor to show us their Hypertension policy; this could not be identified during the interview. However later in the inspection this had been found and shown to the inspection team.
- There was a newly signed policy named "clinical protocols" which contained details for NICE guidance. On the day of the inspection, we found this had not been followed by clinicians.

We were told during the inspection the process for handling repeat prescription when a medication review was due. We found the administrative staff were following the correct procedure and informing the clinicians appropriately if the medication review was overdue. However clinicians were authorising repeat prescriptions to be issued where in some cases when they had passed the review date.

There was a staffing structure in place and staff were aware of their own roles and responsibilities. However, no staff had received an annual review or appraisal. We were told all staff recently had their job descriptions and contract of employment updated; therefore no appraisals would be done until these had been signed.

Leadership and culture

On the day of inspection the lead GP partners did not have the correct arrangements to manage the clinical performance of the practice to operate safely or effectively. They told us they prioritised safe, high quality and compassionate care; however we found serious concerns which did not align with what we were told. The GPs were visible in the practice but did not meet the requirements of the Health and Social Care Act. There were multiple issues and serious concerns identified that threatened the delivery of safe and effective care, which the practice had not identified or adequately managed.

Are services well-led?

Inadequate

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

The provider was aware of and had new systems in place to ensure compliance with the requirements of the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).

This included support training for all staff on the communication with patients about notifiable safety incidents. The practice had newly developed systems in place to ensure that when things went wrong with care and treatment they gave the affected people reasonable support, truthful information and a verbal and written apology.

There was a leadership structure in place and staff felt supported by management.

- Staff told us the practice had a newly developed programme where regular team meetings were held and we saw evidence of these meetings.
- Staff told us there had been many changes in the practice and they had the opportunity to raise any issues at team meetings and felt confident and supported in doing so.
- Staff said they felt supported, particularly by the practice manager in the practice.

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

The practice had taken measures to improve communication with patients. When we inspected the practice in March 2016 they did not have a patient participation group (PPG) or act on feedback from patients. Since that inspection a new PPG had been formed and had met once prior to this inspection. We spoke with three members on the day.

- Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management.

Continuous improvement

The practice were focussing on implementing the new clinical governance system and a range of new policies.

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 Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **How the regulation was not being met:** The registered person did not have personalised treatment and care plans in place to meet their patients individual needs or reflect their individual preferences. This was in breach of regulation 9 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **How the regulation was not being met:** The provider did not provide care and treatment in a safe way for service users. We found that relevant health concerns were not documented in the patient's records. We identified serious inconsistencies in the quality of the recording of patient's consultations with the delivery of care and treatment not responded to. For example, • Patients test results were not being regularly viewed or actioned by clinicians; we saw a number of patients abnormal test results that had not been appropriately actioned or were still outstanding • Patient's referrals were not being processed in a timely manner after consultation with the GPs. • A serious condition had not been documented by the GP partner in the patient's record. • The provider authorised repeat medicines without clear clinical checks prior to issue, to make sure patients

This section is primarily information for the provider

Requirement notices

were not placed at risk place. We reviewed a small sample of the repeat prescriptions awaiting collection, six patients were overdue a medication reviews with dates ranging between one month and back to 2006.
- The provider did not respond appropriately to a medical emergency, we reviewed a significant event relating to a child with suspected meningitis where lifesaving treatment was not given.

This was in breach of regulation 12 (1) (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services 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 read or implement relevant national recognised guidance, for example: • There were inconsistences on the process of how clinicians reviewed relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines. One clinician told us they had not received any updates by emails or any other source and was not aware of any recent r actions taken. The provider did not keep patient records relating to care and treatment fit for purpose. We identified patient information was not always up to date, accurate, complete and properly analysed or reviewed by clinicians.. For example : • We reviewed five patients' medical records and found these lacked quality clinical information. The provider clinical systems and processes were not fully established and did not operate effectively. For example:

This section is primarily information for the provider

Requirement notices

- Clinicians were not competent in accessing clinical protocols from a newly introduced system or from the old system, where all clinical protocols were filed on the computer system.
- Systems were at a very early development stage and had not been embedded fully throughout the practice on the day of the inspection. A number of policies newly introduced or at final review stage were still awaiting sign off; therefore the impact of effectiveness could not be assessed.

Regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

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 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 Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **A urgent notice to suspend all regulated activities was issued with immediate effect for three month, on the 8th November 2016 under Section 31 of the Health and Social Care Act 2008.**

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **A urgent notice to suspend all regulated activities was issued with immediate effect for three month, on the 8th November 2016 under Section 31 of the Health and Social Care Act 2008.**

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **A urgent notice to suspend all regulated activities was issued with immediate effect for three month, on the 8th November 2016 under Section 31 of the Health and Social Care Act 2008.**