# Dalston Medical Group

## 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.

# Summary of findings

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# Summary of findings

## Overall summary

Dalston Medical Group provided services from The Surgery. The Surgery provided a weekday service for over 5000 patients in the Carlisle area. The Surgery open Monday to Friday from 08:30 to 18:30 and had recently introduced appointments at 07:30 but the days this was available varied each week. The service was responsible for providing primary care, which included access to GPs, minor surgery, family planning as well as ante and post natal care. Cumbria Health on Call (CHOC) provided an out of hours service for patients who used the Surgery.

The patients we spoke with and who completed our comment cards were extremely complimentary about the care and treatment being provided. Patients reported that all the staff treated them with dignity and respect. They found the doctors and nurses had a good understanding of their needs.

We found that action was needed to improve the provider's involvement of patients in the development of the service.

We found that staff required appropriate training. Clinical governance processes needed to cover checking competency of clinicians. Recruitment procedures needed to be strengthened.

The arrangements for maintaining the building to a safe standard needed to be in place. The service was not cleaned to an appropriate standard.

Governance and risk management measures were not in place and many quality assurance systems needed to be developed. We found that the provider was not meeting eight of the regulations.

We told the provider they must make a number of improvements.

# Summary of findings

## The five questions we ask and what we found

We always ask the following five questions of services.

**Are services safe?**

Overall the service was not safe. The practice was not clean or well-maintained. Effective systems were not in place to provide constant oversight of safety within the building. Medicines used by clinical staff were inappropriately monitored. Practice staff had not been safely recruited or appropriately trained. Staff did not proactively identify or learn from incidents that occurred within the practice. Staff were unclear about what action they needed to take safeguard patients and make safeguarding referrals.

**Are services effective?**

Overall the service was effective but improvements were needed. Care and treatment was being delivered in line with current published best practice. Patients' needs were met and referrals to secondary care were made in a timely manner. However the team did not use clinical audit tools, or clinical supervision to assess the performance of the staff and overall delivery of appropriate treatment.

**Are services caring?**

Overall the service was caring. All the patients who responded to our comment cards and those we spoke with during our inspection were complimentary about the service. They all found the staff to be kind and compassionate and felt they were treated with respect.

**Are services responsive to people's needs?**

Overall the service was responsive to patients' needs but improvements were needed. The complaints policy was being written but action had been taken to respond to complaints about the service. The views of patients about the service were not routinely sought.

**Are services well-led?**

Overall the service was not well led. Governance structures were not in place. No risk management processes or strategies were used. All of the available policies were out of date. The provider had not ensured staff were appropriately monitored, trained and competent to undertake their role.

# Summary of findings

## What people who use the service say

We received six completed patient comment cards and spoke with 19 people on the day of our visit. We spoke with people from different age groups, including parents and children, and those people with different health conditions.

Patients we spoke with said the practice was very person-centred and they were extremely satisfied with service. They told us all the GPs were considerate and took the time to make sure their health condition was fully explored and treated. They were aware that last year there had been issues within the practice. They commented that it had impacted the overall service at the time but felt it was now getting back to the previous good standard.

All the patients we spoke with were extremely complimentary about the overall friendliness and behaviour of all staff. They all said the doctors and nurses were competent and knowledgeable about their treatment needs. They felt that the service was exceptionally good at ensuring they could easily access appointments.

We saw that during 2013 patients had completed a national patient survey and the results showed the practice was rated as performing better than most.

Patients reported that they felt all the staff treated them with dignity and respect.

## Areas for improvement

**Action the service MUST take to improve**

They must ensure the staff were accessing appropriate training; their practices remained up to date; and that their competency to undertake tasks was assessed. They must check that staff accessed appropriate clinical supervision and met the requirements of their professional body. We considered this was a breach of regulation 23: Supporting workers.

They must monitor and oversee the operation of the practice and make improvements when needed. They must ensure patients were involved in shaping the service. We considered this was a breach of regulation 10: Assessing and monitoring the quality of the service.

They must ensure records detailing the operation of the practice were available and patient records were stored securely. We considered this was a breach of regulation 20: Records.

They must ensure staff consistently follow best practice. That staff identified when errors should be reported and use significant events to learn lessons. We considered this was a breach of regulation 9: Care and welfare of service users.

They must ensure the building was clean and infection control measure were effective. We considered this was a breach of regulation 12: Infection control.

They must ensure medicines within the main practice were subject to appropriate levels of oversight and were stored safely. We considered this was a breach of regulation 13: Management of medicines.

The provider failed to ensure the building was maintained in a manner which protected patient's safety, privacy and dignity. We considered this was a breach of regulation 15: Safety and suitability of the premises.

They must recruit staff safely. We considered this was a breach of regulation 21: Requirements relating to workers.

**Action the service COULD take to improve**

They should ensure staff remained familiar with actions they should take if allegations of abuse had been made about other staff working at the practice.

They should ensure that their complaints procedure is re-written and available for patients.

# Summary of findings

## Good practice

Our inspection team highlighted the following areas of good practice:

The provider had set up processes whereby patients with long-term health conditions were asked to send in information about how they thought the clinical team could assist them to improve their management of the condition and therefore improve their quality of life.

# Dalston Medical Group

**Detailed findings**

## Our inspection team

**Our inspection team was led by:**

Our inspection team was led by a CQC inspector and the team included a GP, a second CQC inspector and a practice manager.

## Background to Dalston Medical Group

The Dalston Medical Group registered as a company who provide primary medical services and one of the GP's acted as the registered manager, which meant they were legally responsible for making sure the practice met CQC requirements.

The Dalston Medical Group provided a weekday service for over 5000 patients in the Carlisle area. Out of hours provision was provided by Cumbria Health On Call (CHOC).

The Surgery opened Monday to Friday from 8:30 am to 6:30 pm and had recently introduced appointments at 7:30 am but the days this was available varied each week. The service was responsible for providing primary care, which included access to GPs, minor surgery, family planning as well as ante and post natal care.

We visited the Surgery as a part of this inspection.

## Why we carried out this inspection

We inspected this out-of-hours service as part of our new inspection programme to test our approach going forward. This provider had not been inspected before and that was why we included them.

## How we carried out this inspection

Before our inspection we carried out an analysis of the data from our Intelligent Monitoring system. This did not highlight any significant areas of risk across the five key question areas. When they registered with CQC the Dalston Medical Group declared they met all of our expectations. As part of the inspection process, we contacted a number of key stakeholders and reviewed the information they gave to us.

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

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

We carried out an announced visit on 6 May 2014 and the inspection team spent nine hours inspecting the practice. We reviewed all areas of the building including the administrative areas. We sought views from patients both

# Detailed findings

face-to-face and via comment cards. We spoke with the practice manager, registered manager, two GPs (who were also partners in the company), a nurse, three administrative staff and the clinical lead for infection control.

We observed how staff handled patient information and dealt with patients making appointments. We reviewed how GPs made clinical decisions. We also talked with carers and family members.

# Are services safe?

## Summary of findings

Overall the service was not safe. The practice was not clean or well-maintained. Effective systems were not in place to provide constant oversight of safety within the building. Medicines used by clinical staff were inappropriately monitored. Practice staff had not been safely recruited or appropriately trained. Staff did not proactively identify or learn from incidents that occurred within the practice. Staff were unclear about what action they needed to take safeguard patients and make safeguarding referrals.

## Our findings

**Safe Patient Care**

NHS England were sent information from the practice and these reports from indicated that the practice had a good track record for maintaining patient safety and rated them as an achieving practice. Information from the quality and outcomes framework, which is a national performance measurement tool, showed that in 2012-2013 the provider was identifying and reporting incidents.

On the day of the visit we found that one of the nurses had misadministered a vaccine. The nurse told us they checked that the patient was no harmed. They also told us that they were not aware that this type of incident needed to be reported to the management team. We found that a patient had attended a hospital outpatient appointment and the consultant asked the GPs to commence a medicine immediately. The staff had not followed this direction and some five weeks lapsed before the patient was seen and the medicine started. Again this was not deemed to be an incident. We found that the staff were not recognising when incidents should be classified as significant events because may have had the potential to cause harm. Therefore they did not see that incidents that had not directly harmed a patient needed to be reported and investigated. The staff were not recognising that they could learn lessons for near misses and by investigating these matters reduce the risk of this happening again.

From our discussions we found that the individual GPs were aware of the latest best practice guidelines such as NICE guidance and incorporated this into their day-to-day practices. However, there was no system in place for ensuring that all of the clinical staff were aware of current best practice. We saw that the paper records that had been put together about current best practice and guidelines for the locum. We found that these were at least two years out of date. We also saw that the patient group directives for nurse practitioners, which detailed which medicines they could prescribe, were out of date. For one instance the PGD for mumps, measles and rubella immunisation did not reflect that one of the vaccines being administered had been changed to a different type.

**Learning from Incidents**

We found no evidence to confirm that, as individuals or as a team, staff were actively reflecting on their practice and

# Are services safe?

learning lessons from incidents. During the previous year we saw that a complaint and two significant events had been reported and investigated. We found no evidence to show that information from these incidents was used to identify any trends or lessons that could be learnt. We noted that the incident relating to access to appropriate treatment should have been reported and investigated as significant events but had not been. In discussions with the GPs and nurses we found that they did not recognise the benefits of them identifying, investigating and analysing any patient safety incidents and near misses.

The practice had signed up to the 'Productive General Practice' programme, which was delivered by the NHS Institute for Innovation and Improvement. The programme expected staff and patients to critically review the service and identify how it could be improved. At the time of the inspection we saw that this programme had not started to be used bit staff at the practice.

We saw that the provider held a weekly meeting with all the GPs. The minutes we reviewed show that they were used to discuss the practicalities of running the service and were not used as an opportunity to share changes to best practice guidelines, medicines alerts and incidents. We were told that the GPs and nurses took lead roles around their special interests such as diabetes, respiratory disease and women's health. However, the practice manager could not provide evidence to demonstrate how any learning about a particular condition was shared across the clinical team. This meant they were not seeing the process as an opportunity for learning and identifying themes or where lessons from one incident could be used to improve their practices in other areas.

**Safeguarding**

Staff were readily able to discuss what constituted a child and adult safeguarding concern. They told us about incidents when they had either raised safeguarding or child protection alerts, in relation to care provider by others. However, they were unclear about what actions they should take if the allegation related to members of the practice staff and the provider had not reported this to relevant authorities. We found no evidence to confirm that staff had received safeguarding and child protection training. Staff told us that they had attended both types of training but not in the last two years. The provider did not have safeguarding policies and procedures in place. Neither did they have a 'Whistle-blower' policy, which describes the expectation that the provider will take on and investigate concerns raised by staff.

**Monitoring Safety & Responding to Risk**

We were told that the provider had ensured all the GPs could readily understand the needs of each patient. However we found that since one GP had left the oversight of that person's patient list was not consistent or comprehensive. This had led to staff not picking up from a discharge letter that one patient needed to be reviewed and prescribed new medication. This patient had waited until their next scheduled review before being seen, which was five weeks after the discharge letter had been received.

Staff were not able to provide us with any evidence to show that the provider and practice manager regularly reviewed the demands on the practice. For example, the number of patient appointments being used; number of patients who did not attend and whether patients had expressed concerns that they could not see a particular GP or nurse. They could not provide any information to confirm staff competency and that their ability to practice was regularly reviewed or that when clinicians needed to have their practice supervised this was occurring or that the supervisor was satisfied with the clinical decision they made.

The patients we spoke with told us they were happy to see any GP as they felt all were competent and knowledgeable. The rotas we reviewed showed that sufficient GPs and other clinicians were on duty to cover all the appointments including the extended hours service.

There was no documentation to confirm that the clinical staff received regular cardiopulmonary resuscitation (CPR) training and training associated with the treatment of anaphylactic shock. It could not be confirmed that staff who used the defibrillator were regularly tested to ensure they remained competent in its use.

**Management of medicines**

We found that the management and administration arrangements in the dispensary were appropriate and safe. The medicines in the dispensary were appropriately stocked and replenished when needed. Lockable facilities were available for controlled drugs. All of the dispensary

staff were qualified pharmacist technicians and the Clinical Commissioning Group (CCG) pharmacist visited on a weekly basis to support the team. We saw that regular audits were completed and checks were made to ensure stock balances were correct for all of the medicines dispensed.

The layout of the waiting area and dispensary room meant the door to the dispensary was not behind the counter. Dispensary staff frequently left the room to go to the counter and serve patients. We saw that the door did not automatically lock and staff never locked it when they left the room to go to the counter. Staff told us that on occasions patients had walked into the dispensary room to request their prescription be filled. They accepted that this accessibility meant there was a potential for medicines to go missing.

We reviewed the dispensary standard operating procedures (SOPs) and found that they needed to be reviewed on an annual basis. We saw that three had been reviewed over the last year. The remaining ones had not been reviewed for over two years. We confirmed that the information contained in the SOPs that had not been reviewed was no longer accurate.

We saw that records were not maintained when clinicians within the main practice took medicines from the dispensary, including controlled drugs. The GPs restocked their equipment bags from the dispensary but only recorded items that had been taken if they were prescribed to a patient. No system was in place to monitor whether other drugs were taken or if these drugs were safely maintained and replenished as needed. We checked two of the GPs bags and found the medicines were in date. However neither bag contained injectable penicillin. A doctor administering this type of medicine as soon as Meningitis is suspected is recommended best practice for this condition.

The nurses did not receive their stocks of medicine (such as vaccines) directly from the dispensary and this meant dispensary staff did not oversee the storage and administration of them. We reviewed the nurse's records for the medicines and found the audit trail was difficult to follow for those. No stock list was in place in the nurse's rooms so we could not establish what medicines they were supposed to hold or had. We saw that throughout the day and when no staff were in the treatment rooms were unlocked. We saw that in both the nurses rooms the fridges were also unlocked, which meant people passing the rooms could access these medicines. All drugs we checked were in date.

In the main practice we found that medicines were stored in a haphazard manner. The medicines were not kept securely or appropriately maintained and could easily be accessed by patients and visitors. For example one nurse kept medicines to treat Anaphylactic shock stored in an unlocked draw of their desk. All of the doors to the treatment and consultation rooms were standing open when not in use and we found that the emergency drugs, needles and other equipment were on display to members of the public accessing the practice. We discussed this with the staff and they told us this had not been a problem, as none had ever gone missing but without accurate records it was not possible to confirm this.

The main practice had standard operating procedures (SOP) and patient group directives (PGD) in place for using certain drugs and equipment and for the nurse prescribers. These documents aimed to ensure all clinical staff followed the same procedures and nurses who prescribed medicines did so safely. All of the SOPs and PGDs we reviewed were out of date and inaccurate. This meant patients could not be confident that they received the most appropriate treatment for their condition.

**Cleanliness & Infection Control**

We spoke with the nurse who had the lead role for infection control. The provider had not ensured that they received refresher training or access to the latest infection control guidance. We found that there were limited infection control policies in place and the ones that were available had not been reviewed for at least two years. They were unaware that one of the provider's policies stated that uniforms were not to be worn outside. We saw that staff came to and from work dressed in their uniform.

We saw that the annual infection control statement had not been completed. Staff could not provide any evidence to show that infection control audits had been completed. We saw that staff did not follow guidance aimed at reducing the risk of accidental injury or infection. For example the sharp boxes were unlabelled, which meant staff could not ensure these items were safely maintained because they would not know when these may be full and they were not ensuring the contractor removing them had

the necessary information to make sure these boxes were disposed of appropriately. Staff could not provide examples of the COSHH guidance, which details how to use various cleaning chemicals. There was no schedule of cleaning for the domestic to follow and no information was available to tell them how to clean premises and fittings properly. Staff could not tell us when items such as curtains, walls and toys had been last cleaned.

The domestic staff worked 12 hours a week, which we found was insufficient to ensure the practice was properly cleaned. We saw that all areas of the practice were dirty. We saw that sink areas were blackened by silver nitrate; there were no hand washing signs; bins were not foot operated, which meant the risk of cross-contamination was not being appropriately reduced; and antibacterial hand gel was not available. We saw that dirty equipment such as dispensing pots were stored on the trolley next to equipment used for invasive procedures. Fabric chairs and curtains were used throughout the practice, which is not in line with current infection control guidelines. The curtains in one room were visibly dirty and staff told us they had not been cleaned since 2012. We found that staff were not taking action to reduce infection risk for patients.

Staff told us that the provider was reliant on the administrative staff to clean up any spilled body fluids. Although these staff knew how to undertake this task we found that none of the staff had received infection control training and there were no protocols in place for dealing with spills.

**Staffing & Recruitment**

The provider did not have a recruitment policy. We looked at a sample of recruitment files for doctors, administrative staff and nurses including files for staff employed within the last year. They contained no references, health statements, Disclosure and Barring Scheme checks, which highlights if people have committed any criminal offence or been barred from working with vulnerable adults and children; checks of clinical staff registration with professional body's such as the General Medical Council (GMC) and Nursing Midwifery Council (NMC). There was no evidence on the files to confirm that they had successfully completed the training necessary for their role. We found that appropriate pre-employment checks were not completed for a successful applicant before they could start work in the service.

The practice manager had been in post for nine weeks and was just in the process of employing a new staff member. She was obtaining references and DBS checks for this person. The provider had not developed any formal application forms for people to complete, there were no health statement or templates to fill in to demonstrate that any gaps in employment history had been explored. The practice manager undertook to develop these documents, as without them the provider could not show they had not ensured suitable people to work at the practice.

We found that the practice had not taken any steps to check the suitability of locum doctors they used and no information at all was available for the two locums who regularly worked at the practice. We made the practice manager aware of the need to obtain information about the locum staff.

**Dealing with Emergencies**

There were no plans in place to deal with emergencies that might interrupt the smooth running of the service. For example the practice did not have a fire risk assessment or a contingency planning document, which details what action to take in all manner of events such as a power failure. We found no evidence to show that staff who would use the defibrillator were regularly tested to ensure they remained competent in its use.

**Equipment**

A defibrillator and oxygen was available for use in a medical emergency and checked each day to ensure it was in working condition. Vaccines were stored in designated fridges in the nurse's treatment rooms. The temperature logs were not consistently completed, which is necessary to ensure medicines do not become unusable, as vaccines should be stored below in between certain temperatures.

A log of maintenance of clinical/emergency equipment was in place and noted when any items identified as faulty were repaired or replaced. However we found that the provider had not developed any system for checking that the building was well-maintained and fit for purpose. No action had been taken to ensure servicing and routine tests were completed on an annual basis. For example we found that the boiler had not had an annual service for over two years and did not appear to have been checked within that time, as it was extremely dirty which meant it posed a fire hazard.

# Are services safe?

We found there was no fire risk assessment in place and limited information to show that fire equipment had been checked or that staff had completed fire drills, which meant patients could not be confident that sufficient fire-fighting equipment was available or staff knew what action to take in the event of a fire.

# Are services effective?

(for example, treatment is effective)

## Summary of findings

Overall the service was effective but improvements were needed. Care and treatment was being delivered in line with current published best practice. Patients' needs were met and referrals to secondary care were made in a timely manner. However the team did not use clinical audit tools, or clinical supervision to assess the performance of the staff and overall delivery of appropriate treatment.

## Our findings

**Promoting Best Practice**

**Reports the provider submitted to the national databases showed they were effectively meeting the needs of patients with long-term conditions such as heart conditions, respiratory disease and dementia. The staff we spoke with said they wanted the practice to promote good patient care and deliver a good service. The clinicians were familiar with current best practice guidance. The GPs and nursing staff we spoke with could clearly outline the rationale for their treatment approaches and we found that this was aimed at ensuring the best outcome for each patient. We found that staff completed assessments of patient's needs. The provider had recently introduced the practice of requesting detailed information about what patients with long-term conditions wanted and needed to improve their quality of life. This was in the early stage of development and therefore had not been translated into care plans for these patients.**

**We found that the staff providing gynaecology and family planning services received regular updates. They, in line with the expectations of the Royal College of General Practitioners guidelines, were assessed in their delivery of these services as well as other general practice expectations. We found that the provider did not maintain records to show that the nurses and GPs continually updated their skills and competencies. One of the staff received clinical supervision from a consultant and there was an agreement in place that when they prescribed medicines they checked their decision with this supervisor. The provider had not checked this was happening. This meant the provider could not demonstrate that clinical staff was safe and competent to treat patients.**

**Management, monitoring and improving outcomes for people**

**The staff could not demonstrate that the team was making use of clinical audits tools or clinical supervision to assess the performance of staff and check how well they delivered the service. We found that the providers did not have formal mechanisms in**

# Are services effective?

## (for example, treatment is effective)

**place to monitor the performance of the practice or any other records to show this occurred. The staff we spoke with discussed how as a group they reflected upon the outcomes being achieved and areas where this could be improved. However there were no records to confirm this was the case.**

**The staff files we reviewed did not contain any records to show that the GPs received both internal appraisal and external professional appraisal. The nursing staff files showed that they had not had access to clinical supervision. The appraisals had not routinely occurred. In the five files we checked one file contained appraisal documentation from 2013; one showed an appraisal had occurred in 2010 and the remaining three files did not contain any appraisal documentation. This meant the provider could not show they were overseeing the performance of the staff working at the practice.**

**Staffing**

**From our review of information about staff training, we found there was no information showing what training and induction staff had received. There were no copies of staff's qualifications or certificates from training courses. The provider had no policies in place to show what their expectations around refresher training were and we found that the current system and processes meant that training was not completed in line with national expectations. We found no evidence to confirm that the provider ensured that the clinicians had access to training resources.**

**The practice manager had recently arranged for the practice to purchase an e-learning training resource, which meant all staff could readily update both mandatory and non-mandatory training. We saw that the mandatory training on this package included fire awareness, information governance, emergency trolley, sharps boxes, handling samples, and equality and diversity. This was yet to be introduced. The practice manager had also created a training matrix, which she intended to use to monitor whether staff were completing the appropriate training. At the time of the inspection there was no information to assist in determining when staff last attended any of the mandatory or clinical specific training.**

**Working with other services**

**We found that the practice staff also worked closely with the local community nursing team and provided facilities for those staff. We heard that good links had also been established with the CHOC to make sure doctors working the out of hours service had full information about patients' needs including care plans for people receiving palliative care.**

**Health Promotion & Prevention**

**We found from the data the practice submitted for the national quality outcome framework (QOF) that they had information about the numbers of people with long-term conditions. We found that the GPs and nurses did regularly review the needs of people with long-term needs. We saw that health promotion information was on display in the areas patients used and leaflets explaining different conditions were also freely available. This meant that preventative work could be completed with all these groups to assist them to improve their health and wellbeing.**

# Are services caring?

## Summary of findings

Overall the service was caring. All the patients who responded to our comment cards and those we spoke with during our inspection were complimentary about the service. They all found the staff to be kind and compassionate and felt they were treated with respect.

## Our findings

**Respect, Dignity, Compassion & Empathy**

**Staff said they had access to interpreter or translation services for patients who needed it. However they found that this was not needed as all the patients attending the practice spoke English fluently and could discuss at length the available treatment options.**

**The service did not have a patient dignity policy in place. However, the staff we spoke with were familiar with the steps they needed to take to protect people's dignity. Consultations took place in purposely designed rooms with an appropriate couch for examinations. However they did not all have privacy screens in place, which should be used to provide more privacy when patients were examined.**

**We noted that the consultation room doors did not have internal locks or signage on the outside of the door to alert people when a patient was being seen. We saw that when doors opened to the rooms such as the minor surgery room the positioning of the couch meant people passing by that room could see the patient in a compromised position.**

**There were no signs explaining that patients could ask for a chaperone during examinations. Staff told us that patients were aware they could ask for a chaperone but this was rarely used. Patients told us that they felt they were unaware that they could ask for a chaperone.**

**We also saw that two of the GPs had left their rooms unlocked with the doors stood open whilst their computers were on and logged onto the system. One of the GPs was not on duty that day and the other GP had left the computer unattended for over an hour with a patient's records being displayed. When we spoke to this GP they did not recognise that this was a breach of patient confidentiality that could need to be reported as a significant event.**

**We observed that the reception staff treated people with respect and ensured conversations were conducted in a confidential manner. The reception**

# Are services caring?

**room had a glass screen in place which was closed in between staff conversations with patients. This was used to assist staff maintain patient confidentiality when talking to patients on the phone.**

**All the patients we spoke with told us they were satisfied with the approaches adopted by staff and felt they took the time to listen. Clinicians were extremely empathetic and compassionate. They said "The staff are second to none" and "The GPs are very good".**

**Involvement in decisions and consent**

**We found that although the provider had not ensured staff received training around the use of the Mental Capacity Act 2005 the clinical staff understood how to make 'best interest' decisions for people who lacked capacity and sought approval for treatments such as vaccinations from children's legal guardian.**

**We saw that healthcare professionals adhered to the Children Act 1989 and 2004. Capacity assessments for adults who may have cognitive impairments and the Gillick competency of children and young people, which checks whether children and young people have the maturity to make decisions about their treatment, were an integral part of clinical staff practices.**

**The patients we spoke with confirmed that their consent was always sought and obtained before any examinations were conducted. We found that where patients had capacity to make their own decisions, appropriate consent was obtained for example for the minor surgery completed in the practice.**

# Are services responsive to people's needs?

(for example, to feedback?)

## Summary of findings

Overall the service was responsive to patients' needs but improvements were needed. The complaints policy was being written but action had been taken to respond to complaints about the service. The views of patients about the service were not routinely sought.

## Our findings

**Responding to and meeting people's needs**

**We found that the practice was accessible to patients with mobility difficulties. There were toilets for disabled patients. Hearing loops were installed at the reception desk and patients could identify they were being called for the appointment because the electronic display boards flashed up their name and the clinician came out to call for them.**

**We saw that the staff had carried out an analysis of patient needs. This analysis was sent to the local CCG and formed a part of the data set they used for assessing the practice's achievement of targets set in the quality outcomes framework. It also assisted the clinicians to check that all relevant people had been called in for a review of their health conditions and for completion of medication reviews. However the recent changes to a new IT system had led to some of this information being lost and the registered manager explained that this meant they had not been able to demonstrate they had met some targets such as for vaccination programmes.**

**We found that well-women and well-men services were provided to patients when required and this was individually tailored to the needs of the patient. The practice held regular clinics for a variety of complex and long-term conditions such as respiratory disease and diabetes. This meant the patients could be confident that, if they had a long-term health condition the GPs and clinicians would make sure any adverse effects of the condition were reduced.**

**Access to the service**

**We found there was no evidence to show that the practice had completed a patient survey and no comments had been posted on NHS choices website. The six patients who completed our comment cards and spoke to us on the day of inspection told us they found booking appointments was easy and they could get to see a GP of their choice in non-urgent situations. Patients could book appointments either face-to-face or over the telephone.**

# Are services responsive to people's needs?

## (for example, to feedback?)

**The provider did not operate a patient participation group (PPG) and could not produce evidence to confirm they had asked patients views about the operation of the service. We found there was no evidence to show patient surveys had been completed. This meant that patients were not being encouraged to share their views about the service with the provider.**

**Concerns & Complaints**

**The people we spoke with told us they had no concerns or complaints about the service but if they did they would raise these with the receptionists. We saw that the complaints policy was out of circulation at the time because the practice manager was updating it. The complaint folder showed that one concern had been raised in the last year and this had been appropriately investigated. However the lack of information for patients on how to make a complaint meant that the provider could not be assured that people were able to raise concerns.**

# Are services well-led?

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

## Summary of findings

Overall the service was not well led. Governance structures were not in place. No risk management processes or strategies were used. All of the available policies were out of date. The provider had not ensured staff were appropriately monitored, trained and competent to undertake their role.

## Our findings

**Leadership & Culture**

**We found that there were not clear lines of accountability within the practice. We found that the nursing team had allocated lead roles for example one nurse was responsible for infection control but the GPs did not follow this practice. This meant that each GP had to ensure that they personally made sure their practice was up to date rather than one GP, for instance, collating and sharing information on recent NICE or patient safety updates across the team. The registered manager told us they had recognised this could lead to inconsistent implementation of guidance. The GPs we spoke with demonstrated a deep understanding of their responsibility for ensuring their practices were up to date but there was no system in place to check this was the case for all of the GPs and locums.**

**We found that the provider had limited engagement with the local CCG and infrequently discussed with them the current performance issues and how to adapt the service to meet the demands of local people. For instance, the provider was not working with the CCG to ensure information about patients with carer responsibilities was captured although the CCG had requested that all practices do this so they could support those people to have the best quality of life.**

**The staff we spoke with all were keen for the service to be patient centred. However there was no documentation or records in place to show how the provider supported them to achieve this goal.**

**Governance Arrangements**

**We found that the governance structures were not in place for managing risks or monitoring the performance of the service. None of the GP partners took a leadership role for overseeing that the systems in place. We found that the lack of oversight led to inconsistent practice; poor medicine management; poor identification of information about incidents;**

# Are services well-led?

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

**poor oversight of clinical supervision arrangements; no action being taken to ensure staff were recruited and trained appropriately and a lack of team cohesion.**

**There was no system in place for the staff to determine when medicine alerts were received, seen by all GPs and appropriate action taken. There was no evidence of forward planning within the practice around the need to review and update policies and check the accuracy of current risk management tools.**

**We found that although complaints and two incidents highlighted over the last year were investigated no system was in place to analyse them in order to find out if lessons could have been learnt. We saw that incidents were not identified or significant events and therefore they were not investigated. We found staff did not understand when they would need to escalate a concern or inform the provider they had made a mistake. This meant the provider could not be assured that staff were raising and investigating incidents.**

**The provider was not encouraging patients to be involved in shaping the service and we found no information was available to show that the senior management team and staff used information from patients to look at how to improve the service being delivered.**

**The practice manager oversaw the day-to-day operation but had only been in post nine weeks. She recognised that the governance arrangements were unsatisfactory but had not had the opportunity to create mechanisms to ensure regular reviews occurred and the service was improved.**

**Systems to monitor and improve quality & improvement**

**We found that there were no effective systems in place to monitor and improve the quality of the service. The provider had not taken action to make sure the building was properly maintained and we saw that routine tests such as those for Legionella had not been completed. Also the boiler had not been serviced on an annual basis and we saw that it was so dirty that this posed a fire hazard. There was not maintenance plan in place, which meant the provider could not demonstrate they were making sure the building remained fit for purpose. We saw that many areas would benefit from redecoration and the dispensary needed to be redesigned to ensure the medicines were securely stored. Also a mechanism needed to be put in place to ensure patients dignity was maintained when they were being examined.**

**However we heard that the practice had recently signed up to be involved in the 'Productive General Practice' programme, which encouraged both staff and the patient participation group members to openly review the service and determine where they could improve. The registered manager anticipated that being involved in this programme would assist them to review and improve the overall service being provided.**

**Patient Experience & Involvement**

**We spoke with people from different age groups, including parents and children, patients with different physical health care needs and with various levels of contact with the practice. All these patients were complimentary about the clinical staff and the overall friendliness and behaviour of all staff. They felt that the service was very good. No patient participation group was in place so the provider could not show that they sought patient's views in a consistent manner or that patient views were listened to and used to improve the service being offered at the practice.**

**Staff engagement & Involvement**

**We saw from a review of staff files that internal annual appraisals were inconsistently completed and in three staff files we found there was no information to show they had ever been undertaken. The practice manager had recently introduced staff meetings. The staff we spoke with told us about the recent meeting and confirmed that they had not previously attended a staff meeting for over two years. Staff stated that in the recent meeting they had been given the opportunity to look at how they could develop skills that would improve the patients' experience of the service.**

**Learning & Improvement**

# Are services well-led?

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

**The lack of overall effective governance arrangements meant there was no system in place to determine if suggestions were acted upon. Or to check how effective the staff were at learning lessons and making improvements to the service.**

**Identification & Management of Risk**

**Many expected records such as systems for monitoring the implementation of current guidelines and guidance, SoPs, PGD, infection control audits were either not available for inspection or were out of date. This meant that all the evidence we reviewed did not provide assurance that the provider had effective systems in place to identify and manage risks.**

This section is primarily information for the provider

# Compliance actions

## Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

| Regulated activity | Regulation |
|---|---|
| Treatment of disease, disorder or injury | Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services<br>**The provider had not taken the proper steps to ensure that patient were protected against the risks of receiving treatment that was inappropriate or unsafe because processes for planning and delivering treatment were ineffective. Regulation 9 (1) (b)** |

| Regulated activity | Regulation |
|---|---|
| Treatment of disease, disorder or injury | Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control<br>**The provider did not operate effective systems to assess the risk of and to prevent, detect and control the spread of a health care associated infection. Regulation 12 (1) and (2)** |

| Regulated activity | Regulation |
|---|---|
| Treatment of disease, disorder or injury | Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines<br>**The provider did not protect patients against the risks associated with the unsafe use and management of medicines, by means of the making of appropriate arrangements for the obtaining, recording, handling, using, safe keeping, dispensing, safe administration and disposal of medicines used by clinicians.** |

| Regulated activity | Regulation |
|---|---|
| Treatment of disease, disorder or injury | Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises |

This section is primarily information for the provider

# Compliance actions

The provider had not ensured that patients and others had access to premises that were adequately maintained. Regulation 15 (1) (c)

| Regulated activity | Regulation |
| --- | --- |
| Treatment of disease, disorder or injury | Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers<br>The provider did not operate effective recruitment procedures which ensured staff were fit to undertake their role. |

This section is primarily information for the provider

# Enforcement actions

## Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

| Regulated activity | Regulation |
|---|---|
| Treatment of disease, disorder or injury | Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers<br>Patients and others were not protected against the risks of unsafe or inappropriate care because the provider did not regularly monitor the quality of the service being provided. Regulation 10 (1) (a) |

| Regulated activity | Regulation |
|---|---|
| Treatment of disease, disorder or injury | Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records<br>The provider had not ensured records were appropriately maintained for the operation of the service or that patients records were securely stored. Regulation 20 (1) (b) and (2) (a) |

| Regulated activity | Regulation |
|---|---|
| Treatment of disease, disorder or injury | Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff<br>The provider did not have suitable arrangements in place in order to ensure that the staff were appropriately supported and trained to deliver care and treatment to patients safely and to an appropriate standard.<br>The provider did not ensure that as part of a system of clinical governance and audit healthcare professionals were enabled to provide evidence to their relevant professional body demonstrating,<br>that they continue to meet the professional standards which were a condition of their ability to practise. |