Birstall Medical Centre

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection on 21 May 2015 and a second unannounced visit on 29 May 2015. Overall the practice is rated as inadequate.

Specifically, we found the practice' inadequate' for providing safe, caring, responsive and well-led services. It was also inadequate for providing services for 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). It was rated as 'requires improvement' for providing effective services.

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

- Patients were cared for in a well maintained and spacious environment that was well equipped to meet their needs.
- Patients were at risk of harm because systems and processes were not in place to keep them safe. For example appropriate recruitment checks on staff had not been undertaken prior to their employment, incoming mail relating to patients was found to have not been addressed, and medication in GP's bags were found to have passed the manufacturers expiry date.
- The practice complaints process was not followed. Lessons learned and actions taken to prevent reoccurrence where not evident or not robust.
- Serious incidents had not been properly recorded and investigated to help prevent re-occurrence and maintain patient safety.
- Patients were positive about their interactions with staff and said they were treated with compassion and dignity. However patients said that they did not always receive continuity of care and that there was a high use of locums.
- Urgent appointments were usually available on the day they were requested. However patients said that they sometimes had to wait a long time for non-urgent appointments and that it was very difficult to get through the practice when phoning to make an appointment.

Summary of findings

- The governance arrangements in practice where not sufficient. Policies and procedures where in draft form, over five years old and had not been reviewed to ensure they reflected current best practice and their relevance.
- The surgery had an independent pharmacy housed within the building. Members of the public using the pharmacy had free and unrestricted access to clinical areas of the surgery.

The areas where the provider must make improvements are:

- Ensure there is a robust system in place to ensure that the information and documentation required has been obtained before people start working at the practice to ensure they are suitable to work with patients.
- Put systems in place to ensure medications and GP's bags are checked to ensure that drugs are safe and are within the manufacturers expiry dates.
- Ensure there are formal governance arrangements in place including systems for assessing and monitoring risks and the quality of the service provision.
- Ensure staff have appropriate policies and guidance to carry out their roles in a safe and effective manner which are reflective of the requirements of the practice.
- Ensure that the complaint policy is followed and that apologies are given where necessary.
- Ensure that full investigations of serious incidents are undertaken and actions and lessons learned are taken to prevent re-occurrence.
- Ensure that there is a process in place for incoming mail that is robust and clinically safe.
- Ensure notifications to the Commission and NHS England are made.
- Undertake an assessment of the risk from Legionella

The areas where the provider should make improvement are:

- Reduce the wait that patients experience in securing a non-urgent appointment
- Take steps to reduce the reliance on locum GP cover to help ensure continuity of care.
- Take steps to prevent members of the public who are customers at the pharmacy from being able to enter clinical areas of the practice.
- Ensure that meetings are properly recorded.

On the basis of the ratings given to this practice at this inspection, I am placing the provider into special measures. This will be for a period of six months. We will inspect the practice again in six months to consider whether sufficient improvements have been made. If we find that the provider is still providing inadequate care we will take steps to cancel its registration with CQC.

Professor Steve Field CBE FRCP FFPH FRCGP

Chief Inspector of General Practice

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. Staff were clear about reporting incidents, near misses and concerns, however the practice did not carry out investigations when things went wrong, lessons learned were not communicated and so safety was not improved. Patients were at risk of harm because systems and processes were not in place in a way to keep them safe. For example incoming mail regarding patients was prioritised by non-clinical staff without a process for them to follow. The infection prevention and control policy had last been reviewed in 2013 . The practice could not demonstrate that any infection prevention and control audit had been conducted. The business continuity plan was inadequate. Drugs in GP bags that were taken on home visits had passed the manufacturers expiry date.

Are services effective?

Requires improvement

The practice is rated as requires improvement for providing effective services. Data showed patient outcomes were comparable to the locality. Staff referred to guidance from the National Institute for Health and Care Excellence and used it routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had not received training appropriate to their roles. Some further training had been identified and planned to meet these needs. Staff worked with multidisciplinary teams.

Are services caring?

Inadequate

The practice is rated as inadequate for providing caring services.The practice was below average for its patient satisfaction scores on consultations with doctors. Patients did not respond positively to questions about their involvement in planning and making decisions about their care and treatment with satisfaction scores well below the CCG averages. Information for patients about the services available was easy to understand and accessible.

Are services responsive to people's needs?

Inadequate

The practice is rated as inadequate for providing responsive services. Although the practice had reviewed the needs of its local population, it had not put in place a plan to secure improvements for all of the areas identified. Feedback from patients reported that access to a named GP and continuity of care was not always available quickly, although urgent appointments were usually available the same day. The practice was equipped to treat patients

Summary of findings

and meet their needs. Patients could get information about how to complain in a format they could understand. However, there was no evidence that learning from complaints had been shared with staff, nor were patients who wished to complain given the appropriate information.

Are services well-led?

Inadequate

The practice is rated as inadequate for being well-led. Staff we spoke with were not clear about their responsibilities in relation to the practice vision or strategy. The practice had a number of policies and procedures to govern activity, but these were not personalised to the practice with some still been in draft form and where over five years old and had not been reviewed since. The practice did not hold regular governance meetings and issues were discussed at ad hoc meetings. The practice was unable to produce any records of meetings. The practice stated that they took place but there was little evidenced in minutes.

The practice had not planned or taken into account the need for additional staff as previous staff had left. The updating of new patient summaries notes were six months behind. There was no evidence of any staff feedback and there had been no staff appraisals for last 18 months and there was no evidence of any supervision of staff.

Summary of findings

The six population groups and what we found

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

Older people

Inadequate

The provider was rated as inadequate for safe, caring, responsive and well led The concerns which led to these ratings apply to everyone using the practice, including this population group. The practice is rated as inadequate for the care of older people.

Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in dementia and end of life care. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs.

People with long term conditions

Inadequate

The provider was rated as inadequate for safe, caring, responsive and well led. The concerns which led to these ratings apply to everyone using the practice, including this population group. The practice is rated as inadequate for the care of people with long-term conditions.

Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. All these patients had a named GP and a structured annual review to check that their health and medication needs were being met. For those people 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

Inadequate

The provider was rated as inadequate for safe, caring, responsive and well led. The concerns which led to these ratings apply to everyone using the practice, including this population group. The practice is rated as inadequate for the care of families, children and young people.

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

Summary of findings

and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this. Appointments were available outside of school hours and the premises were suitable for children and babies.

Working age people (including those recently retired and students)

Inadequate

The provider was rated as inadequate for safe, caring, responsive and well led. The concerns which led to these ratings apply to everyone using the practice, including this population group. The practice is rated as inadequate for the care of working-age people (including those recently retired and students).

The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible and, flexible. Practice data showed that a relatively low 9.4% of patients in the 40-74 years age group had received a health check.

People whose circumstances may make them vulnerable

Inadequate

The provider was rated as inadequate for safe, caring, responsive and well led .The concerns which led to these ratings apply to everyone using the practice, including this population group.

The practice is rated as inadequate for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including travellers and those with a learning disability. Although we saw the register of patients with a learning disability the GP did not know of a system for inviting these patients in for an annual health review.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. It had told 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.

People experiencing poor mental health (including people with dementia)

Inadequate

The provider was rated as inadequate for safe, caring, responsive and well led. The concerns which led to these ratings apply to everyone using the practice, including this population group. The practice is rated as inadequate for the care of people experiencing poor mental health (including people with dementia).

Summary of findings

The practice was able to identify patients experiencing poor mental health or those with dementia. 83% of people experiencing poor mental health had received an annual review however only 14.29% of people with dementia. Dementia screening was actively offered by clinicians, with referral to the memory clinic where appropriate.

Some staff had received dementia awareness training through eLearning.

Summary of findings

What people who use the service say

Prior to our inspection we left comment cards for patients to complete. We received 13 completed comment cards and all were positive about the care and treatment provided. Patients felt staff had a caring nature and treated them with respect and dignity.

We spoke with eight patients who used the service including two members of the patient participation group (PPG). The PPG are a group of patients who work together with the practice staff to represent the interests and views of patients so as to improve the service provided to them.

All the patients we spoke with told us they were happy with the care they received. However they all expressed concerns around the time they had to wait for an appointment and the continuity of care they received as a result of not seeing the same GP on a regular basis. They also expressed their concerns at having to wait up to three and half weeks for an appointment. However one patient stated that if they needed to be seen urgently then they did not find it a problem.

Patients felt they were involved with decisions made about their care and those that had needed a referral making had had it made in a timely fashion and were happy with the service provided.

This feedback was aligned with the national GP patient survey results from January 2015 which included feedback from 97 patients. For example, 79% of respondents were satisfied with the surgery's opening hours and 60% of respondents said the last GP they saw or spoke to was good at involving them in decisions about their care. 82% were able to get an appointment to see or speak to someone the last time they tried . 68% would recommend this surgery to someone new to the area and 51% with a preferred GP usually got to see or speak to that GP.

Patients told us the premises were clean, and that the facilities were accessible and appropriate for their needs.

Areas for improvement

Action the service MUST take to improve

- Ensure there is a robust system in place to ensure that the information and documentation required has been obtained before people start working at the practice to ensure they are suitable to work with patients.
- Put systems in place to ensure medications and GP's bags are checked to ensure that drugs are safe and are within the manufacturers expiry dates.
- Ensure there are formal governance arrangements in place including systems for assessing and monitoring risks and the quality of the service provision.
- Ensure staff have appropriate policies and guidance to carry out their roles in a safe and effective manner which are reflective of the requirements of the practice.
- Ensure that the complaint policy is followed and that apologies are given where necessary.
- Ensure that full investigations of serious incidents are undertaken and actions and lessons learned are taken to prevent re-occurrence.
- Ensure that there is a process in place for incoming mail that is robust and clinically safe.
- Ensure notifications to the Commission and NHS England are made.
- Undertake an assessment of the risk from Legionella

Action the service SHOULD take to improve

- Reduce the wait that patients experience in securing a non-urgent appointment
- Take steps to reduce the reliance on locum GP cover to help ensure continuity of care.
- Take steps to prevent members of the public who are customers at the pharmacy from being able to enter clinical areas of the practice.
- Ensure that meetings are properly recorded.

Birstall Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a second CQC inspector, a GP Specialist Professional Advisor, a Practice Manager Specialist Professional Advisor and an expert by experience. This is a person who has personal experience of using or caring for someone who uses this type of service. The second day of the inspection was made which was again led by a CQC Lead Inspector. The team also included a second CQC inspector and a GP Specialist Professional Advisor.

Background to Birstall Medical Centre

Birstall Medical Centre provides primary medical services to approximately 7,800 patients from two sites, Birstall Medical Centre and Border Drive Surgery, Leicester. Border Drive is registered with the CQC as a location in its own right and as a consequence, not visited during the course of this inspection. The two sites share a common patient list.

The practice has one partner GP and two salaried GPs although one was on maternity leave. There was a nurse prescriber, two nurses and a health care assistant. They were supported by a Business Manager (also a partner), a recently appointed Practice Manager and reception and administrative staff.

The practice holds a General Medical Services (GMS) contract for the delivery of general medical services.

The practice is open between 8am and 6.30pm Monday to Friday. GP consultations are available from 8.30am to11.30am. In the afternoons GP consultations varied, starting at either 2 or 3 pm and usually finishing at 5.30pm.

The practice has opted out of the requirement to provide GP consultations when the surgery is closed. Out- of- Hours services are provided through Leicester, Leicestershire and Rutland Out- of- Hours Service, which is provided by Central Nottinghamshire Clinical Services which patients access via the NHS 111 service.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This 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.

Please note that references to the Quality and Outcomes Framework data in this report relate to the most recent information available to CQC at the time of the inspection.

How we carried out this inspection

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

- Is it safe?
- Is it effective?
- Is it caring?

Detailed findings

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

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

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

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 21 May 2015 and a further unannounced visit on 29 May 2015. During our visit we spoke with a range of staff including Business Manager, Practice Manager, two GPs, Practice Nurse and two reception staff .We spoke with patients who used the service reviewed the personal care or treatment records of patients. We reviewed comment cards where patients and members of the public shared their views and experiences of the service.

Inadequate

Are services safe?

Our findings

Safe track record

The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. For example a recent incident had been reported and investigated as a serious untoward incident. We were able to see evidence not only of a full investigation, but also learning from this and actions that had taken place following to prevent reoccurrence. However we also found evidence that incidents arising from complaints that had not been recorded as such and had not been investigated.

The practice was unable to provide us with the records of any serious incidents, their investigation or learning outcomes for 2014 but we were aware that there had been at least one identified as a result a complaint made by a patient. This showed the practice had not managed these consistently over time and could not show evidence of a safe track record over the long term.

We found that significant events had not been recorded; a patient had contacted the the practice and had been promised a call back from a GP. The conversation with the patient did not take place and the patient died within 24 hours. This had not been logged as a significant event nor investigated as such even though there was a note on the complaint that it had been recorded as such. The resolution of the complaint was unsatisfactory. There was a note on the complaint that stated the resolution was linked to a Serious Incident investigation, however this could not be found.

When asked for the significant events from 2014 the practice was were unable to produce them on either of our two visits. The Business Manager told us that they were aware that there had been some serious incidents reported and recorded but was unable to show us any documents relating to them.

Learning and improvement from safety incidents

We reviewed records of significant events that had occurred during 2015 and saw this system was followed appropriately. A dedicated meeting had been held the day before our inspection to review actions from the three recorded events. We were able to track one incident that related to the vaccines refrigerator and saw records were completed in a comprehensive and timely manner. We saw evidence of action taken as a result and that the learning had been shared with staff. This incident had been reported and investigated very thoroughly by a nurse with the assistance of Public Health. Acting upon the advice of Public Health, patients were not informed that something had gone wrong as it was deemed that there would have been no harm.

Other than the most recent events occurring in 2015 ,there was no evidence that learning had been shared with staff. Significant events was not a standing item on practice meeting agendas.

Staff were aware that the practice manager had forms to use to record incidents and that these were available on the shared drive. However staff we spoke with said that they would inform their line manager. The practice was unable to show us a system used to manage and monitor incidents.

National patient safety alerts were disseminated to practice staff. Staff were required to sign to say that they had read and understood the information and staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for, for example an alert about a patient attempting to gain medication.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed that all staff had received relevant role specific training on safeguarding. We asked members of medical, nursing and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details were easily accessible. We did not see any minutes that related to safeguarding children or vulnerable adults though we were told that these meetings took place. Staff were unable to show us a patient that had a recorded flag on the system.

The practice had appointed dedicated GPs as leads in safeguarding vulnerable adults and children. They had been trained in both adult and child safeguarding and

could demonstrate they had the necessary competency and training to enable them to fulfil these roles. All staff we spoke with told us that the lead for safeguarding was the GP however the GP had recently made the new partner the lead which staff were unaware of.

We saw that there was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments; for example children subject to child protection plans.

There was a chaperone policy, which was visible on the waiting room noticeboard and in consulting rooms and on the practice web site. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). All nursing staff, including health care assistants, had been trained to be a chaperone. Reception staff would act as a chaperone if nursing staff were not available. Receptionists had also undertaken training and understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination. All staff undertaking chaperone duties had received Disclosure and Barring Service (DBS) checks. (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).

We found that incoming mail including correspondence relating to patients was being prioritised by non-clinical administrative staff. We spoke with a receptionist who told us that neither they nor any other member of the reception team who performed this task had received any training nor was there in place any written protocol, policy or formal process to work too. The GP and Managing partner confirmed that this was the case.

The receptionist told us that the tray contained items of correspondence received that week, that being from 26 May. Upon sampling the correspondence we saw eight items of post that had been date stamped by the practice as received on 27 March 2014. Other pieces of mail were date stamped 13 April and 7, 18, 19 and 25 May 2015. The receptionist could not offer any explanation for this but later told us that those from 2014 had been found behind a cupboard at the Border Drive Surgery. We reviewed the patient records to which all of the above correspondence related and saw that none of the letters had been scanned onto the patient records.

Four letters, date stamped 14 April and 7, 19 and 25 May 2015 related to patients who were on palliative care.

We reviewed the patient records to which the four letters related and none of them indicated to staff that these patients may need end of life care. There was also no formal system to ensure such updates were completed. We asked reception staff in relation to the identified patients how they would recognise that the patients were palliative and they were unable to tell us. We spoke with the Managing Partner. They confirmed that the palliative patient register was not up to date. We asked for a copy of the palliative care register. None of the four patients referred to in the letters dated 14 April and 7, 19, and 25 May were evident on the palliative care register that was provided to us on the 29th May 2015 as the most up to date.

One of the letters dated 7 May 2015 had been date stamped 28 May 2015 and was from a Consultant Oncologist stating that the patient had a short number of months to live and should be referred to palliative care in the community. We looked at this patient's record and the letter had not been scanned on the practice computer system and nor was there any evidence of action been taken in accordance with the letter.We have made NHS England and the clinical commissioning group aware of our findngs.

Medicines management

No medicines were kept at the practice other than a limited range of emergency medicines in the GP's bag. The GP's bag had not been checked and we found that the Diazepam and Penicillin that were in one of the GP's bags had expired in December 2014 There was no process or procedure in place for checking the doctors bag although we were told that it was checked monthly.

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a policy for ensuring that medicines were kept at the required temperatures, which described the action to take

in the event of a potential failure. Records showed room temperature and fridge temperature checks were carried out which ensured medication was stored at the appropriate temperature.

Expired and unwanted medicines were disposed of in line with waste regulations.

We did not see a positive culture in the practice for reporting and learning from medicines incidents and errors. Incidents had been recorded, however the learning and actions from these were not robust to prevent reoccurrence, resulting in similar errors being made by different staff.

Cleanliness and infection control

We observed the premises to be clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

An infection control policy and supporting procedures were available for staff to refer to however it was last reviewed August 2013. The practice was unable to provide us with sight of any infection prevention and control audit that had been undertaken. There was also a policy for needle stick injury however it was not dated.

The practice did not have a lead for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. All staff had received training about infection control and received annual updates. We saw no evidence of Infection control audits taking place.

Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms.

The practice had not undertaken a risk assessment for legionella. We were told that they had concluded that the risk was sufficiently low to make formal testing unnecessary, although there was no written evidence to support the decision.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date which was 2015. A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example weighing scales, spirometers, blood pressure measuring devices and the fridge thermometer.

Staffing and recruitment

The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. Records that we looked at showed that staff had not been recruited safely. We looked at the personal files of four nurses.

Records we looked at did not contain evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, no inductions, no health information, or confirmation of registration with the appropriate professional body.

On the day of our initial visit we saw that there were sufficient staff to meet patient needs.

Staff told us there were usually enough staff mainly through the use of locum GP's to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe, although we found there was a six month back-log of new patient summary records. We were also informed that low staffing numbers had impacted on the delivery of some services, for example health checks for patients aged 40-74 years.The practice had recruited staff recently and also had another staff member starting in June 2015.

Monitoring safety and responding to risk

The practice had processes and policies in place to manage health and safety however there was no risk log to identify risks and actions taken. The electrical wiring for the building had not been tested since 2008, the business manager stated that she had tried to obtain a wiring test but the contractors would not test a GP surgery. The practice also had a health and safety policy which was dated and reviewed in May 2013.

The surgery contained an independent pharmacy that was not part of the GP practice. Access to the pharmacy for members of the public was either via an external door

directly to the pharmacy or through the surgery waiting room, through unrestricted doors and into the clinical area. We observed that on one occasion a member of the public came into the surgery, through the doors without challenge and enter the part of the surgery containing the clinical rooms. At that time two of the consultation rooms were temporarily unoccupied but with their doors open, allowing free access. We spoke with the GP and Managing partners who said that there was no risk assessment in place but they had in the past considered blocking the access through the surgery with an internal door.

Arrangements to deal with emergencies and major incidents

The practice had some arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (used in cardiac emergencies). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly. We checked that the pads for the automated external defibrillator were within their expiry date.

An effective and appropriate business continuity plan was not in place to deal with a range of emergencies that may impact on the daily operation of the practice. A document had been downloaded from the internet however it had not been completed with the practice specific information and contact numbers. In parts of the document it stated 'insert practice name'.

The practice had carried out a fire risk assessment in December 2014. Fire Notices were evident in key areas of the building and the fire appliance check was recorded as last completed in October 2014. The last recorded fire training in the folder was May 2013. There was no evidence of a fire plan (evacuation notice) displayed although a handwritten fire plan was evident in a folder in the office. There was a fire warden for the practice however this was a member of cleaning staff who was not a full time staff member and there was no evidence that they had received training for this role.

Requires improvement

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We saw that guidance from local commissioners was readily accessible in all the clinical and consulting rooms.

We discussed with the business manager, GP and nurse how NICE guidance was received into the practice. They told us this was downloaded from the website and disseminated to staff. We saw examples of using NICE guidance in relation to newly diagnosed diabetic patients and also new diagnosis of Hypertension. Staff we spoke with all demonstrated a good level of understanding and knowledge of NICE guidance and local guidelines.

Feedback from patients confirmed they were referred to other services or hospital when required.

Clinical staff we spoke with were open about asking for and providing colleagues with advice and support. The partner GP received peer support from a colleague in and adjacent practice.

Management, monitoring and improving outcomes for people

Information about people's care and treatment, and their outcomes, was routinely collected and monitored and this information used to improve care. Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included scheduling clinical reviews, and medicines management.

The practice showed us two clinical audits that had been undertaken in the 2014. These audits had not run a second cycle due to workload of the GP. One audit was on patients with atrial fibrillation to find out how many of these patients were not on warfarin. This identified 21 patients which were all assessed. Out of these 4 patients where then commenced on warfarin. The audit had taken place in December 2014 but was not yet due for re-audit. Other examples included audits on minor surgery procedures in 2014 and an audit from 2009 in relation to oral Methotrexate.

The Quality Outcomes Framework (QOF) is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions,for example diabetes and implementing preventative measures.The practice used the information collected for QOF and performance against national screening programmes to monitor outcomes for patients. This practice was not an outlier for any QOF (or other national) clinical targets, having achieved a high 99.8% of the total QOF target in 2014, which was above the national average of 94.2%. Specific examples to demonstrate this included:

- Performance for diabetes related indicators was better compared to the national average.
- The percentage of patients with hypertension having regular blood pressure tests was similar to the national average

The practice was aware of all the areas where performance was not in line with national or CCG figures and this was put down to lack of staff and staff changes within the past six months.

The practice's prescribing rates were also similar to national figures however, the number of Ibuprofen and Naproxen Items prescribed as a percentage of all non-steroidal anti-inflammatory drugs Items prescribed was 35.74% compared to the national average of 71.25% . The GP partner felt that this could be due to a previous GP and their prescribing and that this may change in the future.

The practice said that they had made use of the gold standards framework for end of life care. The practice did have a palliative care register however multidisciplinary meetings to discuss the care and support needs of patients and their families had not been minuted. We asked a number of staff how they would recognise a patient as palliative and needing extra support and no one was able to tell us. The palliative register that was run on the 29 May 2015 did not contain names that we had seen previously as being palliative.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. All GPs were up to date with their yearly continuing professional development requirements and all either have been revalidated or had a date for revalidation. (Every GP is appraised annually, and

undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

There had been no annual appraisals for practice staff in the past 18 months that identified learning needs from which action plans were documented to support staff development and training needs

Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and manage those of patients with complex needs. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post.

Emergency hospital admission rates for the practice were slightly higher,for example;

- Emergency cancer admissions per 100 patients on the disease register was 17.1 whereas the national average was 7.4 and
- The number of Emergency Admissions for 19 Ambulatory Care Sensitive Conditions per 1,000 population was 21.5 against the national average of 13.6

The practice was commissioned for the unplanned admissions enhanced service and had a process in place to follow up patients discharged from hospital. (Enhanced services require an enhanced level of service provision above what is normally required under the core GP contract). There was no evidence to show that the enhanced service was having a positive effect in reducing the number of unplanned admissions.

Weekly congnitive behaviour therapy and counselling services were held in the practice by other healthcare providers. The practice was able to refer directy to both these services.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. We saw evidence there was a system for sharing appropriate information for patients with complex needs with the ambulance and out-of-hours services.

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record to coordinate, document and manage patients' care. All staff were fully trained on the system. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference. However we found that there had been considerable delays in updating the system with some clinical information and a six month back-log in the updating of new patient summary care records.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005 their duties in fulfilling it. We saw the protocol for staff to refer to.

Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it) and had a section stating the patient's preferences for treatment and decisions. All clinical staff we spoke with demonstrated an understanding of the Gillick competency test. (These are used to help assess whether a child under the age of 16 has the maturity to make their own decisions and to understand the implications of those decisions).

We saw that written consent was obtained for all minor surgery procedures, however the consent protocol to inform staff was incomplete and not tailored to the practice. It was dated 2007 and there was no evidence of any review. Patients' verbal consent was documented in the electronic patient notes with a record of the discussion about the relevant risks, benefits and possible complications of the procedure. In addition, the practice obtained written consent for significant minor procedures and all staff were clear about when to obtain written consent.

Health promotion and prevention

The practice offered NHS Health Checks to all its patients aged 40 to 74 years and over 75 years old. Practice data showed that a relatively low 9.4% of patients in this age

Requires improvement

Are services effective?

(for example, treatment is effective)

group had received the health check. This was due to the practice not having the number of staff to deal with the demand recently, however we were informed that with the new GP partner and other nursing staff joining the practice this would be one area that would be prioritised.

The practice's performance for the cervical screening programme was 79.98%, which was slightly below the national average of 81.89%. The practice also encouraged its patients to attend national screening programmes for bowel cancer and breast cancer screening.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance was in line with for the majority of immunisations where comparative data was available. For example:

- Flu vaccination rates for the over 65s were 71.45%, and at risk groups 51.84%. These were similar to national averages.
- Childhood immunisation rates for the vaccinations given to under twos ranged from 75.3% to 99% and five year olds from 93.6% to 98.2%. These were comparable to the CCG average.

Inadequate

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey from January 2015.

The practice was not able to provide any evidence that it had actively sought the views of patients over the last year.

The evidence from all these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. The practice was below average for its satisfaction scores on consultations with doctors. .. For example:

- The proportion of respondents to the GP patient survey who stated that the last time they saw or spoke to a GP, the GP was good or very good at treating them with care and concern was 64.64% compared to the national average of 85.31%.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 13 completed cards and the majority were positive about the service experienced. Patients said they felt the practice offered a good service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. Three comments were less positive about the appointment system and the time taken to get an appointment. We also spoke with eight patients on the day of our inspection. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Disposable curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation / treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private and used dates of births to identify rather than names. The practice switchboard was located at the reception desk however the waiting area was large enough so that patients would not overhear.

There was a clearly visible notice in the patient reception area stating the practice's zero tolerance for abusive behaviour.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients did not respond positively to questions about their involvement in planning and making decisions about their care and treatment For example:

- 59% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 86%
- 60% of respondents say the last GP they saw or spoke to was good at involving them in decisions about their care compared to the CCG average of 80%

However patients we spoke with on the day of our inspection told us that health issues were discussed with them and 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 they wished to receive. Patient feedback on the comment cards we received was also positive and aligned with these views.

Staff told us that translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patents this service was available.

Patients we spoke with told us that children were treated in an age appropriate way by staff.

Patient/carer support to cope emotionally with care and treatment

The patient survey information we reviewed showed patients did not rate the practice highly in this area. For example:

- 64.64% said the last GP they spoke to was good or very good at treating them with care and concern, compared to the national average of 85.31%.

Inadequate

Are services caring?

The patients we spoke with on the day of our inspection and the comment cards we received were also consistent with this survey information. For example, these highlighted that staff responded compassionately when they needed help and provided support when required.

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

Staff told us that if families had suffered bereavement counselling was offered if requested however there was no specific protocol or policy.

Inadequate

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patient's needs and had worked hard to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered. However we were aware that there had been pressure on services due to the difficulty encountered in recruiting nursing staff and GPs to work in the practice on a permanent basis. It was hoped that the recent appointment of a nurse together with a new partner GP would reduce the pressure on the current partner GP and reliance upon locums.

The NHS England Area Team and Clinical Commissioning Group (CCG) told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised.

The practice had met with the Public Health team from the local authority and the CCG to discuss the implications and share information about the needs of the practice population identified by the Joint Strategic Needs Assessment (JSNA). The JSNA pulls together information about the health and social care needs of the population in the local area. This information was used to help focus services offered by the practice.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example, longer appointment times were available for patients with learning disabilities. The majority of the practice population were English speaking patients but access to online and telephone translation services were available if they were needed.

The premises and services had been designed to meet the needs of people with disabilities. The practice was accessible to patients with mobility difficulties as facilities were all on one level. The consulting rooms were also accessible for patients with mobility difficulties and there were access enabled toilets. There was a large waiting area with plenty of space for wheelchairs and prams. This made movement around the practice easier and helped to maintain patients' independence.

Staff told us that they did not have any patients who were of "no fixed abode" but would see someone if they came to the practice asking to be seen and would register the patient so they could access services.

There were only male GPs in the practice; therefore patients could not choose to see a female doctor.

The practice provided equality and diversity training through e-learning. Staff we spoke with confirmed that they had completed the equality and diversity training.

Access to the service

The surgery was open from 8 am to 6.30 pm Monday to Friday. GP appointments were available from 8.30 am to 11.30 am. In the afternoons they varied from either 2 pm or 3 pm and usually finished at 5.30pm.

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits and how to book appointments through the website. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed.

Longer appointments were also available if requested. Home visits where made following triage by the GP.

The patient survey information we reviewed showed patients responded positively to questions about access to appointments and generally rated the practice well in these areas. For example:

- 77.57% were satisfied with the practice's opening hours compared to the national average of 79.83%.
- 83.54% said they could get through easily to the surgery by phone compared to national average of 75.4%.

Patients we spoke with were satisfied with the appointments system and said it was easy to use. They confirmed that they could see a doctor on the same day if they felt their need was urgent although this might not be their GP of choice. They also said they could see another doctor if there was a wait to see the GP of their choice. Routine appointments were available for booking eight weeks in advance. Comments received from patients also showed that patients in urgent need of treatment had often been able to make appointments on the same day of

Inadequate

Are services responsive to people's needs?

(for example, to feedback?)

contacting the practice. For example one patient we spoke with said that normally it is a week wait but had rang up that morning and had received an appointment on the same day.

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 draft form and where not practice specific. The process did not relate to how the practice managed the complaints. There was a designated responsible person who handled all complaints in the practice.

We looked at ten complaints received in the last 12 months and found no consistency as to how the complaints were managed. The process stated that complaints would be acknowledged within three working days however we found no evidence of this and it was also stated that complaints would be responded to in the form of a written report. The complaints that we looked at did not all have written responses and some had hand written on the complaint letter received that the GP had contacted and complainant did not wish to take the matter further. We found very little evidence of investigations and found one complaint to be about a patient that had died within 24 hours contact of the practice. This had not been recorded and investigated as a serious incident. The only investigation we could find in relation to this was a two line statement from the Locum GP at that time.

The practice had reviewed the complaints however this was on a basic level with only three of the complaints having actions or lessons learned.

When we visited the practice on the 29 May 2015 we witnessed a patient stating that the wished to make a complaint. The Business Manager was also witness to this and did take name and telephone number of patient following a discussion around the complaint. At no time was the complaints process mentioned to the patient or any complaints information given to them.

Are services well-led?

Inadequate

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

Our findings

Vision and strategy

The practice had a vision to deliver high quality care and promote good outcomes for patients. We found details of the vision and practice values were part of the 2015/16 business plan. The practice vision and values included openness, fairness, respect and accountability. Staff we spoke with were not aware of the existence of the document.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the shared drive on any computer within the practice and also in various folders. We looked at ten of these policies and procedures found some dated 2007 and the only found one to be within the last 12 months. Some of the policies that were on the shared drive where different to the policies in the folder. These had been downloaded from the intranet and some stated "draft" whilst others had not been personalised to the practice, stating "insert practice name".

There was not a clear leadership structure with named members of staff in lead roles. For example, there was a lead GP for safeguarding however the staff that we spoke with all stated a different GP was the lead. Due to numerous staff changes in the practice it was difficult for staff to have clear lines for leads at this time. We spoke with five members of staff and they were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

The Business Manager (managing partner) took an active leadership role for overseeing that the systems in place to monitor the quality of the service were consistently being used and were effective. The included using the Quality and Outcomes Framework to measure its performance (QOF is a voluntary incentive scheme which financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). The QOF data for this practice showed it was performing in line with national standards.

However we found that there had been no oversight or management of such areas as policy and protocol review, summarising of new patient notes or the management of complaints and serious incidents.

There was no evidence of any audit as to the efficiency of the management of incoming medical mail by untrained and unqualified staff to ensure the safety of patients.

We were told that the summarising of new patient notes was currently six months in arrears. The newly appointed practice manager had identified the issue and was taking steps to employ someone to make up the back-log.

The Business Manager was responsible for human resource policies and procedures. We reviewed a number of policies, which were in place to support staff. We were shown the electronic staff handbook that was available to all staff, which included sections on harassment and bullying at work, grievance procedure, disciplinary matters, equal opportunities and dealing with staff capability. Staff we spoke with knew where to find these policies if required. The practice had a whistleblowing policy which was also available to all staff in the staff handbook and electronically on any computer within the practice.

Leadership, openness and transparency

We were aware that there had been an incident in which a patient had died in circumstances that would have given rise of the necessity for the provider to notify the Commission of the death.(Regulation 16 Care Quality Commission (Registration) Regulations 2009.) No such notification had been made nor had the provider made a notification to NHS England.

The partners in the practice were visible in the practice and staff told us that they were approachable and always take the time to listen to all members of staff.

Staff said they felt respected, valued and supported, particularly by the partners in the practice.

Seeking and acting on feedback from patients, public and staff

The practice did not seem to encourage feedback from patients. It had gathered feedback from patients through the patient participation group (PPG), surveys and complaints received. However we found that there was a

Are services well-led?

Inadequate

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

lack of consistency in dealing with the complaints and there was no evidence that the practice had learned from the complaints or reflected on the issues to help prevent re-occurrence.

The PPG met three times per year. The last meeting was in February 2015. We spoke with two members of the PPG and they were unclear about the role they played and told us they did not always feel engaged with the practice. (A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care). They had found it difficult to recruit and currently had four active members.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. However when we looked at staff files and saw that appraisals had not taken place for 18 months. The practice manager confirmed that this was the case.

The practice had until recently been a GP training practice however this had ceased. The GP told us they did not have the capacity to be able to support the scheme.

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 Patient safety was being compromised as a result of there being no process in place to ensure that incoming clinical mail was dealt with by a clinician. Incoming clinical mail and other correspondence was not dealt with in a timely or expeditious manner. New patient summaries were not being updated in a timely manner, posing a potential risk to patient safety. Medicines in GPs bags, to be used on home visits, were past the manufacturers expiry date. Significant events that may have an impact on patient safety had not all been recorded or investigated. Recruitment procedures had not been followed to ensure that staff working in a healthcare environment were suitable and safe to do so. Patients, staff and others using the service were not protected from unsafe premises. No inspection of the fixed wiring at the surgery had been undertaken since 2008. No assessment of the risk from Legionella had been completed.

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 There was no effective business continuity plan in place to be implemented in the event that circumstances arose that threatened the delivery of the service.

This section is primarily information for the provider

Enforcement actions

Patient records, including a record of each patients' care and treatment and decisions taken in relation to their care were not accurate or complete.

Insufficient safeguards and training was in place to ensure that non-clinical staff responsible for making decisions on clinical matters were competent to do so. No protocols or guidance were in place.

There was insufficient governance to ensure that complaints were dealt with consistently, effectively and efficiently and that lessons learned communicated to staff.

Practice policies intended to govern activity and to keep people safe were inadequate and not practice specific. Many were over five years old and had not been reviewed to ensure they were relevant and reflected best practice.