Droylsden Road Family Practice

Quality Report

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

Ratings

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

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Droylsden Road Family Practice on 8 March 2016. Overall the practice is rated as inadequate.

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

- There was no clinical accountability or responsibility in the running of the practice.
- Patients were at risk of harm because inadequate systems were in place to keep patients safe including those for dealing with fire safety and health and safety of the patients.
- The practice had no infection control process, or any record of annual audits having taken place.
- The premises were dirty and cluttered throughout.
- There were hazards throughout the practice with no risk assessments in place.
- Staff were not clear about reporting significant events, incidents and near misses and there was no evidence of learning and communication with staff.
- Patient outcomes were hard to identify as little or no reference was made to audits or quality improvement and there was no evidence that the practice was comparing its performance to others, either locally or nationally.
- There was no record that staff had received regular mandatory training such as infection control; however there was access to online training available for all staff.

The areas where the provider must make improvements are:

- The provider must introduce clinical protocols and undertake clinical audit, care planning and quality improvements.
- Introduce quality assurance processes to act on and monitor histology and test results.
- Introduce processes and policies to ensure a safe practice environment is maintained with regards to Health and Safety of patients for example risk assessments, COSHH and cleaning maintenance.

Summary of findings

- Introduce quality assurance processes for reporting, recording, acting on and monitoring of significant events and medicine management.
- Ensure infection control process and procedures are fully implemented.
- Implement a formal system to ensure all patient records are updated in a timely manner.
- Develop a plan to data summarise all outstanding medical notes.
- Implement processes and update current practice policies to reflect the practice and staff roles accurately.
- Place all clinical medical records into a secure storage.
- Ensure that staff receive appropriate training and supervision to enable them to carry out the duties they are employed to do with a clear record.
- Check all electrical equipment is safe, for example extension leads and plug in heaters.

In addition the provider should:

- Implement a Patient Participation Group (PPG) in order to identify and act on patients' views about the service.
- Install a doorbell at the front door for wheelchair patients.

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

The practice will be kept under review and if needed could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service.

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

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Inadequate

The practice is rated as inadequate for providing safe services and improvements must be made:

- Patients were at risk of harm because there was breakdown in the systems and processes to keep them safe. For example, the practice had failed to adequately address risks relating to infection control, health and safety and fire safety.
- The practice had not maintained appropriate standards of cleanliness and hygiene. We observed the premises to be dirty and cluttered. We observed hazards throughout the practice.
- Staff did not have effective systems to assess, monitor or manage risks to patients who used the services. Opportunities to prevent or minimise harm were missed. For example clinicians were not aware of daily processes and were not adequately undertaking the actions needed to support patient outcomes such as care plans, quality improvements, clinical audits and clinical coding.
- There was no effective system in place for reporting and recording significant events. There was no clinical lead. Lessons were not shared to make sure action was taken to improve safety in the practice.

Are services effective?

Inadequate

The practice is rated as inadequate for providing effective services and improvements must be made.

- Patient outcomes were hard to identify as little or no reference was made to audits or quality improvement and there was no evidence that the practice was comparing its performance to others either locally or nationally.
- There was no systematic process to fully summarise and READ code patient paper notes and historic data into the clinical IT system.
- The practice's uptake for the cervical screening programme was 68.8%, which was below the national average of 81.8%.

Are services caring?

Inadequate

The practice is rated as inadequate for providing caring services and improvements must be made.

Summary of findings

- Data from the National GP Patient Survey showed patients rated the practice lower than others for many aspects of care. For example, 67.6% said the last GP they saw was good at involving them in decisions about their care (CCG average 79%, national average 81%)
- Patients felt the reception staff treated them with care and kindness. Some patients felt they were not believed during consultation.
- Information for patients about the services was available.

Are services responsive to people's needs?

Inadequate

The practice is rated as inadequate for providing responsive services and improvements must be made.

- The clinicians were not aware of and did not review the needs of its local population. For example clinicians were not aware the practice had a carers register.
- There was a designated responsible person who handled complaints in the practice and they would respond to all official complaints in a timely manner. However there was no complaints policy or procedure.
- The equipment used to treat patients and the premises were not clean and hygienic.
- People told us on the day of the inspection that it was difficult to book appointments.

Are services well-led?

Inadequate

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

- There was no clinical leadership or support from partners which had a negative impact on safety and high quality care.
- There were no clinical protocols in place and no audits or quality improvements taking place. There was no clinical accountability or understanding of the day to day running of the practice.
- Policies presented were not a true reflection of daily practice with variations in dates and multiple repeats of the same policy.
- The practice did not hold regular governance meetings and issues were discussed at ad hoc meetings.

Summary of findings

The six population groups and what we found

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

Older people

Inadequate

The practice is rated as inadequate for the care of older people.

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

- Home visits were available for those who were too ill to attend the practice.
- The percentage of patients with COPD who had a review undertaken including an assessment of breathlessness using the Medical Research Council dyspnoea scale in the preceding 12 months (01/04/2014 to 31/03/2015) was 64% lower than national average of 89.9%.
- Systems for discussing and planning a multi-disciplinary package of care for patients with complex or palliative care needs with other health professionals were not robust.

People with long term conditions

Inadequate

The practice is rated as inadequate for the care of people with long-term conditions. This is because the concerns identified in relation to how safe, effective, caring and well led the practice was impacted on all population groups.

- The practice nurse was responsible for the chronic diseases management clinics of patients with long term conditions.
- Structured annual reviews of medicines were not undertaken to check that patients' health and care needs were being met. For example, repeat medication was issued past the annual review date with no policy or process in place.
- The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less(01/04/2014 to 31/03/2015) was 63.39% lower than the national average of 78.03%.

Families, children and young people

Inadequate

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

- The practice would always see children under five years for same day appointments.

Summary of findings

- The premises were suitable for pushchairs to access.
- There were some appointments available outside school hours.
- The percentage of patients with asthma, on the register, who have had an asthma review in the preceding 12 months that includes an assessment of asthma control using the 3 RCP questions. (01/04/2014 to 31/03/2015) was 73.75% compared to national average of 75.35%.

Working age people (including those recently retired and students)

Inadequate

The practice is rated as inadequate for the care of working age people (including those recently retired and students). This is because the concerns identified in relation to how safe, effective , caring and well led the practice was impacted on all population groups.

- The surgery is part of Prime Ministers GP Access scheme offering extended hours and weekend appointments to patients.
- The percentage of patients with physical and/or mental health conditions whose
- notes record smoking status in the preceding 12 months (01/04/2014 to 31/03/2015) was 85.3% lower than national average of 94.1%
- NHS Health checks were available to this population group.
- Travel vaccinations were available.

People whose circumstances may make them vulnerable

Inadequate

The practice is rated as inadequate for the care of people whose circumstances may make them vulnerable. This is because the concerns identified in relation to how safe, effective, caring and well led the practice was impacted on all population groups.

- The practice did hold a register of patients living in vulnerable circumstances. However the clinicians were unaware of this register.
- Staff knew how to recognise signs of abuse in vulnerable adults and children.
- Staff were aware of their responsibilities regarding information sharing and documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

Summary of findings

People experiencing poor mental health (including people with dementia)

Inadequate 

The practice is rated as inadequate for the care of people experiencing poor mental health (including people with dementia). This is because the concerns identified in relation to how safe, effective, caring and well led the practice was impacted on all population groups.

- The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive, agreed care plan documented in the record, in the preceding 12 months (01/04/2014 to 31/03/2015) was 58.8% lower than national average of 88.4%.
- There was no system in place to follow up patients who had attended accident and emergency (A&E) where they may have been experiencing poor mental health.
- The percentage of patients diagnosed with dementia whose care has been
- reviewed in a face-to-face review in the preceding 12 months (01/04/2014 to 31/03/2015) was 77% lower than national average of 84%

Summary of findings

What people who use the service say

The national GP patient survey results published on January 2016. The results showed the practice was performing in line with local and national averages. 361 survey forms were distributed and 122 were returned. This represented 2.5% of the practice's patient list.

- 72.1% found it easy to get through to this surgery by phone compared to a CCG average of 73.4% and a national average of 73.3%.
- 82.2% were able to get an appointment to see or speak to someone the last time they tried (CCG average 58.5%, national average 60%).
- 85.6% described the overall experience of their GP surgery as fairly good or very good (CCG average 81.9%, national average 84.8%).
- 65.5% said they would definitely or probably recommend their GP surgery to someone who has just moved to the local area (CCG average 71.9%, national average 77.5%).

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 36 comment cards most contained positive comments about the practice. Nine mentioned areas where patients were not completely satisfied, for example booking an appointment was difficult. One comment card stated that they felt not believed in consultation and was made to feel like they were making things up. Another stated the premises need a complete overall.

We spoke with seven patients during the inspection, most patients said they were happy with the care they received and thought staff were caring.

Areas for improvement

Action the service MUST take to improve

The areas where the provider must make improvements are:

- The provider must introduce clinical protocols and undertake clinical audit, care planning and quality improvements.
- Introduce quality assurance processes to act on and monitor histology and test results.
- Introduce processes and policies to ensure a safe practice environment is maintained with regards to Health and Safety of patients for example risk assessments, COSHH and cleaning maintenance.
- Introduce quality assurance processes for reporting, recording, acting on and monitoring of significant events and medicine management.
- Ensure infection control process and procedures are fully implemented.
- Implement a formal system to ensure all patient records are updated in a timely manner.
- Develop a plan to data summarise all outstanding medical notes.
- Implement processes and update current practice policies to reflect the practice and staff roles accurately.
- Place all clinical medical records into a secure storage.
- Ensure that staff receive appropriate training and supervision to enable them to carry out the duties they are employed to do with a clear record.
- Check all electrical equipment is safe, for example extension leads and plug in heaters.

Action the service SHOULD take to improve

The provider should:

- Implement a Patient Participation Group (PPG) in order to identify and act on patients' views about the service.
- Install a doorbell at the front door for wheelchair patients.

Droylsden Road Family Practice

Detailed findings

Our inspection team

Our inspection team was led by:

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

Background to Droylsden Road Family Practice

Droylsden Road Family Practice is located on the outskirts of Manchester and is overseen by North Manchester Clinical Commissioning Group (CCG). The practice is in a highly deprived area of Manchester.

The practice is based in a large two storey house. The ground floor held an entrance and reception area with a large waiting area. All the consulting rooms are located on the ground floor with two further smaller waiting areas. There is a disabled toilet on ground floor. The first floor is accessible by stairs to staff offices and storage areas. Access to the upstairs was not secured and could be accessed by anyone.

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

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

The practice has a General Medical Service (GMS) contract with NHS England. At the time of our inspection 4726 patients were registered.

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

Why we carried out this inspection

We inspected this service as part of our comprehensive inspection programme.

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

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?

Detailed findings

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

We also looked at how well services are provided for specific groups of people and what good care looks 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)

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. The inspector:

- Reviewed information available to us from other organisations e.g. NHS England.
- Reviewed information from CQC intelligent monitoring systems.
- Carried out an announced inspection visit on 8 March 2016.
- Reviewed patient survey information.
- Reviewed the practice's policies and procedures.

Inadequate

Are services safe?

Our findings

Safe track record and learning

There was no system in place for reporting and recording significant events to guarantee that sharing, learning, changing, actioning and the overall reviewing of all incidents was taking place. The practice had no clinical lead responsible in the overseeing of the process. When we spoke to the clinicians to provide an example of a significant event, one clinician stated they were unaware of what the practice records.

There were inconsistencies about what should be reported as an event with clinical staff. For example we were told of an incident where a patient had suffered a severe allergic reaction to a vaccination given in clinic, the patient received emergency treatment by form of an injection. We could find no record of this being documented as a significant event.

- Staff told us they would inform the practice manager of any incidents
- We saw that there was a standard form for recording events and a reporting system provided by the Clinical Commissioning Group to input and record events of significance.
- The GPs were not aware of any process or form in relation to recording an incident or significant event and stated they would holdinformal discussions.
- The practice did not have a process to follow up or analyse outcomes after the significant events had taken place.

We reviewed safety records, incident reports and national patient safety alerts. We could find no formal process in the distribution of medical alerts to all clinical staff. Some staff would receive alerts and some staff did not.

Overview of safety systems and processes

The practice had not maintained appropriate standards of cleanliness and hygiene. We observed the premises to be dirty and cluttered. We observed hazards throughout the practice, which were dangerous to patients, staff and all people entering the premises. For example:

- Flooring throughout the practice was visibly dirty. The walls throughout the practice were artexed and had cobwebs in areas and grime in the ridges.
- We observed an unlocked door which would not close fully, which led to an under stair cupboard which stored all the practices electrical fuse boxes and alarm system. Patients could easily access inside this cupboard.
- There were loose hanging wires in two areas of the main reception.
- There were exposed wires from an old telephone box, alongside an exposed water meter and a six inch protruding metal pipe (head height if sitting) from the wall in one of the smaller waiting areas.
- In the second waiting area there was a metal trolley, which had a baby changing mat on with no hygienic wipes or safety warnings.
- The cleaning cupboard contained one mop bucket and mop head which were dirty. There were no COSHH procedures in place or cleaning schedule. The practice hired an external cleaner who attended daily.
- In the consultation rooms and behind main reception area, we observed multiple electrical plug in radiators and wall heaters with trailing wires.
- Throughout the practice there was a build-up of old medical equipment, test kits, confidential files and medicines. For example, we identified multiple items stored in two cupboards which ranged from daily stock used in current practice, such as tongue decompressors, mixed with dirty and out of date items, for example old dirty scales and out of date test packs. There were no processes for checking or stock rotation of medical stock and equipment.
- We observed in one treatment room a number of used drug items on an extremely dirty treatment trolley which included injections, anaesthetic cream and a used implant package. The room was damp, cold, dusty and mouldy. The sink was dirty with a leaking pipe. The windowsill had four used empty water bottles (four litres), half bottle of mouthwash and various other medical items. The floor had a dirty carpet with a baby changing mat under the treatment bed.
- One room where the administration staff worked was extremely cluttered and disorganised. We observed an old fridge which had out of date medicines still stored inside.
- Behind the main reception area we found multiple old dusty patient notes on the windowsill and various places such as on top of old filing cabinets.

Inadequate

Are services safe?

The practice had no systems, processes and practices in place to keep patients safe and safeguarded from abuse, which included:

- Arrangements were not efficient to safeguard children and vulnerable adults from abuse; we did observe relevant legislation and local requirements and policies were accessible to all staff. There was no policy available for staff or locums, however there were posters and flow charts which stated who to contact for further guidance if staff had concerns about a patient's welfare. There was a clinical lead for safeguarding. The GPs did not attend safeguarding meetings; they did provide reports where necessary for other agencies. There was alert to identify children who were at risk; however there was no risk register kept in the practice. There was no record kept of patients under the age of 16 who had or were pregnant.
- Staff received training relevant to their role in 2011 with the newest member having training in 2014. The practice had acquired an E learning system for all staff. All staff had online access for safeguarding adult and children training. The clinicians were last trained in November 2012 to Safeguarding level three; we were told that dates for the clinicians to attend training was set for April or May 2016. We were told that staff did not receive protected learning time.
- All staff who acted as chaperones were trained for the role and had received a Disclosure and Barring Service check (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 an inconsistent response when we asked the staff who the infection control lead was. We found no evidence of any infection control audits taking place. There was a policy for infection control however this did not reflect their practice and was not implemented. Staff had not received training on infection control. There was a lot of medical equipment not clean. For example, we observed couch lamps in consultation rooms and medical trollies, with no formal cleaning procedure in place for staff to follow. There were spillage kits available on site and all staff knew where and how to access these.
- No process or arrangements for managing medicines, including emergency drugs and vaccinations, in the practice. For example, there was no defined process for the vaccine ordering and quantity checks. We were also informed that one GP had an out of date glyceryl trinitrate (GTN) spray that was waiting to be replaced; this spray is used to treat chest pain. Blank prescription pads were not securely stored and there were no systems in place to monitor non collected repeat prescriptions. We observed four boxes of unused blank prescription boxes behind a desk in the upstairs office. Patient Group Directions had been adopted by the practice to allow nurses to administer medicines in line with legislation.
- Patients test results and hospital admissions were not actioned in a consistent way with no clear process to ensure patient safety.
- We reviewed four personnel files and found However the practice could not provide documented evidence of indemnity insurance for a clinical member of the team on the day, nor DBS check for one of the clinical staff.
- There were no formal 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. There was no formal process in place although we saw evidence of the nurse monitoring with their own paper checks.
- One clinician was not aware of where their SMART card was located to access the clinical IT system. SMART cards are 'chip and pin' cards with your name and photograph used in a card reader attached to a computer, this allows access to patient's confidential medical records.

Monitoring risks to patients

Risks to patients were not assessed and well managed.

- There were no procedures in place for monitoring and managing risks to patient and staff safety. There was no health and safety policy available. All electrical equipment had not been checked to ensure the equipment was safe to use. However all clinical equipment had been checked to ensure it was working properly. The practice had no other risk assessments in place to monitor safety of the premises such as control of substances hazardous to health (COSHH) and legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings).

Inadequate

Are services safe?

- We found the fire safety arrangements inadequate, there were no working fire alarms in the practice; therefore no fire testing checks could take place. When we spoke to staff about how to raise the alarm in the event of a fire, they stated they would verbally raise the alarm. This was also reflected in a fire action document displayed in the waiting room.We observed the fire exit to the rear of the practice was locked with a chain and padlock. There had been a fire evacuation on 14/12/2015.
- The practice only had one record to show whether staff were immunised against infectious diseases. For Hepatitis B it is recommended that individuals at continuing risk of infection should be offered a single booster dose of vaccine, once only, around five years after primary immunisation and a blood test. It was not clear who in the practice was at continuing risk of infection. We were informed the GPs were up to date but no records were kept in the practice.
- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system in place for all the different staffing groups to ensure that enough staff were on duty.

Arrangements to deal with emergencies and major incidents

The practice had adequate arrangements in place to respond to emergencies, with no systems to deal with any major incidents.

- There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency.
- All staff received annual basic life support training, we were told every three year and there were emergency medicines available in the treatment room.
- The practice had no defibrillator available on the premises, however oxygen with adult and children's masks were available, there was no process in place to ensure regular checks were taking place.
- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and fit for use.
- The practice had no comprehensive business continuity plan in place for major incidents such as power failure or building damage.

Inadequate

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice told us they did review relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines.

- The practice had no systems in place to keep all clinical staff up to date. Staff had access to guidelines from NICE via google internet and told us they used this information to deliver care and treatment that met peoples' needs.
- The practice had no monitored process that these guidelines were followed through risk assessments, audits and random sample checks of patient records.

Management, monitoring and improving outcomes for people

The practice informed the inspection team that no clinical coding of patients medical records had taken place until June 2015. Since then the practice had been trying to resolve this issue. We did see evidence of a large number of medical records waiting to be summarised. There was no systematic process to fully summarise and READ code patient historic data into the clinical IT system, nor the assurance on how the practice will manage the backlog of 28 boxes of medical records.

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent published results were 71.7% of the total number of points available, with 3.8% exception reporting. (Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects). This practice was not an outlier for any QOF (or other national) clinical targets. Data from 2014/15 showed:

- The patients with hypertension having regular blood pressure tests was 62 % lower than local CCG of 83% and below national average of 84%.
- Performance for diabetes related indicators was 76.6% lower than the CCG average of 84% and national average of 89%.
- The dementia diagnosis rate indicator was 77.3% below the local CCG of 94% and national average of 78.3%.

The practice had no history of recorded clinical audits which demonstrated quality improvement.

- There had been three clinical audits completed in the last two years, none of these were completed two cycle audits.
- We identified the practice was not able to show clinical accountability for the running of the minor surgery clinics and no auditing of the effectiveness of this service had been undertaken. There was also no record kept of any histology being sent for analysis. Histology is the analysis of removed tissue under a microscope to make a precise diagnosis, and exclude conditions such as cancer.

Effective staffing

Most staff had the skills, knowledge and experience to deliver effective care and treatment but this knowledge was inconsistent, specifically across the clinical staff.

- Other than basic life support training staff had not received training that included infection control, mental capacity awareness, fire procedures, equality and diversity and information governance awareness.
- Clinical staff were out of date for level three safeguarding training, last taken in 2012.
- Administration staff had access to an online learning portal however staff had not completed safeguarding training level one.
- Staff did not have protective learning time available to them.
- There was evidence of appraisals taking place however there were no personal development plans in place for staff. The practice manager had not received an appraisal.
- The nurse could demonstrate that attendance to role-specific training and updates relevant to the role e.g. Mental Capacity and The Deprivation of Liberty Safeguards (DoLS), administering vaccinations and taking samples for the cervical screening programme.

Coordinating patient care and information sharing

Inadequate

Are services effective?

(for example, treatment is effective)

The information needed to plan and deliver care and treatment was not available to relevant staff in a timely and accessible way through the practice's patient record system.

- This included a number of care and risk assessments, care plans, medical records and investigation. The practice could not show evidence that they were effective in managing and monitoring test results in a consistent way. Information such as NHS patient information leaflets were available.

Staff worked with other health and social care services to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. This included attending monthly multi-disciplinary meetings.

Consent to care and treatment

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

- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005.
- When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance.
- Where a patient's mental capacity to consent to care or treatment was unclear the GP or practice nurse assessed the patient's capacity.

Supporting patients to live healthier lives

The practice had inconsistent approaches to identify patients who may be in need of extra support.

- The inspection team asked clinical staff about patients in the last 12 months of their lives. The clinician was unable to tell us how many patients were on the clinical IT system and was unaware of any register for palliative care. When we spoke with the practice manager they identified the practice had 64 patients on the palliative care register. The practice has double the national average in cancer deaths.

The practice's uptake for the cervical screening programme was 68.8%, which was below the national average of 81.8%. The practice had already discussed with the inspection team that there had been a coding problem within the practice which could have affected this result.

There was a policy to offer telephone reminders for patients who did not attend for their cervical screening test. The practice demonstrated how they encouraged uptake of the screening programme by using information in different languages and for those with a learning disability and they ensured a female sample taker was available. The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening.

Childhood immunisation rates for the vaccinations given were comparable to CCG/national averages. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 82 % to 100% and five year olds from 94% to 96%.

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

Inadequate

Are services caring?

Our findings

Kindness, dignity, respect and compassion

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

- Curtains were provided in consulting rooms to maintain patients' privacy during examinations, investigations and treatments.
- We noted that consultation and treatment room doors were closed during consultations. However we could hear conversations taking place in the treatment waiting area, therefore confidentiality could be breached.
- Reception staff knew when patients wanted to discuss sensitive issues or appeared distressed; they offered a private room to speak to patients.

We received 36 comment cards most contained positive comments about the practice. Several cards commented on the kindness of the staff. Nine mentioned areas where patients were not completely satisfied; booking an appointment was a common theme. One comment card stated that they felt not believed in consultations and were made to feel like they were making things up. Another stated they will only book to see locum GPs not the regular GPs.

We spoke with seven patients during the inspection, most patients said they were happy with the care they received and thought that staff were caring.

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

- 79.6% said the GP was good at listening to them compared to the CCG average of 86% and national average of 89%.
- 81.8% said the GP gave them enough time (CCG average 84%, national average 87%).
- 92.4% said they had confidence and trust in the last GP (CCG average of 93%, national average of 95%).
- 77.5% said the last GP they spoke to was good at treating them with care and concern (CCG average of 83%, national average of 85%).
- 87.7% said the last nurse they spoke to was good at treating them with care and concern (CCG average of 89%, national average of 90%).

Care planning and involvement in decisions about care and treatment

Most patients told us they felt involved in decision making about the care and treatment they received. However not all patients felt listened to and supported by clinical staff. They did feel they had sufficient time during consultations to make an informed decision about the choice of treatment available to them. Patient feedback on the comment cards we received was also mixed but aligned with these views.

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

- 80.2% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 84% and national average of 86%.
- 67.6% said the last GP they saw was good at involving them in decisions about their care (CCG average 79%, national average 81%)
- 82% said the last nurse they saw was good at involving them in decisions about their care (CCG average 85.6% , national average 84.8%)

Staff told us that translation services were available for patients who did not have English as a first language.

Patient and carer support to cope emotionally with care and treatment

Notices in the patient waiting room told patients how to access a number of support groups and organisations.

The practice held a carers register with 45 patients on the register, this accounted for 0.9 % of the practice population. One clinician told us there was no way to identify carers on the IT system. The practice's computer system did not alert GPs if a patient was also a carer and although they identified patients who were carers, they did nothing with the information.

Inadequate

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice did not review the needs of its local population. They had engaged with the Clinical Commissioning Group (CCG) to secure help with services such as implementing the Incident Reporting system with the practice manager.

- The practice had not maintained appropriate standards of cleanliness and hygiene. Throughout the practice there was a build-up of dirt, dust, mould and clutter.
- We observed multiple hazards throughout the whole practice for example; we observed a metal post for hanging a flat screen TV outside the patient toilet (the TV had to be removed due to patients bumping their head) the metal mount was left protruding from the wall at head height.
- Consultation rooms were cold and damp, we observed plug in wall heaters and radiators in patient's pathways which could easily cause a trip.
- We observed old blood stained finger prints on the reception desk.
- There was disabled toilet access; however the access into the disabled toilet was not secure with separate access via the patient's waiting room through a sliding door with an outside latch.
- The main access into the building for wheelchair users would be difficult if you were not accompanied by another person. There was no means to call for assistance, no ramp and no self-opening doors.
- Translation services were available.
- The practice was currently piloting the new online services.

Access to the service

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

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

- 71.6% of patients were satisfied with the practice's opening hours compared to the CCG average of 75% and national average of 75%.
- 72.1% patients said they could get through easily to the surgery by phone (CCG average 72%, national average 73%).
- 74.19% patients said they always or almost always see or speak to the GP they prefer (CCG average 58.5%, national average 60%).

People told us on the day of the inspection that it was difficult to book appointments.

Listening and learning from concerns and complaints

The practice did not had adequate systems in place for handling complaints and concerns.

- There was a designated responsible person who handled complaints in the practice and they would respond to all official complaints in a timely manner. However verbal complaints were not recorded. There was no complaints policy or procedure.
- The practice held annual meeting where complaints would be discussed; not all staff would be invited to attend. There were no minutes of these meetings documented with no shared learning taken place.
- We saw that information was available to help patients understand the complaints system in the practice leaflet.

We looked at four complaints received in the last 12 months and found these were satisfactorily handled and dealt with in a timely way.

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

There were no vision or strategy for the future documented and staff were unaware of the vision and values for the practice. When we spoke to the administration staff they did all indicate they strive to deliver the best care and service to patients.

Governance arrangements

The arrangements for governance and performance management did not operate effectively.

- There was a staffing structure in place and staff were aware of their own roles and responsibilities. Clinical staff however did not involve themselves in the formulation and embedding of protocols in order to provide support and input to improve services for patients.
- The practice had a number of policies. We found these policies were not a true reflection of daily practice with variations in dates and multiple repeats of the same policy in different forms. We received inconsistent responses about who held lead roles such as infection control .
- The practice did not communicate their policies to staff, for example when we asked staff about the practice's business continuity plan they were not aware of this policy.
- We found complaints that were investigated appropriately had no review or assessment to show whether learning had changed as a result of any action taken.
- We did not see a clear process to identify which staff had undertaken training, for example not all relevant staff had received training on infection control or safeguarding. Both GP partners were out of date for safeguarding level three.
- There was no evidence of continuous clinical and internal audit which is used to monitor quality and to make improvements. When we spoke with the clinician about peer support or implementing improvements, we were told there was no time for improvements.

Leadership and culture

The practice did not have the clear clinical leadership or support from partners, this was reflected on the whole practice's minimal systems and processes, that should ensure safety and high quality care. The GPs were visible in the practice and some staff told us that they were approachable. However they did not meet the requirements of the Health and Social Care Act. There were multiple issues and serious concerns identified that threatened the delivery of safe and effective care, which the practice had not identified or adequately managed.

The provider was aware of and complied with the requirements of the Duty of Candour.

- There were no minutes of discussions at practice meetings. However we were informed informal discussions would take place between staff.
- Staff told us they would raise any issues to the practice manager and said they would feel supported if they did.

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

There was no patient participation group (PPG) at the practice. The practice had minimal engagement with people who used the service only relying on the national patient survey results.

Continuous improvement

We were told that clinical staff have no time to encourage innovation or learning.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **How the regulation was not being met:** Care and treatment was not provided in a safe way for service users because: • The practice had no clinical lead taking accountability in the overall running of the practice. • Patients were at risk of harm because inadequate systems were in place to keep patients safe • Policies and checks relating to health and safety, fire safety and risk assessments were not available. • There was no record of audits or performance improvement process in place to improve practice. • There was no record of minor surgery procedure, including histology and audits. • The registered provider did not have effective systems in place to manage and monitor the prevention and control of infection. • The registered provider did not have suitable arrangements in place for the proper and safe management of medicines. This was in breach of regulation 12 (1) and (2) (a) (b) (c) (d) (e) (f), (g) and (h) 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 15 HSCA (RA) Regulations 2014 Premises and equipment **How the regulation was not being met:** The registered provider had not maintained appropriate standards of cleanliness and hygiene. The registered provider had not risk assessed multiple hazards, some of which included:

This section is primarily information for the provider

Requirement notices

- Protruding 6 inch metal pipe from the wall clearly exposed to any patients.
- Old blood stain on the front reception waiting area desk
- Exposed wires and water metre in waiting area
- Exposed metal bracket at head height
- The registered provider had no COSHH procedures in place or any cleaning schedules available.
- Treatment rooms were damp, cold, dusty and mouldy .

This was in breach of regulation 15 (1) (a) (c) (d) (e) and (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:** The registered provider did not have suitable arrangements in place to manage risks relating to the health, safety and welfare of service users and others were not appropriately assessed, monitored and mitigated. The registered person did not maintain an accurate, complete and contemporaneous record in respect of each service user. The registered provider did not have suitable arrangements in place to ensure all systems and processes were fully established and operated effectively. This was in breach of regulation 17 (1) and (2) (a) (b) (c) (d) (e) (f) 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	Regulation 18 HSCA (RA) Regulations 2014 Staffing **How the regulation was not being met:**

This section is primarily information for the provider

Requirement notices

Treatment of disease, disorder or injury

The registered provider had not ensured that persons employed received appropriate, training to enable them to carry out the duties they were employed to do.

Not all staff received appropriate support, training, and appraisal to enable them to carry out the duties they were employed to perform.

This was in breach of regulation 18 (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.