Dr Ankur Chopra

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?	Good
Are services caring?	Good
Are services responsive to people's needs?	Requires improvement
Are services well-led?	Inadequate

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

Dr Chopra's practice was inspected in October 2015. It was rated inadequate in safe and well-led services. The practice was rated as requires improvement in effective and as good in caring and responsive. As a result the practice was placed into special measures and a warning notice was issued. In March 2016 we carried out a focussed inspection of the areas covered by the warning notice and found that they had not been met. As a result a condition was imposed on the practice to ensure there was sufficient, effective and co-ordinated management support for the practice to achieve compliance with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and to sustain that compliance.

The practice was inspected again on 6 July 2016. The practice is rated as inadequate for safe and well-led services and overall. They are rated as requires improvement for responsive services and good in effective and caring.

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

- Patients were at risk of harm because systems and processes were not in place to keep them safe. For example infection control, maintenance and security issues at the branch surgery had not been sufficiently addressed.
- There was no clear process within the practice for the recording of notifiable incidents under the duty of candour.
- There was limited evidence that complaints had been thoroughly investigated, appropriately responded to or that learning from complaints had been shared with staff.
- Not all nursing staff were trained to the appropriate level of child safeguarding.
- While improvements had been made in relation to appropriate recruitment checks on staff there were still gaps apparent in relation to recruitment records. One new member of staff had commenced in post without a Disclosure and Barring Service check although the practice had carried out an associated risk

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assessment. Another staff member in an interim position had no record of the terms or nature of this position on their file. Contracts of employment had not been signed by the employer and the practice did not hold staff immunity records on file.

- The practice had ensured that staff received an annual appraisal; however induction records for new staff were not completed. Training records were inconsistent and there were gaps in the mandatory training completion for some staff.
- The leadership structure and capacity of the practice was not clear and while there were governance arrangements in place these were limited in relation to the management of risk and appropriate mitigating actions.
- There were ongoing maintenance issues identified at the branch surgery and these had not been adequately addressed. This included an issue with security of the surgery where access was available through a connecting door from the attached residence.
- Staff were clear about reporting incidents, near misses and concerns however there was little evidence of robust investigation processes, learning and communication with staff. Complaints were not adequately addressed and associated records of investigations and actions were not kept.
- Improvements had been made in relation to medicines management however there continued to be some issues relating to this. For example, in relation to the adoption of patient group directions, the availability of emergency medicines, the management of medicine incidents and the use of patients own dressings within the practice.
- Patients were positive about their interactions with staff and said they were treated with compassion and dignity.
- Patient outcomes were high when compared with local and national averages.
- Patients consistently told us they were happy with the treatment and care they received from the practice.

The areas where the provider must make improvements are:

- Introduce effective processes for analysing, recording, acting on, monitoring and learning from significant events, incidents, near misses and complaints.
- Ensure effective processes are in place within the practice for the recording of notifiable incidents under the duty of candour.
- Ensure all staff are trained to the appropriate level of child safeguarding.
- Take action to address identified concerns with infection prevention and control practice.
- Ensure recruitment records include contracts signed by both the staff member and employer and evidence of staff immunity checks.
- Ensure that all staff have appropriate recruitment checks prior to commencing in post and that when staff roles change these changes are reflected in the documents and contracts held.
- Ensure that structured induction processes are in place and recorded for new staff.
- Ensure that all staff complete mandatory training in line with their roles in a regular and timely manner and that training logs are clear and up to date.
- Carry out clinical audits including re-audits to ensure improvements have been achieved based on areas of risk and necessary improvements identified within the practice.
- Ensure that formal governance arrangements are effective including systems for assessing and monitoring risks and the quality of the service provision.
- Clarify the leadership structure and ensure there is leadership capacity to deliver all improvements.
- Ensure that maintenance and security issues at Guestling (branch surgery) are addressed in a timely manner and with sufficient regard for the associated risks.
- Ensure that ongoing medicine management issues are effectively addressed. This must include ensuring that the appropriate emergency medicines are available to reflect the risks associated with procedures being undertaken within the practice.

The provider should also:

- Ensure that information for carers is accessible, including the use of links through the practice website.

This service was placed in special measures in February 2016. Insufficient improvements have been made such

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that there remains a rating of inadequate overall and for safe and well-led services. We are now taking further action in relation to this provider and will report on this when it is completed.

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.

- Although the practice carried out investigations when there were unintended or unexpected safety incidents, these were not sufficiently thorough and lessons learned were not communicated and so safety was not improved. Records relating to investigations and communication with patients were insufficient.
- Not all nursing staff were trained to the appropriate level of child safeguarding.
- Patients were at risk of harm because systems and processes were not implemented in a way to keep them safe. For example there was inadequate security at the branch surgery, infection control processes were not embedded, cleaning practices were insufficient at the branch surgery, and maintenance issues were not dealt with in a timely way.
- Medicines were not managed in a way that kept people safe due to a lack of appropriate emergency medicines, patient group directions not being adopted in line with requirements, a dispensing error not being appropriately logged and addressed and dressings prescribed for and brought to the practice by one person had been returned to stock.
- There had been improvements in recruitment practices from a previous inspection, however issues remained in terms of staff contracts not being appropriately signed, staff immunity not being checked and interim role changes not being subject to contractual or role definition amendments.

Are services effective?

Good

The practice is rated as good for providing effective services.

- Data showed patient outcomes were high compared to the national average. For example performance for diabetes related indicators was similar to the local and national average at 92.6% compared to 93% (CCG) and 89.2%. Performance for mental health related indicators was better than local and national averages at 100% compared to 97.2% (CCG) and 92.8% (national).
- Rates for cervical screening and childhood vaccines were higher than or comparable to local and national averages.
- Clinical audits were being undertaken.

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- Multidisciplinary working was taking place with involvement from external professionals and clinical meetings were regularly undertaken with neighbouring practices.

Are services caring?

Good

The practice is rated as good for providing caring services.

- Data from the national GP patient survey showed patients rated the practice higher than others for several aspects of care.
- Patients 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.

Are services responsive to people's needs?

Requires improvement

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

- Urgent appointments were available on the same day.
- The practice had appropriate facilities and was equipped to meet people's needs.
- Patients could get information about how to complain in a format they could understand. However, there was limited evidence that complaints had been thoroughly investigated, appropriately responded to or that learning from complaints had been shared with staff.
- Results from the national GP patient survey showed that the practice scored highly in comparison to other local and national services in relation to access to services and satisfaction with care and treatment.

Are services well-led?

Inadequate

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

- The practice had a vision for a future that included merging with a neighbouring practice but the strategy for this was unclear. Staff and leadership roles were not always clear.
- While it was clear that the GP and nurse practitioner were taking the lead clinically, it was unclear where the management responsibility for the practice lay. Interim roles were in place so there was no overarching or consistent management presence.
- The practice had recently developed a number of policies and procedures to govern activity and these were in the process of

being adopted, however these did not individually include details of review dates and the process for approval. There was a central log of when policies were due to be renewed but sections on the policies relating to who authorised them were not always completed.

- There was a lack of governance structure. For example risk management activities were inconsistent and there was a lack of urgency in addressing areas of risk such as security and maintenance issues at the branch surgery.
- Significant event and complaint analysis, investigation and learning were not sufficiently robust.
- The practice held regular meetings and had undertaken staff appraisals. Staff reported that communication had improved in recent months.
- The practice had an active PPG.

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

Due to the issues identified within the practice the service is rated as inadequate for the care of older people. The identified issues included the management of medicines; maintenance and security issues; a lack of robust risk management processes; issues relating to recruitment, induction and staff training; and, a poorly structured leadership approach. However;

- The practice offered proactive, personalised care to meet the needs of the older people in its population.
- The practice was responsive to the needs of older people, and offered home visits and urgent appointments for those with enhanced needs.
- Nationally reported data showed that outcomes for patients for conditions commonly found in older people were comparable to local and national averages. For example performance relating to secondary prevention of coronary heart disease at 100% was comparable to the national average of 95%.

People with long term conditions

Inadequate

Due to the issues identified within the practice the service is rated as inadequate for the care of care of people with long-term conditions. The identified issues included the management of medicines; maintenance and security issues; a lack of robust risk management processes; issues relating to recruitment, induction and staff training; and, a poorly structured leadership approach. However;

- Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority.
- Performance for diabetes related indicators was similar to the local and national average at 92.6% compared to 93% (CCG) and 89.2%.
- Longer appointments and home visits were available when needed.
- For those patients with the most complex needs, the clinical team worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Inadequate

Due to the issues identified within the practice the service is rated as inadequate for the care of care of families, children and young people. The identified issues included the management of

Summary of findings

medicines; maintenance and security issues; a lack of robust risk management processes; issues relating to recruitment, induction and staff training; and, a poorly structured leadership approach. However;

- There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. Immunisation rates were relatively high for all standard childhood immunisations.
- Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this.
- The practice's uptake for the cervical screening programme was 83.62% which was comparable to the CCG average of 81.83% and above the national average of 74%.
- 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

Due to the issues identified within the practice the service is rated as inadequate for the care of care of working age people (including those recently retired and students). The identified issues included the management of medicines; maintenance and security issues; a lack of robust risk management processes; issues relating to recruitment, induction and staff training; and, a poorly structured leadership approach. However;

- The needs of the working age population, those recently retired and students had been identified and the practice offered early morning GP and nursing appointments and telephone appointments for this group of patients.
- The practice was proactive in offering 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

Due to the issues identified within the practice the service is rated as inadequate for the care of people whose circumstances may make them vulnerable. The identified issues included the management of medicines; maintenance and security issues; a lack of robust risk management processes; issues relating to recruitment, induction and staff training; and, a poorly structured leadership approach. However;

Summary of findings

- The practice worked with multi-disciplinary teams in the case management of vulnerable people.
- The practice had 25 patients on their learning disabilities register and worked closely with patients, carers and families to complete regular patient reviews. Appointments were offered at the end of surgery if requested to ensure that the surgery was less busy for patients with special needs.
- Staff knew how to recognise signs of abuse in vulnerable adults and children and they were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies out of normal working hours.

People experiencing poor mental health (including people with dementia)

Inadequate 

Due to the issues identified within the practice the service is rated as inadequate for the care of people experiencing poor mental health (including people with dementia). The identified issues included the management of medicines; maintenance and security issues; a lack of robust risk management processes; issues relating to recruitment, induction and staff training; and, a poorly structured leadership approach. However;

- 90.9% of patients with poor mental health had a structured care plan in place which was 8.1% higher than local average and 13.7% higher than national average.
- Performance for mental health related indicators was better than local and national averages at 100% compared to 97.2% (CCG) and 92.8% (national).
- The practice worked with multi-disciplinary teams in the case management of people experiencing poor mental health and those with dementia.

Summary of findings

What people who use the service say

The national GP patient survey results were published on 7 July 2016. The results showed the practice was performing above local and national averages. 224 survey forms were distributed and 115 were returned. This represented 3% of the practice's patient list.

- 96% of patients found it easy to get through to this practice by phone compared to the national average of 73%.
- 98% of patients were able to get an appointment to see or speak to someone the last time they tried compared to the national average of 76%.
- 96% of patients described the overall experience of this GP practice as good compared to the national average of 85%.
- 92% of patients said they would recommend this GP practice to someone who has just moved to the local area compared to the national average of 79%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 20 comment cards which were all positive about the standard of care received. These included comments about the caring and sensitive staff, feeling listened to and general comments about patients feeling happy or satisfied with the service.

We spoke with five patients during the inspection. All five patients said they were satisfied with the care they received and thought staff were approachable, committed and caring.

Areas for improvement

Action the service MUST take to improve

- Introduce effective processes for analysing, recording, acting on, monitoring and learning from significant events, incidents, near misses and complaints.
- Ensure effective processes are in place within the practice for the recording of notifiable incidents under the duty of candour.
- Ensure all staff are trained to the appropriate level of child safeguarding.
- Take action to address identified concerns with infection prevention and control practice.
- Ensure recruitment records include contracts signed by both the staff member and employer and evidence of staff immunity checks.
- Ensure that all staff have appropriate recruitment checks prior to commencing in post and that when staff roles change these changes are reflected in the documents and contracts held.
- Ensure that structured induction processes are in place and recorded for new staff.
- Ensure that all staff complete mandatory training in line with their roles in a regular and timely manner and that training logs are clear and up to date.
- Carry out clinical audits including re-audits to ensure improvements have been achieved based on areas of risk and necessary improvements identified within the practice.
- Ensure that formal governance arrangements are effective including systems for assessing and monitoring risks and the quality of the service provision.
- Clarify the leadership structure and ensure there is leadership capacity to deliver all improvements.
- Ensure that maintenance and security issues at Guestling (branch surgery) are addressed in a timely manner and with sufficient regard for the associated risks.
- Ensure that ongoing medicine management issues are effectively addressed. This must include ensuring that the appropriate emergency medicines are available to reflect the risks associated with procedures being undertaken within the practice.

Action the service SHOULD take to improve

- Ensure that all carers are identified within the practice and that a register is held.

Dr Ankur Chopra

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 pharmacy inspector and a practice manager specialist adviser.

Background to Dr Ankur Chopra

Dr Ankur Chopra offers general medical services to people living in Hastings. There are approximately 3850 registered patients. The practice is registered as an individual. Dr Chopra is supported by a nurse practitioner, two nurses and a team of receptionists and administration staff. There was no practice manager in post at the time of our inspection as the previous manager had retired. Staff told us there were no plans to recruit a permanent manager at the present time as the practice was considering a partnership/merger agreement with a neighbouring practice. At the time of inspection there was an interim project manager in post who was working with the practice to improve systems and processes. In addition the practice had promoted a member of the reception team to provide office management support and take day to day responsibility for the practice.

The practice was open between 8.30am to 6.30pm Monday to Thursday and 8.30am to 5.oopm on Fridays. The practice worked with a neighbouring practice to ensure reciprocal arrangements for cover on site for emergencies between 8.00am and 6.30pm on a daily basis. Early morning appointments were available from 7.30am at both Guestling and Roebuck surgeries during the week. 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.

The patient population included a 2% lower proportion of children when compared with the local average and slightly (1.4%) more patients over the age of 75 than the national average. The practice had 12% less patients with a long standing health condition than the local average and lower than average unemployment.

The practice runs a number of services for its patients including asthma clinics, child immunisation clinics, diabetes clinics, new patient checks, and weight management support.

Services are provided from:

Roebuck House, High Street, Hastings, East Sussex, TN34 3EY

A branch surgery is located at:

Guestling Surgery,Chapel Lane, Guestling, Hastings, TN35 4HN

The practice has opted out of providing Out of Hours services to their patients. There are arrangements for patients to access care from an Out of Hours provider IC24.

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. This was a follow up inspection following the practice being placed into special measures as a result of a previous inspection.

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 6 July 2016. During our visit we:

- Spoke with a range of staff including interim management staff, nursing staff, reception staff, the GP, nurse practitioner and spoke with patients who used the service.
- Observed how patients were being cared for and talked with carers and/or family members
- Reviewed an anonymised 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 a system in place for reporting and recording significant events.

- Staff told us they would inform the office manager of any incidents. There was a recording form available on the practice's computer system.
- The incident recording form included sections to record preventable and non-preventable factors as well as an action plan and follow up. There was no section relating to the recording of notifiable incidents under the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).
- We viewed three significant events that had been recorded between March and May 2016. There were inconsistencies in how incidents were recorded. For example we viewed one record where a box of medicines including controlled drugs, from a patient who had died 20 months previously had been found on a shelf in reception. The significant event monitoring form was incomplete in terms of action plan and follow-up and it was unclear from this record if staff had been interviewed and the incident thoroughly investigated to identify contributing factors and lessons to reduce the risk of reoccurrence.
- There was limited recorded evidence that when things went wrong with care and treatment, patients were informed of the incident, received reasonable support, truthful information, a written apology and were told about any actions to improve processes to prevent the same thing happening again. However, staff did tell us that patients received a verbal apology when things went wrong.
- The practice did not appear to carry out a thorough analysis of significant events. There was no significant event log and records kept did not include details of investigations and action plans to ensure adequate improvements.

We reviewed safety records and incident reports. We were told that significant events would be discussed at meetings, however these were not recorded in the minutes of meetings we viewed and significant events was not a standing agenda item. This was an ongoing concern that had been highlighted during a previous inspection and it continued to be unclear how lessons were shared and action was taken to improve safety in the practice. For example, we saw that an incident where an urgent referral for investigation which was not received by the hospital was brought to the attention of the practice when the patient returned four weeks later with worsening symptoms. The action plan on the recording form included that the incident would be discussed at the practice meeting on 16 April 2016. There was no evidence that this happened. In addition the action stated that staff faxing a referral should record that they had done so, however this would not necessarily lead to improved practice without a check or audit that all referrals had been received.

Overview of safety systems and processes

The practice had clearly defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from abuse, which included:

- Arrangements were in place to safeguard children and vulnerable adults from abuse. These arrangements reflected relevant legislation and local requirements. Policies were accessible to all staff through the intranet although these were not visible within the practice. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. The nurse practitioner was the lead member of staff for safeguarding. The nurse practitioner attended safeguarding meetings when possible and they and the GP provided reports where necessary for other agencies. Staff demonstrated they understood their responsibilities and most had received training on safeguarding children and vulnerable adults relevant to their role. The GP and nurse practitioner were trained to child safeguarding level three. A second nurse had a record of attending level one child safeguarding but not level two.

- A notice in the waiting room advised patients that chaperones were available if required. All staff who acted as chaperones were trained for the role and had received a Disclosure and Barring Service (DBS) check. (DBS 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).
- The practice did not sufficiently maintain appropriate standards of cleanliness and hygiene. For example while the main surgery appeared to be clean, at the branch

surgery at Guestling we saw that there was visible dust in the nurses room, discolouration of the carpet in the waiting area and a toilet was visibly dirty. Reception staff at the branch surgery were not all clear about how to access spill kits. The practice nurse was the infection control clinical lead although they had not yet attended the appropriate leads training. They were due to attend this later in the month following our inspection. Following concerns raised at a previous inspection the project manager and office manager had met with the infection control lead for the CCG the week before inspection, who walked through the surgery with them to identify areas for improvement. The practice nurse was not involved in this but was aware of the advice given and told us of plans to properly and regularly audit the practice in relation to infection control once they had attended training. We saw evidence that the practice had taken some action to improve infection control, for example by replacing curtains with disposable ones. There was an infection control protocol in place although staff had not received up to date training other than handwashing. Annual infection control audits had not been carried out consistently. Waste management arrangements were in place although at Guestling surgery we saw sharps bins that had not been correctly labelled.

- The arrangements for managing medicines, including emergency medicines and vaccines, in the practice did not always keep patients safe (including obtaining, prescribing, recording, handling, storing, security and disposal). For example we found that whilst medicines were stored securely at Roebuck surgery, a door connecting Guestling surgery with an attached residential property was only lockable from the inside of the residential property. This meant that unauthorised people could access dispensed medicines awaiting collection, along with the prescription forms which were attached to them. However a table had been put against the door to try and prevent access from the residential property. The practice confirmed that they had been unable to make alternative arrangements due to the lease arrangements with the owner of the residential property. Processes were in place for handling repeat prescriptions which included the review of high risk medicines. The practice carried out regular medicines audits, with the support of the local CCG pharmacy teams, to ensure prescribing was in line with best practice guidelines for safe prescribing. Blank prescription forms and pads were securely stored and there were systems in place to monitor their use. Patient Group Directions had been adopted by the practice to allow nurses to administer medicines in line with legislation. However, at Roebuck surgery we found two PGDs which had been signed by the doctor but not dated, and another which had been signed by a practice nurse but not the GP. A further PGD had been signed by a GP from a neighbouring practice, not by Dr Chopra as the authorising manager. Patient Group Directions (PGDs) used for the administration of vaccines must be signed and dated by the authorising manager.
- On 06 July 2016 the near miss log in the dispensary at Guestling showed a dispensing error which had reached a patient on 15 June 2016. This was logged as a near miss and not an error. This meant that it had not been shared with the main practice as a significant event. As a result, no significant event analysis was undertaken.
- All medicine and vaccine refrigerators at both the main practice and the Guestling branch surgery had their minimum and maximum temperatures checked and recorded daily. On 06 July 2016 we found that an appropriate container had been obtained and the cold chain was validated, with appropriate records kept. This was an area of improvement following previous inspections.
- There was a named GP responsible for the dispensary and all members of staff involved in dispensing medicines had received appropriate training and had opportunities for continuing learning and development. The practice used standard operating procedures (SOPs) for dispensing, which staff had signed. The SOPs had been reviewed recently and contained a future date for review. The dispensary manager had also amended these in light of previous significant events to ensure that practice would be safer as a result. The dispensary manager had undertaken initial audits of controlled drugs and fridge temperature monitoring to help work towards safer practice. Medicines safety alerts were received and acted upon.
- The practice held stocks of controlled drugs (medicines that require extra checks and special storage because of their potential misuse) and had procedures in place to manage them safely. Improvements from a previous inspection included entries in the controlled drug

register being signed by a GP and the register being appropriately maintained. There were also arrangements in place for the destruction of controlled drugs.

- On 1 March 2016 the practice did not hold the expected list of emergency medicines and there was no risk assessment in place for this. This was still the case on 06 July 2016. The practice did not have an appropriate risk assessment and the practice did not store a range of emergency medicines which are relevant to the medical procedures undertaken. Additionally, ampoules of two different concentrations of a medicine used to treat severe allergic reactions were found stored loose in the emergency medicines bag. The practice had not ensured that these medicines were stored in a manner which minimised the risk of incorrect selection. Processes were in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.
- We reviewed five personnel files and found appropriate recruitment checks had been undertaken prior to employment for staff appointed within recent months. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks of gaps in employment. This was an area of improvement from previous inspections. However, one long standing member of staff still did not have a full employment history record held on file.
- The practice had ensured that most staff had the appropriate checks through the Disclosure and Barring Service which was a further area of improvement from previous inspections. However, we saw that one member of staff had recently commenced in post without a check or a risk assessment although the check had been applied for.
- We saw that there was a process in place for checking the immunity of staff in the form of a record sheet within staff files; however these had not been completed in any of the staff files we viewed. Since the inspection the practice have sent further information that demonstrates progress in ensuring that all clinical staff have a record of their immunity.
- There were contracts of employment held on file; however none of those we viewed had been signed by the employer, only by the staff member.
- There was no record of contractual changes or revised role definition for a member of staff appointed to an interim role.

Monitoring risks to patients

There were some inconsistencies in how risks to patients were assessed and well managed.

- There were procedures in place for monitoring and managing risks to patient and staff safety. There was a health and safety policy available with a poster in the reception office which identified local health and safety representatives. The practice had up to date fire risk assessments and carried out regular fire drills. All electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly. The practice had a variety of other risk assessments in place to monitor safety of the premises such as control of substances hazardous to health and infection control and legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings). However, while we saw that regular temperature checks were carried out in line with the legionella risk assessment the temperatures on 20 June 2016 had been below the required temperature. We viewed a note stating that a contractor had been contacted but there was no evidence that the required work had been carried out and on the day of inspection the water from the hot taps was cool to the touch.
- There were maintenance issues at the branch surgery, such as a broken window. We were told that a quote had been sought for a replacement; however there was no evidence of action being taken to rectify this.
- Security at the branch practice was compromised due to the practice being accessible to unauthorised personnel via a residence attached to the surgery. The practice had not assessed the risk of this and had failed to take action to rectify it.
- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system in place for all the different staffing groups to ensure enough staff were on duty and we saw that recruitment had taken place to improve staffing of reception, the dispensary and nursing teams.

Arrangements to deal with emergencies and major incidents

Inadequate

Are services safe?

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

- There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency.
- Most staff received annual basic life support training although one member of the nursing team had not attended a basic life support update for more than two years. There were emergency medicines available in the treatment room.
- The practice had a defibrillator available on the premises and oxygen with adult and children's masks. A first aid kit and accident book were available.
- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and stored securely. The practice had made improvements from a previous inspection in relation to the storage and accessibility of emergency medicines. However, there continued to be issues with the expected emergency medicines not in place within the practice. For example, the practice were carrying out coil insertions where there are specific risks associated with the procedure and the practice did not have the appropriate emergency medicines in stock to manage this.
- We were told that the practice had a business continuity plan in place for major incidents such as power failure or building damage, however staff were unable to locate this at the time of our inspection.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice assessed needs and delivered care in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines.

- The practice had systems in place to keep all clinical staff up to date. Staff had access to guidelines from NICE and used this information to deliver care and treatment that met patients' needs.
- Staff we spoke with were familiar with best practice guidance and patients' needs were thoroughly assessed in relation to this.

Management, monitoring and improving outcomes for people

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 99.9% of the total number of points available which was 4.2% above the national average. Exception reporting was 3.4%, 5.8% below the national average. (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:

- Performance for diabetes related indicators was similar to the local and national average at 92.6% compared to 93% (CCG) and 89.2%.
- Performance for mental health related indicators was better than local and national averages at 100% compared to 97.2% (CCG) and 92.8% (national).
- 93.2% of patients on the COPD (chronic obstructive pulmonary disease) register had had a review including an assessment of breathlessness in the preceding 12 months. This was 8.7% above local and 13.3% above national averages.

The practice were higher than average prescribers of antibacterial and hypnotic medicines and we saw that the GP was working with the CCG prescribing advisor and utilising advice relevant to this, however these rates had remained high over a period of several months.

There was evidence of some quality improvement including clinical audit.

- There had been three clinical audits undertaken in the last six months, none of these were completed audits where the improvements made were implemented and monitored. However, we saw that a second cycle of a diabetic audit was in progress.
- The practice participated in local audits and peer review.
- Findings were used by the practice to improve services. For example, recent action taken as a result included improving coding for patients on the diabetic register and review of patients on the diabetic register with high blood pressure.

Information about patients' outcomes was used to make improvements in relation to patient assessments and history taking.

Effective staffing

There was some evidence that staff had the skills, knowledge and experience to deliver effective care and treatment.

- The practice were developing an induction programme for all newly appointed staff. This covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality. However, we were told this was a new programme that was in the process of being developed. We viewed the files of three new staff, none of which had a completed or partially completed induction record on file.
- The practice could demonstrate how they ensured role-specific training and updating for relevant staff. For example, for those reviewing patients with long-term conditions. Nursing staff we spoke with told us they had attended training in areas such as diabetes, wound care and spirometry.
- Staff administering vaccines and taking samples for the cervical screening programme had received specific training which had included an assessment of competence. Staff who administered vaccines could

Good

Are services effective?

(for example, treatment is effective)

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.

- The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. Staff had access to an online training system and additional face to face training was available in areas such as fire safety and basic life support. All staff had received an appraisal within the last 12 months which was an improvement from previous inspections.
- Staff had access to training that included: safeguarding, fire safety awareness, and basic life support and information governance. However, there were inconsistencies in completion of these courses. For example only three out of seven administrative and reception staff had attended equality and diversity training and only four out of seven had a record of attending fire training. Only three out of sixteen staff had a record of completing information governance training.

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.

Staff worked together and with other health and social care professionals to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. This included when patients moved between services, including when they were referred, or after they were discharged from hospital. Meetings took place with other health care professionals on a monthly basis when care plans were routinely reviewed and updated for patients with complex needs. We also saw that patients being discharged from hospital would be contacted and offered an appointment for review.

Consent to care and treatment

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

- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005.
- When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance.
- Where a patient's mental capacity to consent to care or treatment was unclear the GP or practice nurse assessed the patient's capacity and, recorded the outcome of the assessment.
- Procedures such as joint injections and coil insertions required written consent and we saw evidence of this. We did not see audits of consent.

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, carers, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation and lifestyle issues were signposted to the relevant service.
- Nurses provided information and advice about a range of health and wellbeing issues including health checks. We saw that patients had access to a variety of information leaflets.

The practice's uptake for the cervical screening programme was 83.62% which was comparable to the CCG average of 81.83% and above the national average of 74%. 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 ensuring a female sample taker was available. The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening. 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 comparable to CCG/national averages. For example,

Good

Are services effective?

(for example, treatment is effective)

childhood immunisation rates for the vaccinations given to under two year olds ranged from 92% to 96% and five year olds from 92% to 97%. Both of these ranges matched the CCG average.

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.

Good

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.

All of the 20 patient Care Quality Commission comment cards we received were positive about the service experienced. 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 five patients including on 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. Comment cards highlighted that staff responded compassionately when they needed help and provided support when required.

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:

- 93% of patients said the GP was good at listening to them compared to the clinical commissioning group (CCG) average of 89% and the national average of 89%.
- 91% of patients said the GP gave them enough time compared to the CCG average of 87% and the national average of 87%).
- 98% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 95% and the national average of 95%)
- 85% of patients said the last GP they spoke to was good at treating them with care and concern compared to CCG average of 86% and the national average of 85%.
- 94% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 93% and the national average of 91%.
- 97% of patients said they found the receptionists at the practice helpful compared to the CCG average of 90% and the national average of 87%.

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. Results were in line with local and national averages. For example:

- 88% of patients said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 87% and the national average of 86%.
- 84% of patients said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 83% national average of 82%.
- 88% of patients said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average of 87% and the national average of 85%.

The practice provided facilities to help patients be involved in decisions about their care:

- Staff told us that translation services were available for patients who did not have English as a first language.
- We were told that information leaflets were available in easy read format should a patient need them.

Patient and carer support to cope emotionally with care and treatment

Patient information leaflets were available in the entrance to the surgery. This included information for patients and carers on how to access support services as well as specific guidance on a number of areas.

Good

Are services caring?

The practice's computer system alerted GPs if a patient was also a carer and a register of carers was held. We were told that written information was available to direct carers to the various avenues of support available to them. There was a link to information for carers on the practice website; however this link was not working when we viewed it.

Staff told us that if families had suffered bereavement, the GP contacted them and they would be offered an appointment as needed.

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. For example;

- There were longer appointments available for patients with a learning disability.
- Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice.
- The practice had a register of vulnerable patients who were at risk of hospital admission and held regular meetings to discuss their care.
- Same day appointments were available for children and those patients with medical problems that require same day consultation.
- Patients were able to receive travel vaccinations available on the NHS as well as those only available privately/were referred to other clinics for vaccines available privately.
- There were disabled facilities, including a lift and translation services were available.

Access to the service

The practice was open between 8.30am to 6.30pm Monday to Thursday and 8.30am to 5.00pm on Fridays. The practice worked with a neighbouring practice to ensure reciprocal arrangements for cover on site for emergencies between 8.00am and 6.30pm on a daily basis. Early morning appointments were available from 7.30am at both Guestling and Roebuck surgeries during the week. 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 better when compared to local and national averages.

- 84% of patients were satisfied with the practice's opening hours compared to the national average of 78%.
- 96% of patients said they could get through easily to the practice by phone compared to the national average of 73%.

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

The practice had a system in place to assess:

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

Reception staff had guidance of the types of issues that should be referred to the GP, nurse or the emergency services.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns.

- Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England.
- There was a designated responsible person who handled all complaints in the practice.
- We saw that information was available to help patients understand the complaints system in the form of an information leaflet.

We looked at four complaints received in the last 12 months and found that these were not satisfactorily handled. For example, one record of a complaint about the care received by a patient included a response letter sent by a GP from a neighbouring practice. Staff told us the letter had not been sent and was followed up by a letter sent by Dr Chopra two days later which was also held on file. However, there were limited records kept about the investigation and action taken in relation to complaints. A further complaint from a patient about not receiving the results of an abnormal scan until they followed it up themselves a month later included evidence that their initial complaint had not been responded to. While we saw that this complaint had been discussed at a staff meeting in May 2016 the discussion was focussed on action taken as a result of the complaint rather than analysis of what had gone wrong. There was no complaints log and no records of investigations for any of the four complaints we viewed. It was therefore difficult to see how lessons were learnt from individual concerns and complaints and there was no evidence of analysis of trends or action being taken to improve the quality of care.

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 staff had a clear aim to deliver high quality care and promote good outcomes for patients.

- The practice had a documented mission statement. A presentation on the day of inspection by a GP from a neighbouring practice included elements of a five year plan. We were not shown a strategy or business plan on the day of inspection, although a business plan was subsequently sent to us..
- Staff we spoke with understood that there were plans for the practice to merge with neighbouring practices and the staffing structure was being shaped towards this future. For example, an interim office manager had been appointed with a view to them working closely with a practice manager in the future who would have responsibility for different practices.

Governance arrangements

The practice had begun to develop an overarching governance framework to support good quality care. However, much of this structure was not properly embedded within the practice and it was unclear how the practice intended to do this. For example;

- There was a staffing structure in place and that staff were aware of their own roles and responsibilities. However, there had been a number of changes to roles in recent months and staff told us some roles were still to be properly embedded. The uncertain future in terms of possible merger meant that staff were not always clear about ongoing roles and responsibilities, however all staff we spoke with told us they were made aware of changes when they happened.
- Practice specific policies were implemented and were available to all staff on the intranet. Not all policies included a record of approval dates and who approved them. However, we were told that the development of policies was a work in progress and that all clinical policies were approved by the GP and where there were significant changes in a policy staff were required to sign that they read and understood this.We were later sent a central log from the practice's policy management system that indicated all policies had a review date included.
- While the practice had begun to undertake audits there was no programme of continuous clinical audit and it was therefore unclear how audit was used to monitor quality and to make improvements. The practice had not identified areas of risk where audit could be used to help manage that risk. For example, there was an incident where an urgent referral for investigation had not been received by the hospital and the practice had been alerted to it by the patient several weeks later. Action as a result of this incident had not included the use of audit to measure quality and safety of referral processes, or to ensure future safety netting to reduce the risk of a repeat incident.
- There were some arrangements for identifying, recording and managing risks, issues and implementing mitigating actions. For example, water temperature testing was carried out regularly in line with a legionella risk assessment. However, action taken following a drop in water temperature was not timely and the responsibility for this was unclear.
- Dressings which had been previously dispensed for patients from local community pharmacies were found in stock medicines cupboards at both Guestling and Roebuck surgeries.

Leadership and culture

The leadership roles within the practice were not always clearly defined. For example, while the practice was a single handed practice there was an additional GP from a neighbouring practice whose role we were told was to provide business continuity in emergencies. However, there was evidence they had taken on some operational leadership duties such as approving a patient group directive (PGD) within the practice. Following the retirement of the practice manager at the end of March 2016, there were a number of management roles within the practice. For example, the practice manager for a neighbouring practice had been covering Dr Chopra's practice although we were told they left this post in May 2016. In addition, there was a project manager in post supporting the practice to improve their systems and processes, although it was unclear how long this post was in place for. There was a newly appointed interim office manager who we were told was undertaking a practice management course in the near future although there were no recruitment records on file to indicate the details of this role.

Are services well-led?

Inadequate

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

There was a lead for infection control although they had yet to attend infection control training for this role and the nurse practitioner was the safeguarding lead. Staff told us that a permanent leadership structure was dependent on future partnership/merger arrangements that were not being implemented until the practice was 'out of special measures'. Staff we spoke with seemed clear about leadership roles for specific issues such as safeguarding, complaints and reporting incidents.

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

- We were told that the practice gave affected people reasonable support, truthful information and a verbal apology but not necessarily a written apology. Records relating to incidents were not always clear. For example, an incident where a patient had not received test results in a timely way did not include details of the original incident where the patient appeared to have raised it in person. The only correspondence on file was a letter from the patient complaining that the incident had not been addressed and an apology from the then practice manager stating there had been confusion about which member of staff was going to address their concern.
- The practice had not kept written records of verbal interactions as well as written correspondence.

Staff told us they generally felt supported by management and that there had been improvements in this area.

- Staff told us the practice held regular team meetings.
- Staff told us there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and felt confident and supported in doing so.
- Staff said that communication had improved and that they were involved in discussions about how to run and develop the practice.

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

The practice encouraged and valued feedback from patients, the public and staff. It proactively sought patients' feedback and engaged patients in the delivery of the service.

- The practice had an active patient participation group (PPG). The PPG met regularly and made suggestions for improvements to the practice management team. The PPG had raised some concerns with the practice about cleanliness and maintenance which had not yet been addressed although we were told that some quotes for works had been obtained. We were told that the PPG felt that communication could be improved within the practice.
- The practice had gathered feedback from staff through staff meetings and appraisals. Staff we spoke with felt there had been an improvement in communication since staff meetings had become more regular. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management.

Continuous improvement

There was a focus on improvement within the practice and a staffing structure had been created to support improvements following a previous inspection. We saw that a number of areas had begun to be addressed, however continuous learning and improvement at all levels within the practice was not always visible. Sustainability of improvements was not apparent within the current structure of the practice and we did not see clear plans in place for how these improvements would be taken forward. The practice team were keen to develop the service, however improvements made were not sufficiently robust enough to provide assurances and the leadership of the practice was not sufficiently clear.

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 18 HSCA (RA) Regulations 2014 Staffing How the regulation was not being met: The provider had failed to ensure that staff received such appropriate training as is necessary to enable them to carry out the duties they are employed to perform. This was in breach of regulation 18 (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 provider had failed to ensure the medicine management and infection control systems were robust and safe. 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 The provider had failed to ensure there was an adequate governance framework in place. This was in breach of regulation 17 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed The provider had failed to ensure the recruitment procedure was robust and satisfactory information was not available for staff employed by the practice. This included information set out in schedule 3 of the act. This was a breach of Regulation 19 (1) (2) (3) and schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.