# Drs Busch, Rhys-Davies & Rajput

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

# Summary of findings

## Contents



## Overall summary

We carried out an announced comprehensive inspection at Drs Busch, Rhys-Davies & Rajput (Stickney Surgery) on 24 November 2016. Overall the practice is rated as requires improvement.

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

- There was an open and transparent approach to safety and a system in place for reporting and recording significant events, however there was no effective system to ensure learning was cascaded to staff.
- No system was in place to record, analyse and prevent dispensing errors.
- Some clinical staff had been recruited and were working at the practice without all the relevant checks being undertaken to help ensure their suitability.
- Staff had not received annual appraisal of their work and performance.
- Staff assessed patients' needs and delivered care in line with current evidence based guidance. Staff had the skills, knowledge and experience to deliver effective care and treatment.
- Effective management of the dispensary was lacking.
- The practice was responsive to the needs of patients and tailored its services to meet those needs.
- Care and treatment was provided by dedicated and caring staff.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment. However the practice had not taken steps to identify carers.
- Information about services and how to complain was not readily available and there was no effective system to ensure learning from complaints was cascaded to staff.
- Patients said there was continuity of care and same day appointments were available.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a new leadership structure and staff told us they felt supported.

# Summary of findings

- Data from the Quality Outcomes Framework showed the practice to be significantly lower that both local and national averages across a wide range of clinical indicators.
- There was no effective system to ensure patients with long term conditions were recalled for review and staff we spoke with about this matter were unclear of the process.

The areas where the provider must make improvement are:

- Ensure that all appropriate recruitment requirements are completed before staff start work at the practice.
- Ensure that staff receive regular appraisal to enable them to carry out the duties they are employed to perform.
- Introduce a process to ensure that learning from significant events and complaints is cascaded to staff to help prevent recurrence.
- Improve the arrangements for the management of dispensary to facilitate 'near-miss' recording and analysis.
- Take steps to ensure that there is effective system of recall for patients with long term conditions.
- In the absence of accurate coding for the purposes of QOF, make alternative arrangements to ensure the practice has a real time oversight of performance and patient outcomes.
- Ensure an effective systems in place to ensure all clinical staff are kept up to date with guidelines from the National Institute for Health and Care Excellence.
- Ensure that information on the complaints procedure is available and that there is an effective process for dealing with complaints and significant events and responding to those affected.

The areas where the provider should make improvement are:

- The practice should initiate meetings to discuss children subject to safeguarding. The practice should also consider identifying and monitoring children who did not attend appointments in secondary care.
- Take pro-active steps to identify and support carers.
- Display notices regarding chaperoning in patient waiting areas.
- Ensure continued monitoring of newly implemented process for repeat prescriptions.
- Take active steps to monitor and assess patient satisfaction and the systems currently in place were not effective.
- Continue to monitor the repeat prescription process to ensure its efficacy.

**Professor Steve Field** CBE FRCP FFPH FRCGP

Chief Inspector of General Practice

# Summary of findings

## The five questions we ask and what we found

We always ask the following five questions of services.

**Are services safe?**

**Requires improvement**

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

- There was a system in place for reporting and recording significant events.
- However lessons learned were not shared with staff to make sure action was taken to improve safety in the practice.
- When things went wrong there was no evidence that patients received reasonable support, truthful information, and a written apology.
- There was no system in place for the 'near miss' recording of errors prior to dispensing medicines.
- There was no analysis of post-dispensing errors reported by patients to identify any trends or recurring themes.
- The practice had clearly defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from abuse, however we found there were no meetings held to discuss children considered to be at risk.
- The appropriate recruitment procedures, intended to protect patients, had not always been completed before staff started work at the practice.
- Notices explaining that chaperones were available were not displayed in patient waiting areas.
- There were effective systems in place to ensure the practice could continue to function in the event of foreseeable events such as fire, flood or loss of utilities.

**Are services effective?**

**Requires improvement**

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

- Staff worked with other health care professionals to understand and meet the range and complexity of patients' needs.
- Staff assessed needs and delivered care in line with current evidence based guidance however there was no effective system for ensuring all staff were made aware of them.
- Clinical audits had been completed and there was evidence that they contributed to quality improvement .
- Staff had the skills, knowledge and experience to deliver effective care and treatment.

# Summary of findings

- Data from the Quality and Outcomes Framework (QOF) showed patient outcomes were generally lower than both the CCG and national average across a range of clinical indicators. Exception reporting was generally lower than both CCG and national averages.
- There was no evidence of appraisals and personal development plans for all staff.

Although we saw that there was a formal induction process there was no evidence that newly appointed staff had been through it.

**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.
- The practice hosted a friendship club, aimed at older and bereaved patients with the intention of reducing isolation.
- On site counselling was available in times of bereavement.
- The practice had identified 18 carers which was 0.35% of the patient list.
- Some conversations between patients and clinicians could be overheard by patients waiting in one part of the practice.

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

Requires improvement

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

- Practice staff reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group to secure improvements to services where these were identified for example through the unplanned admissions enhanced service.
- Patients with a medical need were able to see or have a telephone consultation with a GP or clinician on the same day. Clinical assessments were all made by GPs or an appropriately trained and qualified clinician.
- The practice had good facilities and was well equipped to treat patients and meet their needs.

# Summary of findings

- The practice complaints procedures were not in line with recognised guidance and contractual obligations for GPs in England. Information about how to complain was not readily available and there was no evidence that learning from complaints was shared with staff and other stakeholders.

**Are services well-led?**

**Inadequate**

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

- The practice now had a clear vision and strategy to deliver high quality care and promote good outcomes for patients, which we were told had not always been the case. Staff were clear about the vision and their responsibilities in relation to it.
- One GP who was relatively new to the practice had completed the NHS Leadership Course and was taking a very active role in improving the management of the practice and outcomes for patients.
- There was a new leadership structure and staff felt supported by management although GPs told us there was much work to be done to raise the practice to a high standard.
- The practice had a number of policies and procedures to govern activity and held regular meetings for all staff groups.
- There was no clear oversight of practice performance or effective systems to ensure learning from complaints and significant events was cascaded to staff.
- There was no system in place to provide oversight of dispensing errors.
- Staff had not received individual appraisal of their performance.
- The partners encouraged a culture of openness and honesty. However the practice did not have the systems in place to share learning and outcomes from incidents with staff.
- The practice did not have an effective patient participation group.

# 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**

Requires improvement

The practice is rated as requires improvement for patients in this group. This is because the practice was rated as requiring improvement for being safe , effective, responsive and inadequate well led. It was rated as good for being caring. The issues identified as requiring improvement overall affected all patients including this population group.

- The practice offered proactive, personalised care to meet the needs of the older people in its population.
- The practice had not participated in the clinical commissioning group initiated Older Adults Service which provided the opportunity for additional funding to meet the needs of this group of patients.
- The practice was responsive to the needs of older people, and offered home visits and urgent appointments for those with enhanced needs.

**People with long term conditions**

Inadequate

The practice is rated as inadequate for patients in this group.

- GPs and nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority.
- Data from the Quality and Outcomes framework showed that the clinical indicators for diabetes care were 79%, which was 15% below the CCG and 11% below the national average.
- The poor recording and coding for the purposes of QOF, made real time oversight of performance and patient outcomes difficult to determine. Staff were unsure of the system used to recall patients for review.
- Patients with long term conditions who were unable to attend the surgery as a result of infirmity or illness were seen at home.
- All these patients had a named GP. For those patients with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

**Families, children and young people**

Requires improvement

The practice is rated as requires improvement for patients in this group. This is because the practice was rated as requiring

# Summary of findings

improvement for being safe , effective, responsive and inadequate for well led. It was rated as good for being caring. The issues identified as requiring improvement overall affected all patients including this population group.

- The practice offered a full range of long-acting reversible contraception, and free condoms to C-Card holders.
- Children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this.
- Rates of cervical screening were in line with both CCG and national figures.
- Appointments were available outside of school hours and the premises were suitable for children and babies.
- The practice provided a full range of immunisations for babies, children and young people. Immunisation rates were higher than the CCG and national average for all standard childhood immunisations.
- The community midwife who ran clinics out of the practice.
- The practice carried out postnatal and six week baby checks.

**Working age people (including those recently retired and students)**

Requires improvement

The practice is rated as requires improvement for patients in this group. This is because the practice was rated as requiring improvement for being safe , effective, responsive and inadequate for well led. It was rated as good for being caring. The issues identified as requiring improvement overall affected all patients including this population group.

- The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered by offering on-line repeat prescription ordering and the booking of appointments on-line.
- The practice was proactive in offering online services as well as a full range of health promotion and screening that reflected the needs for this age group.
- The practice did not offer extended hours appointments to help meet the needs of patients in this group, although results from the GP patient survey indicated that this was not an issue to most patients.

**People whose circumstances may make them vulnerable**

Requires improvement

The practice is rated as requires improvement for patients in this group. This is because the practice was rated as requiring

improvement for being safe , effective, responsive and inadequate for well led. It was rated as good for being caring. The issues identified as requiring improvement overall affected all patients including this population group.

- The practice held a register of patients living in vulnerable circumstances including homeless people those with a learning disability.
- The practice regularly worked with other health care professionals in the case management of vulnerable patients. It did not participate in the learning disability directed enhanced service and so was not required to provide people living with a learning disability an annual physical health check.
- The practice informed vulnerable patients about how to access various support groups and voluntary organisations.
- Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.
- The practice's computer system alerted GPs if a patient was also a carer or was cared for. The practice had identified 18 patients who were either cared for or carers, which was 0.37% of the practice list. There was no formal process in place to help identify carers.

**People experiencing poor mental health (including people with dementia)**

Requires improvement

The practice is rated as requires improvement for patients in this group. This is because the practice was rated as requiring improvement for being safe , effective, responsive and inadequate for well led. It was rated as good for being caring. The issues identified as requiring improvement overall affected all patients including this population group.

- The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who had a comprehensive agreed care plan documented in the record in the preceding 12 months was 33%, which was 47% lower than the CCG average.
- The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those with dementia.
- The practice carried out advance care planning for patients with dementia.
- There was a good understanding of how to support patients with mental health needs and dementia. Staff had received specific training in dementia awareness.

# Summary of findings

- Counselling was available in-house.

# Summary of findings

## What people who use the service say

The national GP patient survey results were published in July 2016. 214 survey forms were distributed and 128 were returned. This represented a return rate of 60% compared to the national average of 38%.

Patients rated the practice significantly higher than others in many areas, including;

- 98% of patients found it easy to get through to this practice by phone compared to CCG average of 61% and the national average of 73%.
- 91% of patients were able to get an appointment to see or speak to someone the last time they tried compared to the CCG average of 72% and national average of 76%.
- 97% of patients described the overall experience of this GP practice as good compared to the CCG average of 83% and national average of 85%.
- 96% of patients said they would recommend this GP practice to someone who has just moved to the local area compared to the CCG average of 74% and national average of 80%.

Health watch had received nine comments regarding the service. Four were critical of the dispensing process, one commented on the parking difficulties, one commented on a seemingly wasteful administration process and three were complimentary about the care and treatment.

As part of our inspection we asked for CQC comment cards to be completed by patients prior to our inspection. We received 43 comment cards which were positive about the standard of care received. All commented upon the caring attitude of staff and GPs, the quality of care and treatment and the cleanliness and facilities at the surgery. Two cards contained negative comments about the time taken by the practice to process repeat prescriptions.

## Areas for improvement

**Action the service MUST take to improve**

- Ensure that all appropriate recruitment requirements are completed before staff start work at the practice.
- Ensure that staff receive regular appraisal to enable them to carry out the duties they are employed to perform.
- Introduce a process to ensure that learning from significant events and complaints is cascaded to staff to help prevent recurrence.
- Improve the arrangements for the management of dispensary to facilitate 'near-miss' recording and analysis.
- Take steps to ensure that there is effective system of recall for patients with long term conditions.
- In the absence of accurate coding for the purposes of QOF, make alternative arrangements to ensure the practice has a real time oversight of performance and patient outcomes.
- Ensure an effective systems in place to ensure all clinical staff are kept up to date with guidelines from the National Institute for Health and Care Excellence.
- Ensure that information on the complaints procedure is available and that there is an effective process for dealing with complaints and significant events and responding to those affected.

**Action the service SHOULD take to improve**

- The practice initiate meetings to discuss children subject to safeguarding concerns should be introduced. The practice should also consider identifying and monitoring children who did not attend appointments in secondary care.
- Have a suitable process in place to ensure the dispensary is effectively managed.
- Review the waiting arrangements in the corridor so as to mitigate the risk of patient/clinician conversations being overheard.
- Take pro-active steps to identify carers.

# Summary of findings

- Display notices regarding chaperoning in patient waiting areas.

# Drs Busch, Rhys-Davies & Rajput

**Detailed findings**

## Our inspection team

**Our inspection team was led by:**

Our inspection team consisted of CQC lead inspector **,** a GP specialist adviser and a practice manager specialist advisor.

## Background to Drs Busch, Rhys-Davies & Rajput

Drs Busch, Rhys-Davies & Rajput, known as Stickney Surgery provides primary medical services to approximately 5,200 patients from a single surgery situated in the village of Stickney, Lincolnshire.

Public transport links are poor and there are pockets of rural deprivation and isolation.

The practice has a higher number of older patients than the national average. The practice has a higher number of patients with long term conditions than the national average.

At the time of our inspection the practice healthcare was provided by three male GP partners, one female salaried GP (whole time equivalent WTE 0.6), one nurse practitioner (whole time equivalent WTE 0.5), two practice nurses (WTE 1.6) and one health care assistant (WTE 1.0). They are supported by a team of dispensers, management, administration, reception and housekeeping staff.

The practice is located within the area covered by NHS Lincolnshire East Clinical Commissioning Group (CCG). A CCG is an organisation that brings together local GP's and experienced health professionals to take on commissioning responsibilities for local health services.

The practice is registered to provide the regulated activities of Surgical procedures; Maternity and midwifery services; Diagnostic and screening procedures; Treatment of disease, disorder or injury.

The practice has General Medical Services (GMS) contract which is a contract between the GP partners and the CCG under delegated responsibilities from NHS England.

It is a dispensing practice to eligible patients.

The surgery is open from 8am to 6.30pm Monday to Friday.

The practice has opted out of providing out-of-hours services to their own patients. The out-of-hours service is provided by Lincolnshire Community Health Services NHS Trust and is accessed by NHS111.

We had not previously inspected this practice.

## 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.

# Detailed findings

## 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 24 November 2016.

During our visit we:

- Spoke with a range of staff including GPs, practice manager, dispensers, receptionists, nurses and administration staff.
- 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.
- Spoke with members of the Friends of Stickney Surgery patient group and
- Spoke with members of The Jack and Jill friendship and support group.

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

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

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

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

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

Requires improvement

# Are services safe?

## Our findings

**Safe track record and learning**

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

- Staff told us they would inform the practice manager of any incidents and there was a recording form available on the practice's computer system. The incident recording form supported the recording of notifiable incidents under the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).
- We reviewed the six significant events that had been recorded in the previous 12 months and saw that they had been investigated with effective evidence collection and analysis.
- However we saw no evidence that when things had gone wrong with care and treatment, patients were informed of the incident, received reasonable support, truthful information, an apology and were told about any actions to improve processes to prevent the same thing happening again.
- We did not see any evidence that learning from these events had been cascaded to staff to help prevent recurrence.
- There was no evidence of meetings to discuss significant events and any trends.
- Patient safety alerts and those issued by the Medicines and Healthcare Products Regulatory Authority were dealt with by the practice manager who took appropriate action to ensure they were brought to the attention of relevant staff. For example we saw evidence that patients in receipt of interacting medicines such as amlodipine and simvastatin had been reviewed and alternative medication prescribed. Computer software alerted clinicians if drug interaction or alerts existed at the time of prescribing.
- GPs carried out regular searches of patient records to identify patients in receipt of potentially high risk medication such as warfarin and methotrexate to ensure appropriate prescribing practice.

**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. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. A GP partner was the lead for safeguarding.
- The GPs attended safeguarding meetings when possible and provided reports where necessary for other agencies. Staff demonstrated they understood their responsibilities and all had received training on safeguarding children and vulnerable adults relevant to their role. GPs were trained to child safeguarding level three and nurses to level two or three.
- GPs told us that the lack of a health visitor associated with the practice had a detrimental effect and made continuity of care for patients in this risk group difficult, although internal practice meetings were held to discuss these issues. Invites were extended to link workers but not generally accepted.
- 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). Face to face chaperone training had been delivered in house. Whilst there were posters displayed in consultation rooms, there was no notices in the patient waiting area to explain that patients were entitled to have a chaperone.
- The practice maintained appropriate standards of cleanliness and hygiene. We observed the premises to be very clean and tidy. A nurse practitioner was the infection control lead who liaised with the local infection prevention teams to keep up to date with best practice. There was an infection control protocol in place and staff had received up to date training. Infection control audits were undertaken and we saw evidence that action was taken to address any improvements identified as a result.
- We reviewed six personnel files and found that not all the appropriate recruitment checks had been undertaken prior to employment. For example we found

that for one recently employed nurse there were no references or identity documents. A recently appointed healthcare assistant similarly did have any references recorded.

- All staff regardless of their role had the appropriate checks through the Disclosure and Barring Service and for GPs and nurses the appropriate checks regarding registration with their professional body.
- Arrangements for managing medicines were checked at the practice. Medicines were dispensed at the surgery for Dispensary staff showed us standard operating procedures (SOPs) which covered all aspects of the dispensing process (SOPs are written instructions about how to safely dispense medicines), a system was in place to ensure relevant staff had read and understood SOPs. Prescriptions were signed before being dispensed and there was a process in place to ensure this occurred.
- The partners told us they could dispense to 99% of patients. There was a named GP responsible for the dispensary. We saw records showing all members of staff involved in the dispensing process had received appropriate training, regular checks of their competency and annual appraisals. The practice held stocks of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse), and had an SOP in place covering all aspects of their management. Controlled drugs were stored in a controlled drugs cupboard, access to them was restricted and the keys held securely. Balance checks of controlled drugs were carried out regularly and there were appropriate arrangements in place for their destruction. Expired and unwanted medicines were disposed of in accordance with waste regulations. There was a procedure in place to ensure dispensary stock was within expiry date and we saw evidence to show that this was taking place.
- There was a system in place for the management of repeat prescriptions including high risk medicines. We saw that regular monitoring of patients in receipt of methotrexate and warfarin.
  Staff kept a record of errors relating to the dispensary. However we found that all of the entries related to errors that had been reported by patients. There was no indication of which dispensers were responsible for the individual errors and no attempt had been made to analyse the incidents although it was clear that there were recurring themes.
- There were no 'near-miss' records to show that dispensers were picking up errors prior to dispensing medicines to patients and therefore it had not been possible to show any trends or areas for improvement.
- We saw records relating to recent medicine safety alerts, and action taken in response to these. They were dealt with by the practice manager. Dispensary staff we spoke with were unaware of the process but confirmed that if they needed to know about them it would have been communicated to them, however copies were not kept in the dispensary.
- Monitored dose systems were offered to patients who struggled to take their medicines. Staff knew how to identify medicines that were not suitable for these packs and offered alternative adjustments to dispensing where possible.
- We checked medicines stored in the treatment rooms and medicines refrigerators and found they were stored securely with access restricted to authorised staff. The surgery held stocks of emergency medicines and processes were in place to ensure they were within expiry date.
- Records we reviewed showed that there had been patient dissatisfaction in the way repeat prescriptions were handled and that the practice was experiencing delays in fulfilling them. In response an audit had been undertaken between August and October 2016 where a number of underlying factors contributing to the delays had been identified. Action had been taken in response and although it had been only a short time since changes were made, turnaround times had been reduced as had the backlog of work for the dispensers.
- There was no dispensary manager and this function was one of those undertaken by the practice manager, although they had no experience of working in a dispensary. We spoke with the GPs about this and they indicated that they had identified that the dispensary was an area that required improvement and it was their intention to appoint a dedicated dispensary manager.

**Monitoring risks to patients**

Requires improvement

# Are services safe?

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 displayed 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 it 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 the control of substances hazardous to health, asbestos in buildings, infection control and legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings).
- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system in place for all the different staffing groups to ensure enough staff were on duty .

**Arrangements to deal with emergencies and major incidents**

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

- There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency.
- All staff received annual basic life support training .Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and stored securely.
- The practice had a defibrillator and oxygen available on the premises. A first aid kit and accident book were available.

The practice had a disaster recovery and continuity plan in place for major incidents and foreseeable events that might affect the running of the practice such as power failure , building damage or loss of utilities .

Requires improvement

# Are services effective?

(for example, treatment is effective)

## Our findings

**Effective needs assessment**

GPs 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. However there were no effective systems in place to ensure all clinical staff were kept up to date with guidelines from NICE and used this information to deliver care and treatment that met patients' needs.

GPs told us that they held ad hoc discussions regarding NICE guidance and planned to introduce a structured system of review and compliance.

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

The Quality and Outcomes Framework (QOF) is the annual reward and incentive programme detailing GP practice achievement results. QOF is a voluntary process for all practices in England and was introduced as part of the GP contract in 2004.

The most recent published results for the year 2015/16 were 77% of the total number of points available across the combined clinical and public health domains. This was 18% below both the CCG and national average.

These results showed a significant decline on the figures for 2014/15 where the total QOF achievement was 87%.

The partners told us that the previous partnership had not considered QOF achievement as a priority and as result the practice did not have effective systems in place to ensure accurate coding which was essential in attaining high QOF achievement.

There was limited use of templates to manage the recall of patients living with long term conditions and the staff we spoke with who were responsible for recalls were unsure of the process.

The practice did not have an effective system of sending out reminder letters to patients who did not attend for a review.

Data from 2015/16 showed:

- Performance for diabetes related indicators was worse than the national average. The practice achieved 79% in these combined clinical indicators which was 15% lower than the CCG average and 11% below the national average.
- Performance for the dementia indicators was 50% which was 47% below both the CCG and national average.
- Performance for the rheumatoid arthritis indicators was 17% which was 77% below the CCG average and 79% below the national average.

Exception reporting across all clinical indicators was lower than both CCG and National averages and overall was 6% compared to the CCG average of 9.9% and national average of 9.2%.

There was evidence of quality improvement including clinical audit.

- We saw evidence of two clinical audits completed in the last two years, both were completed audits and related to the prescribing of contraceptive implants. Information from the audits had resulted in a more effective system of ensuring improved outcomes for patients.

**Effective staffing**

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

- 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 such as diabetes.
- Staff administering vaccines and taking samples for the cervical screening programme had received specific training which had included an assessment of competence. Staff who administered vaccines could demonstrate how they stayed up to date with changes to the immunisation programmes, for example by access to on line resources and discussion with fellow clinicians.
- The learning needs of staff were identified through reviews of practice development needs. Staff had access to appropriate training to meet their learning needs and to cover the scope of their work. However we looked at the files of four members of staff who had been

employed at the practice for more than 12 months and found that none had taken part in a recent appraisal of their performance, with one not having had an appraisal since 2009.

- Staff received training that included: safeguarding, fire safety awareness, basic life support and information governance.
- Although we saw that there was an induction schedule for newly appointed staff, there was no evidence that any staff had been through the induction process.
- The partners recognised thatthe relatively new nursing team required additional training in specific areas, in particular in dealing with patients with long term conditions and that the practice was understaffed at health care assistant level. The partners were taking steps to address the situation.

**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. Multi-disciplinary meetings were attended by Macmillan and district nurses.

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**Consent to care and treatment**

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

- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005.

When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance.

- Where a patient's mental capacity to consent to care or treatment was unclear the GP or practice nurse assessed the patient's capacity and recorded the outcome of the assessment.
- The process for seeking consent was monitored through patient records audits.

**Supporting patients to live healthier lives**

The practice 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 smoking and alcohol cessation .Patients were signposted to the relevant service where the service was not provided in-house, for example the Quit 51 smoking cessation programme.
- The practice offered a comprehensive range of contraceptive and sexual health services, includinga full range of long-acting reversible and emergency contraception.
- Staff were able to offer dietary and weight loss advice.

The practice's uptake for the cervical screening programme was 80%, which was comparable to the CCG average of 74% and the national average of 74%. There was a policy to offer telephone reminders for patients who did not attend for their cervical screening test. 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.

The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening where uptake was higher than both CCG and national averages. For example:

- 79% of women aged 50-70 had been screened for breast cancer in the last 36 months compared to the CCG average of76% and national average of 72%.
- 64% of patients aged 60-69 had been screened for bowel cancer in the last 30 months compared to the CCG average of60% and national average of 58%.

Requires improvement

# Are services effective?

## (for example, treatment is effective)

Childhood immunisation rates for the vaccinations given were comparable to CCG and national averages. For example, childhood immunisation rates for the vaccinations given to two year olds ranged from 90% to 98% which was comparable to the CCG average of 90% to 97% and five year olds from 93% to 100% which was comparable to the CCG average of 87% to 95%.

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.
- Reception staff knew when patients wanted to discuss sensitive issues or appeared distressed they could offer them a private space to discuss their needs.
- However three patients we spoke with were critical of the waiting area in the corridor as it was possible to overhear the conversations between patients and clinicians when waiting in this area. The practice took action to mask the conversations through use of a radio.
- The practice had a number of wheelchairs available that it loaned to patients on a short term basis as required.

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. They also stated that staff responded compassionately when they needed help and provided support when required.

We spoke with three members of the patient representative group called Friends of Stickney Surgery. They also told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

Results from the national GP patient survey 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:

- 94% of patients said the GP was good at listening to them compared to the clinical commissioning group (CCG) average of 88% and the national average of 89%.
- 93% of patients said the GP gave them enough time compared to the CCG average of 86% and the national average of 87%.
- 99% 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%.
- 94% of patients said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 84% and 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 92% and national average of 91%.
- 98% of patients said they found the receptionists at the practice helpful compared to the CCG average of 86% and the national average of 87%.

**Care planning and involvement in decisions about care and treatment**

Patients said they felt involved in decision making about the care and treatment they received. They also said 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:

- 90% of patients said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 86% and national average of 86%.
- 85% of patients said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 81% and national average of 82%.
- 89% of patients said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average of 90% national average of 85%.

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

Good

# Are services caring?

- Translation services were available for patients who did not have English as a first language.
- The practice information leaflet was clear and simply set out and provided a wide range of information.
- The practice website was easily accessible, informative and translated in a wide range of different languages .

**Patient and carer support to cope emotionally with care and treatment**

Patient information leaflets and notices were available in the patient waiting area which told patients how to access a number of support groups and organisations. Information about support groups was also available on the practice website.

The practice's computer system alerted GPs if a patient was also a carer or was cared for. The practice had identified 19 patients who were either cared for or carers, which was 0.37% of the practice list. We asked the GPs why this figure was so low and they stated that up until the recent changes within the partnership there had never been any positive action to identify people in this group and also coding on the patient records had been an issue. They gave us assurances that they would take immediate action, with assistance from outside agencies, to increase the numbers and to rectify the coding errors.

Written information was available to direct carers to the various avenues of support available to them.

Staff told us that when families suffered bereavement, the practice contacted them and offered signposting to counselling and support services, including an in-house counsellor.

The practice hosted a friendship club known as the Jack and Jill Club, which had originated at the practice as a response to the need for bereaved patients to be brought out of isolation and loneliness. The club had been functioning for several years and was open to none Stickney Surgery patients. We met several members of the club as it was their Christmas party on the day of our inspection. They were extremely positive about the club, its aims and its success in meeting its aims. We saw that two members of staff were becoming involved to help co-ordinate the group and its activities.

Requires improvement

# Are services responsive to people's needs?

(for example, to feedback?)

## Our findings

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

We saw limited evidence of engagement with the clinical commissioning group or NHS England to identify and meet the needs of the local population. For example the practice did not participate in the older adults admission avoidance scheme which was a scheme initiated by the CCG and which provided additional funding. We asked the partners why this was the case and we were told that the previous partnership had not wished to take part. They assured us that such initiatives would in the future be carefully considered and they would take part if appropriate to enhance outcomes for patients.

However the practice did;

- Offer longer appointments for patients with a learning disability.
- Offer home visits for older patients and patients who had clinical needs which resulted in difficulty attending the practice.
- Ensure that patients who hadbeen assessed as having a need to be seen that day were given a consultation appointment.
- Offered travel vaccinations available on the NHS as well as those only available privately.
- There were disabled facilities, a hearing loop and translation services available.
- Other reasonable adjustments were made and action was taken to remove barriers when patients find it hard to use or access services. For example the surgery had good same level access, automatic opening doors to aid wheelchair and mobility scooter users and all clinical rooms were on the ground floor, although patients told us that the physical layout of the building made access for mobility scooters difficult.
- The practice distributed dispensed medicines to three local post offices to allow patients with limited access to the surgery the opportunity to collect their medicinescloser to where they lived. Partners told us they were actively exploring the possibility of providing a medicines delivery service as part of their practice development.

**Access to the service**

The surgery was open between 8am and 6.30pm Monday to Friday. The practice was closed on one Thursday afternoon per month for staff protected learning time.

Appointments could be made in person, by telephone or on-line. There was no extended hours opening but the results from the patient survey showed that a high percentage of patients were satisfied with the opening hours.

GPs and clinicians assessed:

• whether a home visit was clinically necessary; and

• the urgency of the need for medical attention.

In cases where the urgency of need was so great that it would be inappropriate for the patient to wait for a GP home visit, alternative emergency care arrangements were made.

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

- 89% of patients were satisfied with the practice's opening hours compared to the CCG average of 78% and national average of 79%.
- 98% of patients said they could get through easily to the practice by phone compared to the CCG average of 61% and the national average of 73%.

**Listening and learning from concerns and complaints**

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

- Its complaints policy and procedures were not in line with recognised guidance and contractual obligations for GPs in England. For example the eight complaints we looked at which had been recorded from November 2015 to November 2016, had no letters of acknowledgement or copies of the written responses to the complainant. There was no structure to the process and no conclusion of the investigation into the complaint.
- There was no evidence that the learning was cascaded to staff to help prevent re-occurrence.

Requires improvement

# Are services responsive to people's needs?

## (for example, to feedback?)

- The practice manager was the designated responsible person who handled all complaints in the practice.
- There was no information displayed in the patient waiting area to help patients understand the complaints system and there was nothing on the practice website that gave any information about the complaints process. Staff told us they referred anyone who wished to complain to the practice manager.

# 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**

We found that the practice was in a state of transformation and that new leadership from GP partners was having a demonstrable effect on staff behaviours and the systems and process needed to deliver safe and effective care and treatment.

The practice had commenced review of infrastructures and were planning to implement systems and processes to ensure effective care.

The vision statement was clear and realistic and stated ,'To deliver the best possible care within available resources.' The partners told us they had a five year plan and were currently in the 'crisis management' phase, fixing the essentials before moving on to the long term.

There was a clear vision to provide a safe and caring service and patient feedback was aligned to that vision.

- There was clear evidence that the partners and staff had worked hard to improve the practice and monitored outcomes and adapted procedures to improve the running of the practice, for example through changes to the dispensing system and proposed changes to the management of this part of the service.

**Governance arrangements**

The practice had an overarching governance framework which supported the delivery of the strategy and quality care going forward.

- There was a clear staffing structure and that staff were aware of their own roles and responsibilities.
- Practice specific policies were implemented and were available to all staff.
- However the arrangements for identifying, recording and managing risks, issues and implementing mitigating actions were not effective, for example in respect of dispensing 'near miss' recording and errors.
- In the absence of any focus on QOF achievement and poor coding, and any other measure, we could not be assured that a comprehensive understanding of the performance of the practice was maintained.
- The GP partners assured us that they were confident that effective recall systems for patients living with diabetes, asthma and chronic pulmonary obstructive disease would be in place by the end of the year.

**Leadership and culture**

- On the day of inspection the partners in the practice demonstrated they had the experience to run the practice and ensure high quality care. Staff told us they prioritised safe, high quality and compassionate care. Staff told us the partners were approachable and always took the time to listen to all members of staff.
- The partners were aware of 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). However we saw no written evidence that when things went wrong people affected had been offered an apology where appropriate.
- Staff told us the practice held regular team meetings.
- There was a clear leadership structure in place and staff we spoke with were up-beat, enthusiastic and said they felt supported by management
- Staff said 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.
- All staff were involved in discussions about how to run and develop the practice, and the partners encouraged all members of staff to identify opportunities to improve the service delivered by the practice.

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

- The practice valued feedback from patients, the public and staff. It had sought patients' feedback, for example with regard to the problems with repeat prescriptions and engaged patients in the delivery of the service. We met with three members of the Friends of Stickney Surgery, which although consisting of patients, did not consider itself to be a patient participation group. We were told that the group had only five members and they met four or five times a year. The group concerned themselves primarily with fundraising that had purchased, in some cases, items of equipment that

# Are services well-led?

Inadequate

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

should have been supplied by the practice. They had not played an active part in working with the provider and to promote health, improved quality of care and improved patient outcomes.

- The practice had not taken any steps to gauge patient opinion in the absence of an effective patient participation group.
- There was no evidence of staff being supported through annual appraisal. The practice manager told us that they were aware of the shortcoming, but this had not been considered a priority by the previous senior partner. They stated they had started to address the backlog.
- The practice had gathered feedback from staff through staff meetings and discussion. Staff members told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management.
- Staff told us they felt involved and engaged to improve how the practice was run.

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<br>Maternity and midwifery services<br>Surgical procedures<br>Treatment of disease, disorder or injury | Regulation 17 HSCA (RA) Regulations 2014 Good governance<br>**How the regulation was not being met:**<br>The registered provider did not have in place effective systems to manage patients with long term conditions.<br>The registered person did not have in place a system to ensure that relevant staff were kept appraised of guidance from National Institute for Health and Care Excellence.<br>The registered person did not have effective systems in place to ensure that learning from significant events and complaints was cascaded to staff to help prevent recurrence.<br>This was in breach of Regulation 17(1) and (2)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. |

| Regulated activity | Regulation |
|---|---|
| Diagnostic and screening procedures<br>Maternity and midwifery services<br>Surgical procedures<br>Treatment of disease, disorder or injury | Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment<br>The registered person did not do all that was reasonably practicable to assess, monitor, manage and mitigate risks to the health and safety of patients who use services. They had failed to identify the risks posed by not ensuring staff were appropriately recruited.<br>The registered person had not done all that was practicable to mitigate risks to the health and safety of patients by having systems to identify, record and monitor dispensing errors and near misses.<br>This was in breach of regulation 12(1)(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. |

This section is primarily information for the provider

# Requirement notices

| Regulated activity | Regulation |
| --- | --- |
| Diagnostic and screening procedures<br>Maternity and midwifery services<br>Surgical procedures<br>Treatment of disease, disorder or injury | Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints<br>The registered person did not have in place an accessible system for identifying, receiving, recording, handling and responding to complaints by service users and other persons in relation to the carrying on of the regulated activity.<br>This was in breach of Regulation 16 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. |

| Regulated activity | Regulation |
| --- | --- |
| Diagnostic and screening procedures<br>Maternity and midwifery services<br>Surgical procedures<br>Treatment of disease, disorder or injury | Regulation 18 HSCA (RA) Regulations 2014 Staffing<br>The registered person did not support staff by way of regular appraisal.<br>This was in breach of Regulation 18(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. |