Ravensbury Park Medical Centre

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?	Inadequate
Are services effective?	Inadequate
Are services caring?	Requires improvement
Are services responsive to people's needs?	Inadequate
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 Ravensbury Park Medical Centre on 11 January 2017. Overall the practice is rated as inadequate.

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

- There was not an effective system in place for reporting, recording and learning from significant events.
- There was not an effective system for acting upon patient safety alerts, and no evidence that patient safety alerts had been acted upon.
- The systems and processes to keep patients safe and safeguarded from abuse, were not effective or well-embedded.
- There were weaknesses in the practice arrangements to prevent and control the spread of infections
- Arrangements for managing medicines, including emergency medicines and vaccines, in the practice were not sufficient to keep patients safe
- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed, but at times there were not sufficient staff to meet patients' needs.
- Appropriate recruitment checks had not been undertaken, including checks of records through the Disclosure and Barring Service for all clinical staff and those carrying out chaperoning duties.
- Risks to patients were not adequately assessed or managed.
- The practice did not have all of the medicines required to manage emergencies, and there was no plan in place for major incidents such as power failure or building damage.
- Data from the Quality and Outcomes Framework (QOF) showed patient outcomes were at below the national average, particularly for diabetes and hypertension (high blood pressure).

Summary of findings

- There was minimal quality improvement activity, and little evidence that this activity had led to improvement in patient care. There were not adequate systems in place to monitor the practice performance and adherence to guidance, and to ensure improvement.
- Data from the national GP patient survey showed patients rated the practice higher than others for several aspects of care from GPs, but below average for aspects of care from nurses. Patient satisfaction with how they could access care and treatment was below the national average.
- The practice did not have an effective system in place for handling complaints.
- The practice had a number of policies and procedures to govern activity, but these were not regularly updated and they were not well embedded. .
- There was no effective system in place to ensure that staff received the training required for their roles.
- The practice held regular whole team meetings, but no regular governance or clinical meetings.

The areas where the provider must make improvement are:

- Ensure all risks to patients are assessed and acted upon in relation to patient safety alerts, medicines management, infection control and fire risk management.
- Ensure patients are safeguarded from abuse.
- Ensure that all relevant recruitment checks are completed, including Disclosure and Barring Service checks or risk assessments of those with relevant roles, and ensure staff receive the training required for their roles.
- Ensure that there are sufficient staff to meet patients' needs.
- Ensure that there are adequate arrangements to respond to emergencies and major incidents.
- Implement an effective system for handling complaints.
- Develop and implement appropriate practice-specific policies which are clear and accessible to all staff.
- Monitor the practice performance and adherence to guidance and take action on evidence of poor or deteriorating performance.

The areas where the provider should:

- Review how patients with caring responsibilities are identified and recorded on the clinical system to ensure information, advice and support is made available to them.
- Review and act upon the results of the national GP patient survey.
- Implement an effective system to record and follow up on actions discussed in meetings.

I am placing this service in special measures. Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate for any population group, key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

Professor Steve Field CBE FRCP FFPH FRCGP

Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Inadequate

The practice is rated as inadequate for providing safe services.

- There was not an effective system in place for reporting, recording and learning from significant events. Records kept were incomplete.
- There was not an effective system for acting upon patient safety alerts, and no evidence that patient safety alerts had been acted upon.
- The policy to keep patients safe and safeguarded from abuse had a GP listed as the lead who was not working at the practice, and staff were not familiar with it. Not all clinical staff had had recent safeguarding training.
- Arrangements for managing medicines, including emergency medicines and vaccines, in the practice were not sufficient to keep patients safe.
- Appropriate recruitment checks, including a check of records through the Disclosure and Barring Service had not been undertaken, for clinical staff or for staff undertaking chaperone duties.
- Risks to patients were not adequately assessed or managed. There was no premises' or fire risk assessment. There had been no recent testing of electrical equipment or fire safety equipment. There were not all of the emergency medicines we would expect and there was no plan in place for major incidents such as power failure or building damage. There were weaknesses in the practice arrangements to prevent and control the spread of infections.

Are services effective?

Inadequate

The practice is rated as inadequate for providing effective services.

- Data from the Quality and Outcomes Framework (QOF) showed that there were a number of areas where performance had fallen below the national average, particularly for diabetes and hypertension (high blood pressure).
- There was minimal quality improvement activity, and little evidence that this activity had led to improvement in patient care.
- Not all staff had received the training required for their roles, and most essential training was completed after the inspection was announced. There was evidence of appraisals for all staff.

Summary of findings

- There were no regular meetings with health care professionals to assess and plan ongoing care and treatment for patients with complex needs.
- Staff generally assessed needs and delivered care in line with current evidence based guidance with the exception of cervical cytology where the practice were not able to provide evidence of up to date training for one of the GPs.

Are services caring?

Requires improvement

The practice is rated as requires improvement for providing caring services.

- Data from the national GP patient survey showed patients rated the practice higher than others for several aspects of care from GPs, but below average for aspects of care from nurses.
- Patients we spoke to said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.
- Information for patients about the services available was easy to understand and accessible.
- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.
- The practice had identified 22 patients as carers (less than 0.5% of the practice list).

Are services responsive to people's needs?

Inadequate

The practice is rated as inadequate for providing responsive services.

- Results from the national GP patient survey showed that patient's satisfaction with how they could access care and treatment was below the national average, although some results were comparable to local averages. For example, 63% of patients said that that the last time they wanted to see or speak to a GP or nurse from their GP surgery they were able to get an appointment, compared to the local average of 71% and the national average of 76%.
- People told us on the day of the inspection that they were generally able to get appointments when they needed them, but that it was sometimes difficult.
- Although the practice generally provided home visits for patients that needed them, it did not do so when they had short-notice staff absence that staff were unable to fill.

Summary of findings

- The practice did not have an effective system in place for handling complaints. There was confusion about the policy in place, and the records we checked showed that the practice was not following recognised guidance in responding to complaints.
- The practice premises were purpose built, with good access for people with impaired mobility.

Are services well-led?

Inadequate

The practice is rated as inadequate for being well-led.

- The governance framework did not support the delivery of good quality care. There were not effective arrangements for identifying, recording and managing risks, issues and implementing mitigating actions.
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- The practice had a number of policies and procedures to govern activity, but these were not tailored to the practice or reviewed regularly. Some policies were incomplete or incorrect.
- There were not adequate systems in place to monitor the practice performance and adherence to guidance, and to ensure improvement.
- There was not an effective system in place to ensure that staff received the training required for their roles.
- Practice meetings took place, but there was no evidence of actions being effectively documented and followed up. There were no regular governance or clinical meetings.
- The patient participation group was active and staff had opportunities to give feedback.

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 provider was rated as inadequate for safety, effectiveness, responsiveness and for being well-led and requires improvement for being caring. The issues identified as inadequate overall affected all patients including this population group.

- The practice was responsive to the needs of older people, andurgent appointments were available for those with enhanced needs. Home visits were generally offered, although these had been withdrawn when there was short-notice staff absence that staff were unable to fill.
- Older patients had a named GP to support their care.

People with long term conditions

Inadequate

The provider was rated as inadequate for safety, effectiveness, responsiveness and for being well-led and requires improvement for being caring. The issues identified as inadequate overall affected all patients including this population group.

- Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority for appointments.
- Performance for diabetes and hypertension (high blood pressure) related indicators was below average. For example, 41% of patients with diabetes had well controlled blood pressure, compared to the local average of 74% and the national average of 78%. Twenty five patients (7%) were excepted, compared to 8% locally and 9% nationally). (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).
- Longer appointments were available when needed. Home visits were generally offered, although these had been withdrawn when there was short-notice staff absence that staff were unable to fill.
- All these patients had a named GP and a structured annual review to check their health and medicines needs were being met.

Summary of findings

Families, children and young people

Inadequate

The provider was rated as inadequate for safety, effectiveness, responsiveness and for being well-led and requires improvement for being caring. The issues identified as inadequate overall affected all patients including this population group.

- There were systems in place to identify children living in disadvantaged circumstances.
- Immunisation rates were below average for some standard childhood immunisations.
- The practice's uptake for the cervical screening programme was 79%, which was comparable to the CCG average of 82% and the national average of 82%.
- Appointments were available outside of school hours and the premises were suitable for children and babies.

Working age people (including those recently retired and students)

Inadequate

The provider was rated as inadequate for safety, effectiveness, responsiveness and for being well-led and requires improvement for being caring. The issues identified as inadequate overall affected all patients including this population group.

- The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care.
- The practice offered online services as well as a full range of health promotion and screening that reflects the needs for this age group.

People whose circumstances may make them vulnerable

Inadequate

The provider was rated as inadequate for safety, effectiveness, responsiveness and for being well-led and requires improvement for being caring. The issues identified as inadequate overall affected all patients including this population group.

- Staff had not all had the required training in keeping vulnerable people safe from abuse. The practice policy did not have an appropriate person listed as the safeguarding lead, and not all staff were clear who they should contact if they had concerns.The practice had no arrangements in place for effective working with other health care professionals in the case management of vulnerable patients.
- The practice offered longer appointments for patients with a learning disability. Five of the 14 patients on the practice's learning disability register had received an annual health check.

Summary of findings

- The practice informed vulnerable patients about how to access various support groups and voluntary organisations.

People experiencing poor mental health (including people with dementia)

Inadequate

The provider was rated as inadequate for safety, effectiveness, responsiveness and for being well-led and requires improvement for being caring. The issues identified as inadequate overall affected all patients including this population group.

- 80% of patients with schizophrenia, bipolar affective disorder and other psychoses had their alcohol consumption recorded, compared to the local average of 90% and the national average of 90%. 3% of patients excepted, local average 6% and national average 10%).
- 88% of patients diagnosed with dementia who had their care reviewed in a face to face meeting in the last 12 months, which is comparable to the national average.(No patients were excepted).
- The practice had no regular meetings with other multi-disciplinary teams for the case management of patients experiencing poor mental health, including those with dementia.

Summary of findings

What people who use the service say

The national GP patient survey results were published in July 2016. Two hundred and ninety-four survey forms were distributed and 113 were returned. This represented 2% of the practice's patient list. The results showed the practice was performing in line with and below local and national averages.

- 63% of patients found it easy to get through to this practice by phone compared to the local average of 63% and the national average of 73%.
- 63% of patients were able to get an appointment to see or speak to someone the last time they tried compared to the local average of 71% and the national average of 76%.
- 71% of patients said they would recommend this GP practice to someone who has just moved to the local area compared to the local average of 75% and the national average of 80%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 13 comment cards all but one of which were positive about the standard of care received.

We spoke with seven patients during the inspection. These patients said they were satisfied with the care they received and thought staff were approachable, committed and caring, but that it was sometimes difficult to get an appointment.

Ravensbury Park Medical Centre

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, a second CQC inspector and a practice manager specialist adviser.

Background to Ravensbury Park Medical Centre

Ravensbury Park Medical Centre is in Merton, south west London. The practice had 4976 patients when we inspected.

The surgery is purpose built premises, over two floors. There is some patient parking and the area is well served by public transport. The building has level access. The practice rents the premises from a private landlord. Also in the same building are a pharmacy, a café and a flat (all rented from the same landlord).

Compared to the England average, the practice has more young children as patients (age up to nine) and fewer older children (age 10 – 19). There are more patients aged 20 – 49, and many fewer patients aged 50+ than at an average GP practice in England. The surgery is based in an area with a deprivation score of six out of 10 (1 being the most deprived), and has a higher level of income deprivation affecting older people and children. Compared to the English average, more patients are unemployed.

The practice is run by three partners, two GPs (one male and one female) and one non-clinical partner, who is the practice manager. At the time of the inspection, two doctors were working at the practice, the female partner and a female salaried GP, supported by two regular locum GPs, as the male GP partner is not practicing. The practice offers 16 GP sessions per week. There are two practice nurses, who both work part-time.

The practice is open between 8am and 7pm Monday to Friday, with late opening on Tuesday (until 8pm) and Wednesday (until 8.30pm). Appointments with GPs are available between from 8am and 6.30pm Monday to Friday, and until 8pm on Tuesday and 8.30pm on Wednesday. When the practice is closed cover is provided by a local service that provides out-of-hours care.

The practice offers GP services under a Personal Medical Services contract in the Merton Clinical Commissioning Group area. The practice is registered with the CQC to provide family planning, surgical procedures, diagnostic and screening procedures, treatment of disease, disorder or injury and maternity and midwifery services.

This is the first time that the CQC has inspected the practice under this rating methodology. The practice was inspected on 6 February 2014 under the previous methodology, when it was found to be compliant with the regulations in force at that time.

The practice is registered with CQC as single-handed provider, although it is operating as a partnership. We have reminded the practice that correct registration is a legal obligation and that we will take action if they do not correct their registration.

Detailed findings

Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on11 January 2017.

During our visit we:

- Spoke with a range of staff and spoke with patients who used the service.
- Observed how patients were being cared for and talked with family members.
- Reviewed a sample of the personal care or treatment records of patients.
- Reviewed comment cards where patients and members of the public shared their views and experiences of the service.

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

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

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

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

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

Inadequate

Are services safe?

Our findings

Safe track record and learning

There was not an effective system in place for reporting and recording significant events.

- We looked at the records of four significant events documented in 2016 and talked to staff about the process. Staff gave different accounts of the process for reporting significant events.
- The reports that had been written about significant events were unsatisfactory, as they lacked necessary detail. For example, there was no patient identifier and no dates. Reports were written by a non-clinical staff member.
- We looked at minutes of clinical meetings for evidence that significant events had been discussed. There were only two clinical meetings in 2016, in July and August. No significant events were discussed at the August 2016 meeting. Only one of the documented significant events was recorded as having been discussed at the clinical meeting in July 2016. Two members of staff told us about a significant event that they recalled took place in early 2016 (a failure of the fridge used to store vaccines), which had not been documented as a significant event and, from the minutes we reviewed, had not been discussed at a clinical meeting so there was no system for cascading learning.

There was not an effective system for acting upon patient safety alerts.

- None of the GPs and nurses could describe a recent example, or provide any evidence of review of alerts or action that had been taken in response. Clinical meeting minutes had no reference to safety alerts.
- We asked the practice to send evidence of action taken and planned in relation to the medicines safety alerts for the last three years, and for details of the process to ensure that all alerts would be acted upon in future. We were sent evidence related to only two alerts and no evidence that any alerts had been shared with all of the clinicians in the practice. The search for simvastatin and amlodipine showed that eight patients were on dosages that the 2012 alert advised to be potentially harmful. We were also sent a statement that patients' medicines had been changed and the affected patients contacted.
- The practice sent us a new policy but this relied on alerts being received by post and from third-parties, rather direct email reports from the central alert system.

Overview of safety systems and processes

The systems and processes to keep patients safe and safeguarded from abuse, were not sufficiently robust or well-embedded:

- The member of staff listed in the policy as the lead for safeguarding was not working in the practice at the time of the inspection (and had not been for many months). There was no evidence of training in either child or adult safeguarding for one of the two nurses. Other staff were trained to the required level in child safeguarding, level 3 for GPs, level 2 for the nurse and level 1 for non-clinical staff. We asked non-clinical staff about safeguarding; two were unclear as to who the safeguarding lead was and one was not clear as to whether there was a policy in place and what the procedure was to report concerns. After the inspection we were sent evidence that the nurse had now completed safeguarding training, and that the safeguarding policy had been updated with a different GP as the safeguarding lead.
- A notice in the waiting room advised patients that chaperones were available if required, but that requesting a chaperone might cause an examination or procedure to be delayed and postponed (if a suitable staff member was not available). Two members of staff had received training as chaperones, but the majority had not (although this was planned). None of the members of staff performing chaperone duties had received a Disclosure and Barring Service (DBS) check (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable). There was no risk assessment. We were told DBS checks for chaperones had been requested but had not been received at the time of the inspection.

We observed the premises to be clean and tidy, but the practice arrangements to prevent and control the spread of infections were not effective:

- Neither of the two nurses, one of whom was the infection control clinical lead, had completed recent infection control training. After the inspection, the practice sent us certificates that showed general

infection control training for clinical staff had been completed by both nurses. However, no evidence was provided of role-specific training for the nurse who was the infection control lead. There were no spillage kits, and non-clinical staff members did not have a clear understanding of the correct procedures for cleaning up bodily fluids.

- There were two infection control policies in place, one in a paper file and one on the computer system, which were different. The policy on the computer did not contain full details of the arrangements for preventing and controlling infections. For example, there were no details of procedures for changing privacy curtains in the clinical rooms, and the procedures for sharps bins did not include the time limit after which bins should be disposed of. We noticed that the disposable privacy curtains had not been changed for more than nine months (since 18 April 2016) when they should be replaced every six months and there was a sharps bin dated 30 August 2016 when they should be changed every four months. A few days after the inspection, the practice sent us a new checklist for sharps bin disposal and evidence that new disposable privacy curtains had been ordered.
- There was no appropriate cleaning schedule. The practice sent us a copy of a cleaning schedule, but this was very brief and did not detail the areas to be cleaned or the products that should be used. There was no reference to a colour coding system to prevent cross contamination during the cleaning process and no details of the procedures for the cleaning equipment after use (for example the disposal or washing of cloths and mops).
- There had been an external infection control audit in April 2016 and we saw evidence that action was taken to address any improvements identified as a result.

The arrangements for managing medicines, including emergency medicines and vaccines, in the practice were not sufficient to keep patients safe (including obtaining, prescribing, recording, handling, storing, security and disposal):

- The vaccine fridges were left unlocked with key in situ in an unlocked room throughout the inspection. We raised this at the start of the day, but the fridges and the room remained unlocked all day.
- Staff told us that that consulting rooms were not usually locked during the day.
- The main practice supply of blank prescription forms and pads were securely stored, but there were no systems in place to monitor their use, and blank forms were left in clinical rooms overnight and during the day, when the rooms were not locked.
- We checked the emergency medicines in the practice and found that the emergency oxygen supply had expired on 9 January 2017 (two days before our inspection). After the inspection the practice sent us evidence that new oxygen had been ordered.
- We checked the practice prescribing policy. Although we saw evidence that prescribing of high risk medicines was being managed safely, these processes were not documented in the prescribing policy.
- The practice received support from the local CCG pharmacy team to support safe prescribing. The practice had carried out one medicine audit, of prescribing for urinary tract infections.
- Patient Group Directions (PGDs) had been adopted by the practice to allow nurses to administer medicines in line with legislation. (PGDs are written instructions for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment.)

We reviewed the personnel files of two recently recruited staff members and found complete recruitment checks had not been undertaken prior to employment.

- The file of one non-clinical staff member lacked an application form, CV and employment history. The Disclosure and Barring Check (DBS) had been requested by a previous employer, with no evidence of a subsequent check to ensure that there had been no changes to the staff member's record.
- There was no DBS check in the file of a nurse. After the inspection the practice sent us a copy of a DBS check, from a voluntary position, several years previous to employment with the practice, meaning there had been no recent check on the staff member's record and the practice had not completed a risk assessment to identify and mitigate against any risks this posed.
- The practice manager told us that DBS checks had been requested for the nurse and staff acting as chaperones.

Inadequate

Are services safe?

Monitoring risks to patients

Risks to patients were not adequately assessed or managed.

- There was no premises' risk assessment or fire risk assessment. A few days after the inspection the practice sent us a copy of a premises' risk assessment but this related only to common areas of the building, such as the entrance hall, and did not include an assessment of the risks to patients from the medical centre.
- The fire alarm, fire extinguishers and emergency lights had not been serviced since October 2015. A few days after the inspection, the practice sent us evidence that the fire extinguishers were serviced on 16 January 2017.
- Fire evacuation drills took place every two months. Records were incomplete, since, for example, there was no record of the time taken to evacuate. The practice manager told us that the fire alarm was also tested every two months, but there was no record to confirm this.
- Clinical equipment was checked to ensure it was working properly, but there was no testing of portable electrical appliances to check that they were safe. This decision had not been made as part of a documented risk assessment. A few days after the inspection the practice sent us evidence of a booking for portable appliance testing by an external contractor for 27 January 2017.
- There were no Control of Substances Hazardous to Health (COSHH) assessments.
- A legionella risk assessment had been carried out, and water sampling and temperature checking.

Arrangements were in place for planning and monitoring the number of staff and mix of staff needed, but at times there were not sufficient staff to meet patients' needs.

- There was at least one occasion (3 January 2017) when a notice on the practice website advised patients that there would be no home visits or telephone consultations that day as there were insufficient clinical staff. Patients were advised to go to a walk in centre, call 999 or go to A&E. During the inspection one of the GPs told us that this had happened on at least one other occasion. Staff told us that the practice did not use agency locum GPs, partly because of cost. In response to the draft report, the practice told us that they were registered with "at least three locum agencies". We asked the practice for evidence that the agencies were approached and were unable to supply a locum GP on 3 January 2017. The practice told us that they did not have any evidence of this, but that practice did use locum agencies "when required".
- Although there was a system of appointments for patients that needed to be seen on the same day, including patients over the age of 75 and children, when the appointment slots were allocated patients were directed by reception to go to the walk-in centre or A&E.
- Non-clinical staff told us that it was sometimes a challenge to staff reception adequately, especially when staff were on leave or off sick. In response to the draft report, the practice told us that staff had misinterpreted our question and that there is a protocol in place to cover staff absence.

Arrangements to deal with emergencies and major incidents

The practice did not have adequate arrangements in place to respond to emergencies and major incidents.

- The practice supply of emergency medicines did not have all of the medicines we would expect, given the practice population and activities. The missing medicines included: diazepam (for epileptic seizures), benzylpenicillin (for suspected bacterial meningitis), and GTN spray (for suspected heart attack). There was no documented risk assessment in place to evidence the reason for not having these medicines. A few days after the inspection we were sent evidence of an order placed for most, but not all of the missing medicines and , and no risk assessment for these decisions.
- The defibrillator and emergency oxygen were stored on an open trolley in an unlocked room. The medicines we checked (apart from the emergency oxygen) were in date and stored securely.
- The paediatric oxygen mask was not stored with the emergency oxygen and the pads necessary to use the defibrillator had expired in June 2016.
- There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency.
- All staff had received annual basic life support training.

Inadequate

Are services safe?

The practice did not have a business continuity plan in place for major incidents such as power failure or building damage. A few days after the inspection we were sent a business continuity plan policy and procedure. This was incomplete, as several fields had been left blank, including contact details for staff and essential suppliers.

Inadequate

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

- Staff had access to National Institute for Health and Care Excellence (NICE) best practice guidelines; however patients treatment was not always delivered in line with these. In addition, treatment was not revised in response to information from the Medicines and Healthcare products Regulatory Agency.

Management, monitoring and improving outcomes for people

The practice participated in the Quality and Outcomes Framework (QOF). (QOF is a system intended to improve the quality of general practice and reward good practice).

The most recent published results (2015/16) were 85% of the total number of points available, compared to the local average of 94% and the national average of 95%. The overall practice exception rate was 3%, compared to 5% locally and 6% nationally). (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).

The practice was an outlier for several of the QOF targets.

- Performance for diabetes and hypertension (high blood pressure) related indicators was below average.
  - 41% of patients with diabetes had well controlled blood pressure, compared to the local average of 74% and the national average of 78%. Twenty five patients (7%) were excepted, compared to 8% locally and 9% nationally).
  - 61% of patients with diabetes had their HbA1c (a measurement of blood sugar over time) last measured at 64 mmol/mol or less, compared to the local average of 72% and the national average of 78%. (2% of patients excepted, compared to 10% local and 12% national average).
- 64% of patients with diabetes had well controlled total cholesterol, compared to the local average of 76% and the national average of 80%. (6% of patients excepted, compared to 15% local and 13% national average).
- Performance for mental health related indicators was generally comparable to the national average.
  - 91% of patients with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive, agreed care plan, compared to the local average of 89% and the national average of 89%. (3% of patients excepted, local average 9% and national average 13%).
- 80% of patients with schizophrenia, bipolar affective disorder and other psychoses had their alcohol consumption recorded, compared to the local average of 90% and the national average of 90%. (3% of patients excepted, local average 6% and national average 10%).
- 88% of patients diagnosed with dementia had a face-to-face review of their care, compared to the local average of 85% and the national average of 84%. (No patients were excepted).

Data published by from Public Health England showed that performance in several of these indicators had been below average since 2012/13, with further deterioration in 2015/16.

We asked for information on the practice's performance against some key QOF indicators for the current year, with ten weeks until the end of the recording year. This showed that the practice's performance had not improved.

There was little quality improvement activity, and little evidence that this activity had led to improvement in patient care.

- One clinical audit had been completed in the last two years, of prescribing for urinary tract infections. This used a standard template created by the Royal College of GPs, for an audit of 20 patients, and had no other details of the method.
- When the first check was carried out (no date recorded) 75% of prescriptions issued were in line with local and national prescribing guidelines. When this was checked again, in February 2016, 90% of the prescribing checked was in line with guidelines. There was no information about the 10% of prescriptions which were outside of guidelines to indicate that these decisions were clinically justified, and no action plan to improve the practice performance further.

Inadequate

Are services effective?

(for example, treatment is effective)

- Cervical sample audits carried out in 2013 and 2014 showed high rates of inadequate samples (5% and 16%). The partners we met could not provide any evidence of the practice's current performance.
- The 2013 cervical smear audit noted that 32% of results were not appropriately recorded (read coded) on the practice information system. The 2014 audit noted that 20% of results were not appropriately read coded, but with no discussion and no further action plan to improve the read coding.

Effective staffing

Not all staff had had the training required for their roles.

- We checked the records of five staff members. There were no certificates in either of the two nurses' files for fire safety or infection control training. There was no evidence of training in safeguarding children or safeguarding adults for one nurse and one non-clinical staff member. There was no evidence of information governance training for four of the five staff members we checked. After the inspection we were sent the missing certificates but no evidence of competence.
- The dates on the certificates that were in the files and some of those which were sent after the inspection showed that almost all training had been completed after we announced the date of our inspection.
- We checked evidence that staff undertaking specific roles had received relevant training. Nursing staff had received recent training in care for patients with diabetes and with respiratory conditions (such as asthma).

  The 2013 cervical smear audit referred to nurse and GP cervical sample takers. We asked for evidence that they had received specific training which had included an assessment of competence. A second audit of cervical screening samples undertaken in 2014 concluded that "cervical smear takers" needed to attend update training "as soon as possible". Nursing staff had attended training on sample taking in 2015, but no evidence of recent training was provided for the GP sample taker.

  In response to the draft report, the practice told us that the GP stopped taking samples for the cervical screening programme in January 2014. The practice told us that from 2014 to 2016 only one nurse was taking samples, when a second nurse joined the practice. The practice told us that the 2014 audit therefore looked at only samples taken by the nurse in making the recommendation for update training.

- The practice had an induction programme for all newly appointed staff. The records we checked of two staff members appointed in February and March 2016 showed that they had completed their mandatory training (in topics as safeguarding, infection prevention and control, fire safety, health and safety) after our inspection date was confirmed, and one had not completed training in information governance.
- 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.
- There was support for revalidating nurses and GPs. All staff had received an appraisal within the last 12 months.

Coordinating patient care and information sharing

The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practice's patient record system and their intranet system.

- This included care and risk assessments, care plans, medical records and investigation and test results.
- The practice shared relevant information with other services in a timely way, for example when referring patients to other services.

We saw evidence that GPs acted upon written information from other health and social care professionals, for example, when patients were discharged from hospital.

There were monthly meetings to discuss the care of palliative care patients, but no regular meetings with other health care professionals (for example, health visitors or district nurses) to assess and plan ongoing care and treatment for patients with complex needs.

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.

Inadequate

Are services effective?

(for example, treatment is effective)

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.

Supporting patients to live healthier lives

The practice identified patients who may be in need of extra support. For example, patients receiving end of life care and carers. Patients were signposted to relevant services, such as dieticians or smoking cessation advice.

The practice's uptake for the cervical screening programme was 79%, which was comparable to the Clinical Commissioning Group (CCG) average of 82% and the national average of 82%. A female sample taker was available. There were failsafe systems in place to ensure results were received for all samples sent for the cervical screening programme and the practice followed up women who were referred as a result of abnormal results.

Childhood immunisation rates for the vaccinations given were mixed.

- 96% of children aged one had received the full course of recommended vaccines, which was above the expected standard, but overall performance in immunisations recommended for children up to two years of age was below the expected standard, due to less than 90% of children age two receiving the Haemophilus influenza type b and Meningitis C (83%), booster for Pneumococcal infection (85%) and measles, mumps and rubella (MMR – 83%) immunisations at age two.
- Rates of MMR immunisation at age five were in line with average; 93% of children received the first dose (local average 86% and national average 94%) and 79% received the second dose (local average 75% and national average 88%).

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.

Requires improvement

Are services caring?

Our findings

Kindness, dignity, respect and compassion

We observed members of staff were courteous and very helpful to patients and treated them with dignity and respect.

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

We received 13 comment cards all but one of which were positive about the standard of care received. Patients said they felt the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect.

We spoke with one member of the patient participation group (PPG). They also told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

Results from the national GP patient survey indicated the practice was at or below average for its satisfaction scores on consultations with GPs, and below average for satisfaction scores on consultations with nurses. For example:

- 82% of patients said they found the receptionists at the practice helpful compared to the Clinical Commissioning Group (CCG) average of 85% and the national average of 87%.
- 78% 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%.
- 74% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 98% and the national average of 91%.
- 83% of patients said the GP was good at listening to them compared to the CCG average of 87% and the national average of 89%.
- 78% of patients said the GP gave them enough time compared to the CCG average of 84% and the national average of 87%.
- 87% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 90% and the national average of 92%

Care planning and involvement in decisions about care and treatment

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

Results from the national GP patient survey showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment from GPs, but less positively about care from nurses. For example:

- 86% of patients said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 83% and the national average of 86%.
- 77% of patients said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 79% and the national average of 82%.
- 71% of patients said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average of 82% and the national average of 85%.

The practice had not carried out any analysis of the results of the national GP patient survey.

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.

Requires improvement

Are services caring?

Patient and carer support to cope emotionally with care and treatment

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 22 patients as carers (less than 0.5% of the practice list).

Staff told us that if families had suffered bereavement, their usual GP contacted them or sent them a sympathy card. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service.

Inadequate

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

- Home visits were usually available for older patients and patients who had clinical needs which resulted in difficulty attending the practice. However on 3 January 2017 the practice advised patients that there would be no home visits or telephone consultations that day as there were insufficient clinical staff. Patients were advised to go to a walk in centre, call 999 or go to A&E. During the inspection one of the GPs told us that this had happened on at least one other occasion. The two partners we met told us that the practice did not use agency locum GPs, partly because of cost.
- There were some same day appointments available for children and those patients with medical problems that require same day consultation. When the standard on-the-day appointments were taken, patients were added to a waiting list for a cancellation or review in a reserved slot. These slots were for patients over the age of 75, patients sent to the practice by A&E and "emergency appointments". All staff confirmed that children under the age of five were prioritised for the "emergency" slots and for any cancellations, but if they were all allocated, reception staff direct patients (including parents of under 5s) to go to a walk-in centre or A&E, with no routine process for review by a GP.
- The practice offered GP appointments until 8pm on Tuesday and 8.30pm on Wednesday for patients who could not attend during normal opening hours.
- There were longer appointments available for patients with a learning disability.
- Patients were able to receive travel vaccinations available on the NHS as well as those only available privately.
- The premises were accessible and translation services available.

Access to the service

The practice was open between 8am and 7pm Monday to Friday, with late opening on Tuesday (until 8pm) and Wednesday (until 8.30pm). Appointments with GPs were available between from 8am and 6.30pm Monday to Friday, and until 8pm on Tuesday and 8.30pm on Wednesday. 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. Patients could book appointments on line.

Results from the national GP patient survey showed that patient's satisfaction with how they could access care and treatment was below the national average, although some results were comparable to local averages.

- 63% of patients said that that the last time they wanted to see or speak to a GP or nurse from their GP surgery they were able to get an appointment, compared to the local average of 71% and the national average of 76%.
- 63% of patients said they could get through easily to the practice by phone, compared to the local average of 63% and the national average of 73%.
- 87% of patients were satisfied with the practice's opening hours, compared to the local average of 90% and the national average of 92%.

People told us on the day of the inspection that they were generally able to get appointments when they needed them, but that it was sometimes difficult.

Apart from the occasions when the practice advertised on its website that it was not providing home visits due to staff shortages, GPs called patients requesting a home visit 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.

Listening and learning from concerns and complaints

The practice did not have an effective system in place for handling complaints.

- There were two complaints policies in the practice, one, shown to us by the practice manager was in line with recognised guidance and contractual obligations for GPs in England. Reception staff showed us a different document, which was not in line with guidance and had different timescales (e.g. for acknowledging complaints).
- There was a poster in the reception area about the complaints system, but no information for patients to refer to away from the practice (no complaints information in leaflet form, or on the practice website).

Inadequate

Are services responsive to people's needs?

(for example, to feedback?)

We looked at five complaints received in the last 12 months and found that neither policy was being followed. For example for two complaints there was no correspondence on file; one complaint had an acknowledgment but no final response and one complaint had a final response with no details of next steps if the complainant was not satisfied. Details were not kept of verbal exchanges with complainants.

Are services well-led?

Inadequate

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

Our findings

Vision and strategy

The practice had a philosophy of individual patient care but was not delivering on it.

Governance arrangements

The overarching governance framework was not effective and did not support the delivery of the strategy and good quality care.

Practice specific policies were not well embedded or implemented.

- The practice had purchased a suite of policies from an external commercial supplier which had not been personalised to the practice and included polices which were not relevant, for example on radiography with was not provided at the practice. There was a mix of paper and electronic policies, which led to confusion for staff about their location and which ones to follow. There was no evidence of review of the policies.
- We looked at the policies that had been created by the practice, rather than purchased. The policies that had been updated were incomplete, for example the infection control policy that the practice created did not contain all of the detail required to ensure that guidelines were followed, as (for example) it did not refer to changing disposable privacy curtains.,.
- Staff recruitment records were incomplete, and the practice had not undertaken their own Disclosure and Barring Service checks on the two nurses.

Arrangements for identifying, recording and managing risks, issues and implementing mitigating actions were not robust.

- There was no premises' risk assessment or fire risk assessment. There were templates for risk assessments in the files of policies that the practice had purchased, but these had not been completed. There were no processes in place to assess and reduce other risks, such as those from substances hazardous to health or electrical appliances. Systems to ensure that essential emergency equipment and supplies were in place and maintained were not effective, for example, fire safety equipment had not been recently serviced.
- The practice had not developed a business continuity plan for major incidents, despite having a blank template in theirpolicy files. After the inspection we were sent a business continuity plan that was marked as being in operation, despite the fields for essential information (staff telephone numbers, supplier contact details, alternative site) being blank.
- There was not an effective system for acting upon patient safety alerts. The action taken in response to the feedback given during the inspection did not adequately address the risks to patients.

There were not adequate systems in place to monitor the practice performance and adherence to guidance, and to ensure improvement.

- Data published by from Public Health England showed that the practice's performance in Quality and Outcomes Framework (a system intended to improve the quality of general practice and reward good practice) had been below average on several key measures since 2012/13, with further deterioration in 2015/16.
- There was little quality improvement activity, and little evidence that this activity had led to improvement in patient care. The practice was failing to evaluate their cervical screening service, as required by the contract for this work. Where monitoring had identified issues with the practice's performance, these were not effectively addressed.
- On at least one occasion the practice had failed to provide any home visits or telephone consultations, in breach of the contractual obligations, and with no formal assessment of risks to patients. This event occurred because of short-notice staff absence. No arrangements had been put in place to ensure that there was no re-occurrence.
- There was not an effective system in place to ensure that staff received the training required for their roles. There was no training policy. Almost all of the training evidence we saw showed that it been completed after we confirmed the date of our inspection. Most staff had not completed recent information governance training, we were told this was because the practice had not had access to an online training site.

Are services well-led?

Inadequate

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

- No action plan had been put in place to address the below average patient satisfaction as measured by the national GP patient survey.

There was a clear staffing structure and staff were aware of their own roles, although they were not always clear on how to carry out their responsibilities (for example, if they had safeguarding concerns or to prevent and control of infections).

Leadership and culture

Staff told us they felt well-supported within their teams, but would not necessarily approach the partners for support. In response to the draft report, the practice told us that staff had misinterpreted our question and that there is a system of delegated responsibility, reducing the need to approach the partners for support.

- The practice held regular whole team meetings. Staff told us they had the opportunity to raise issues at team meetings, but some staff said that this had not necessarily lead to improvements.
- Minutes of a partners meeting (held in October 2016) said that the practice would aim to have clinical meetings every week and partners meetings approximately every four weeks. There was no evidence of any partners meeting between October 2016 and the inspection (January 2017).
- Only two clinical meetings had been held in 2016, in July and August. Nurses did not attend the meetings and only the locum GPs attended the clinical meeting in August.
- We looked at minutes of all of the meetings. We could find no evidence of actions being effectively documented and followed up.

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

The practice had mechanisms to get feedback from patients and staff.

- The practice had gathered feedback from patients through the patient participation group (PPG). The PPG last met in May 2016. Planned meetings in September and November were cancelled, in part because practice staff were not available. The PPG discussed improvements with the practice management team. For example, the PPG worked with the practice to create some car parking for patients. The PPG approved a patient questionnaire at the May 2016 meeting, but the practice had not yet distributed this to patients. The practice had discussed the GP patient survey results with the PPG.
- The practice gathered feedback from staff through staff meetings, appraisals and discussion. Staff told us they would give feedback if they had any concerns.

Continuous improvement

We saw no evidence of continuous improvement.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **How the regulation was not being met:** Systems and processes were not established and operated effectively to prevent abuse of service users. • The practice safeguarding policy listed a GP who has not been in the practice since December 2015 as the safeguarding lead. • Non-clinical staff were not clear who the lead was or what they should do if they have concerns. • There was no evidence of adult or child safeguarding training for one of the two nurses. • No DBS checks for chaperones had been carried out. There was no risk assessment to support this decision. This was in breach of regulation 13(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 Surgical procedures Treatment of disease, disorder or injury	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints **How the regulation was not being met:** The registered person had not established and operated effectively an accessible system for identifying, receiving, recording, handling and responding to complaints by service users and other persons in relation to the carrying on of the regulated activity. • There were two complaints policies, one (bought in and in line with guidance) in a file and one (practice developed, with different timelines and not in line with guidance) which was handed to us by reception staff.

This section is primarily information for the provider

Requirement notices

- There was a poster in reception about complaints, but no information for patients to take away (complaints leaflet or complaints details in the practice leaflet) and no details of the complaints procedure on the practice website.
- We looked at 5 complaints which showed neither policy was being followed: two had no documentation, one no closing correspondence, and one had undated closure correspondence with no ombudsman details. No details were recorded (dates etc.) of verbal exchanges. There was no tracking system.

This was in breach of regulation 16(1)(2) 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 Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **How the regulation was not being met:** The registered person had not: • assessed the risks to the health and safety of service users • done all that was reasonably practicable to mitigate any such risks • ensured that persons providing care or treatment to service users had the qualifications, competence, skills and experience to do so safely • ensured that the premises and equipment used were safe to use for their intended purpose • ensured the proper and safe management of medicines • taken effective measures to prevent and control the spread of infections. 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 Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **How the regulation was not being met:** Systems or processes were not established to enable the registered person to: • assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity • assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity

This section is primarily information for the provider

Enforcement actions

- maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided;
- maintain securely such other records as are necessary to be kept in relation to persons employed in the carrying on of the regulated activity, and the management of the regulated activity.

This was in breach of regulation 17(1)(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.