West End Surgery

Quality Report

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

Ratings

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

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

This service was previously registered and inspected under a previous provider. The new registration as a partnership took effect from 25 August 2017, which included one GP partner who had been the previous registered provider. Although this was a new registration as a partnership, the practice had been operating under these managerial arrangements since August 2016 with delays in finalising the new registration with the CQC.

The Care Quality Commission (CQC) initially carried out an announced comprehensive inspection at West End Surgery in March 2015 when the practice received an overall requires improvement rating. A further inspection on 11 January 2016 rated the practice as inadequate for providing safe, effective, responsive and well-led services and requires improvement for providing caring services. The overall rating for the practice was inadequate and it was placed in special measures for a period of six months. Following a subsequent inspection on 6 September 2016, West End Surgery was rated requires improvement overall and requires improvement within each of the five domains. A requirement notice was issued following this inspection to ensure action was taken to meet the legal requirements within our regulations in respect of pre-employment recruitment checks. However, the practice was found to have increased its capacity, both in terms of management and clinical staff, and it was identified that changes were being made to sustain improvements in quality. The practice was therefore taken out of special measures.

The full reports from all of the previous inspections relating to the former provider can be found by selecting the 'all reports' link for West End Surgery on our website at www.cqc.org.uk.

We carried out this unannounced comprehensive inspection at West End Surgery on 2 and 13 October 2017. This inspection was undertaken due to the change in the registered legal entity providing the service, which had changed from a single-handed GP to a partnership in August 2017. The inspection was unannounced due to information of concern reported to the CQC. Overall the practice is rated as inadequate.

Our key findings were as follows:

Summary of findings

- The practice had insufficient operational management in place. The practice management did not have an ongoing or regular presence on site. In addition, there was limited evidence of clinical leadership to drive improvements within the practice.
- Two of the three GP partners did not work at the practice, and were part of the IMH Group, which is a network of primary care sites across the country whose aim is to help the NHS to deliver its five year plan. The group manages over 50 sites, including GP practices, walk-in centres, and urgent care centres.
- There were limited formal governance arrangements in place and the clinical oversight of processes needed to be strengthened.
- Patients were at risk of harm because some systems and processes were not in place to keep them safe. For example, the practice did not have effective procedures in place to deal with alerts received from the Medicines and Healthcare products Regulatory Agency (MHRA) or alerts related to patient safety. We found that some alerts had not been reviewed to keep patients safe.
- Staff told us that they assessed patients' needs and delivered care in line with current evidence based guidance. However, we were not assured that there were effective systems to ensure guidance was acted upon, and notes from clinical meetings did not reference that new guidance had been discussed.
- Staff fulfilled their responsibilities to raise concerns, and to report incidents. The incidents were reviewed by clinical staff and managers, but we found that there was greater scope for learning and providing evidence of any agreed actions being completed. We saw examples that similar issues had recurred as effective learning had not been implemented by the practice.
- We saw examples of poor compliance with infection control standards. Despite several audits by the local Infection Prevention and Control Team over the course of the last 12 months, the practice was still failing to meet a range of assessment criteria and act upon recommendations.
- The practice was not operating effective systems to ensure they had assessed and put control measures in place to manage all identifiable risks. For example, they had not assessed risks associated with fire and other environmental and health and safety risks. This was exacerbated by the fact that areas of the premises were used to accumulate old and discarded equipment.
- Most patients said they were treated with compassion, dignity and respect and they were involved in decisions about their treatment. Data from the latest national GP patient survey showed that there had been improvement since the previous survey 12 months earlier.
- Information about services and how to complain was available on request and easy to understand. However, the internal procedure for handling complaints and the system for responding to complaints needed to be improved.
- Staff training records could not be provided at the time of our inspection. We found that there was insufficient evidence to confirm staff had the appropriate skills and knowledge to deliver care and treatment.
- Patients said they were generally able to access urgent appointments but there was mixed feedback from patients about their experience in obtaining a routine appointment, or seeing the same GP for continuity.
- A refurbishment plan had been considered to address areas of the premises which had been identified for improvement, including better access for patients with a disability, but this was still awaiting financial support.
- Medicines were not always stored safely and we found that some medicines had exceeded their expiry date. The management of blank prescriptions within the practice needed review to ensure that they were fully secured in line with the practice policy and national guidance.
- Regular team meetings for the whole practice team were not taking place. The last meeting had occurred in November 2016. We found that when issues had been raised by staff, they had not always been acted on.
- There was no completed documentation to evidence that new staff received an induction and support. Competency assessments were incomplete and did not cover all of the relevant responsibilities and tasks undertaken.
- Not all staff had received regular appraisals. Those inductions that had been completed were brief and did not provide clear objectives or feedback on the role.

Summary of findings

- A range of policies and procedures were in place to govern activity within the practice. However, we saw evidence that these were not always adhered to in practice, and not all staff were aware how to access them.

Importantly, the provider must make improvements to the following areas of practice:

- Ensure care and treatment is provided in a safe way to patients, for example, by reviewing all relevant patient safety alerts, including those issued from the Medicines and Healthcare products Regulatory Agency (MHRA), and taking timely and appropriate follow up actions; and proper and safe management of medicines.
- Ensure that the premises are suitable for the purpose for which they are being used. This includes upholding standards of hygiene and ensuring the property is properly maintained and compliant with health and safety regulations.
- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care. This includes the effective management of complaints and systems to monitor internal processes.

The areas of practice where the provider should make improvements are:

- Improve the identification of carers in order to provide them with appropriate support.
- Improve the uptake of annual learning disability health checks.

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

The service will be kept under review and urgent action has been taken by the imposition of conditions on the location's registration with the CQC.

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

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Inadequate

The practice is rated as inadequate for providing safe services.

- The process for reviewing medicines alerts did not ensure that patients were kept safe. We found that some alerts had not been reviewed, and searches had failed to identify and follow up all the relevant patients who may be affected by these alerts. This presented a risk to patient safety.
- Staff understood how to raise concerns and to report incidents. Lessons were not widely shared with all staff to improve patient experience and services. We observed that there was greater scope to apply learning following some incidents, and to provide clear evidence of the actions taken to prevent future recurrences.
- The practice had some systems, processes and practices in place to keep patients safe and safeguarded from abuse. However, staff training could not be evidenced as being up to date, and child safeguarding meetings had not taken place for several months at the time of our inspection.
- The practice had not fully assessed potential areas of risk including fire, environmental and other health and safety related issues. Where concerns had been identified such as through infection control audits and a legionella risk assessment, the practice had been slow to respond, and had no clear plan in place to rectify the presenting issues.
- Medicines were not safely stored and some were noted to be out of date. This included the storage and transportation of vaccines, and emergency medicines.
- The management of blank prescriptions within the practice was not always undertaken in line with recognised best practice, and did not adhere to the practice's own protocol.
- Practice Group Directions could not be located when we visited the practice on 2 October. Patient Specific Directions were not being correctly used to ensure that the healthcare assistant could administer specified medicines under the direction of a prescribing clinician.
- The provider was unable to demonstrate that appropriate recruitment checks had been undertaken prior to employment.

Are services effective?

Inadequate

The practice is rated as inadequate for providing effective services.

Summary of findings

- Data from the Quality and Outcomes Framework (QOF) for 2016-17 showed patient outcomes were below average compared to local and national averages. The most recently published results showed the practice had achieved 92% of the total number of points available. This was 7% below the CCG average and 4% below the national average.
- Staff told us that they used current evidence based guidance to assess the needs of patients and deliver effective care. However, there was limited evidence that this was reviewed as a clinical team and that information was shared with locum GPs and nurses.
- We were unable to view any evidence of a completed staff induction. Competency assessments were used inconsistently and did not provide assurance that staff were appropriately trained to fulfil their key responsibilities.
- There was limited evidence of appraisals and personal development plans for all staff.
- Staff training records were largely absent. We were told this was due to a change in the online training provider. We found examples of gaps in knowledge, including amongst clinicians. Some staff informed us they were undertaking tasks without receiving the appropriate training.
- Staff worked with other health care professionals to understand and meet the range and complexity of patients' needs. Monthly multidisciplinary meetings were held within the practice to discuss vulnerable patients. However, outcomes from this meeting were not shared with all clinicians.

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 mostly in line with others for aspects of care.
- Most patients said they were treated with compassion, dignity and respect and they were involved in decision making about their care and treatment.
- Information for patients about the services available was accessible and easy to understand.
- The practice had identified 19 patients as carers; this was equivalent to 0.5% of the practice's patient list. The practice had not nominated a member of staff to act as a carers' champion, and we saw no evidence that carers were being actively supported.
- During our inspection we observed that staff treated patients with kindness and respect, and maintained patient confidentiality.

Summary of findings

- Feedback received from community based staff members, and care home staff, who worked with the practice, indicated that the practice team were caring towards their patients, and listened to the views of other professionals and care staff.

Are services responsive to people's needs?

Inadequate

The practice is rated as inadequate for providing responsive services.

- Patients told us that it could be difficult to obtain routine appointments when they needed them, although urgent appointments were usually available the same day.
- Data from the national GP patient survey showed patient feedback was mixed for being responsive. For example, 69% of patients were satisfied with the practice's opening hours compared to the CCG average of 83% and the national average of 76%. However, there had been an improvement by almost 10% in patients who said they could get through easily to the practice by phone since last year.
- Patients told us that continuity of care was problematic and that they frequently had to see a locum GP. This was reflected in the 2017 national GP survey in which 38% of patients said they usually got to see or speak to their preferred GP. This compared against a CCG average of 65% and a national average of 56%
- The premises were in need of refurbishment. The site was not fully compliant with the Equality Act 2010 and access for people with limited mobility was problematic in some areas.
- A TV screen displayed health messages in the waiting area, and a visual display called in patients to see the clinician.
- Information about how to complain was available upon request, although this was not clearly displayed in the waiting area or on the practice website. We saw that the provider had been slow to respond to complaints and the system was not working smoothly.

Are services well-led?

Inadequate

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

- The partnership did not proactively engage with the practice team, apart from the one GP partner based on site. There was not a clear distinction between the partnership and the corporate body (IMH), although the partnership retained the responsibility to fulfil requirements with their CQC registration and to comply with essential standards of care.

Summary of findings

- Managers did not have the necessary experience, knowledge, capacity or capability to lead effectively. Leaders were out of touch with what was happening during day-to-day service delivery. There was no regular practice management presence on site at the time of our inspection.
- Clinical leadership was not evident and did not drive forward any improvements.
- Governance arrangements were insufficient to support the safe delivery of care.
- We found that full practice team meetings had not taken place since November 2016. There was a lack of systems to ensure that staff were kept up to date.
- Policies and procedures were in place within the practice. However, we found that these were not always adhered to, and that some staff were not aware how to access them.
- Systems and processes to identify, assess and monitor risk within the practice were limited.
- IMH had arranged an event to consider the development of a vision at a corporate level in late October 2017. However, there was no clear understanding of a practice vision or the development of objectives/values at the time of our inspection.
- The practice had a patient participation group (PPG) but the practice was not working with them productively. Meetings had not taken place regularly and the practice had not taken the opportunity to allow the PPG to champion the patients' voice effectively.

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

We rated the practice as inadequate for providing safe, effective, responsive and well-led services, and as good for being caring. The concerns which led to these ratings apply across all the population groups we inspected.

- Older patients had an allocated named GP responsible for their care, although some patients said that they rarely saw the named GP.
- The needs of older people were met through urgent appointments and home visits where these were required.
- Monthly multi-disciplinary meetings were held with community based health professionals to ensure the needs of the most vulnerable patients were being met.
- Routine monthly visits were scheduled at two local care homes where older patients were residents. Urgent requests were responded to on the same day. Each of the homes had a named GP for continuity.

People with long term conditions

Inadequate

We rated the practice as inadequate for providing safe, effective, responsive and well-led services, and as good for being caring. The concerns which led to these ratings apply across all the population groups we inspected.

- The absence of any designated and regular practice nurse input at the practice since April 2017 had meant that long-term conditions reviews had been overseen by GPs.
- There was no clear call and recall system in operation. This meant that patients with more than one condition would be seen at separate reviews of individual conditions.
- The CCG employed pharmacist working at the practice ensured that medicines reviews were undertaken as required with patients.
- Services such as spirometry (a test to assess lung function) and ECGs were offered on site. However, we raised concerns with regards to the oversight of spirometry and the practice agreed to suspend this service until effective governance arrangements were in place.
- For those patients with the most complex needs, the practice team worked with relevant health and care professionals such

Summary of findings

as the community matron and district nurses, to deliver a multidisciplinary package of care. The practice liaised with specialist nurses and teams to provide expert advice when this was indicated.

Families, children and young people

Inadequate

We rated the practice as inadequate for providing safe, effective, responsive and well-led services, and as good for being caring. The concerns which led to these ratings apply across all the population groups we inspected.

- The practice could not evidence that staff had received relevant safeguarding training although staff mostly had a sufficient understanding of safeguarding procedures.
- No safeguarding meetings had taken place since February 2017, following a reconfiguration of health visiting teams locally. There were plans to get these formally reinstated with the school nurse.
- Childhood vaccination rates had been below local averages for standard childhood immunisations. Our inspection highlighted that the recall system for children was not working effectively.

Working age people (including those recently retired and students)

Inadequate

We rated the practice as inadequate for providing safe, effective, responsive and well-led services, and as good for being caring. The concerns which led to these ratings apply across all the population groups we inspected.

- Of the 27 returned patient questionnaires we provided during our inspection on 2 October 2017, 70% of patients said that appointments did not run to time with delays reported of up to an hour. People who were working said this created difficulties for them.
- Extended hours surgeries were not provided. There were no early morning appointments available and the first appointment with a GP was usually at 8.50am. The last GP appointment was usually at 5.20pm.
- The practice had a number of telephone consultations each day and some patients told us that they had found this service to be beneficial.
- The practice offered online services including online appointment booking and the ordering of repeat prescriptions.

Summary of findings

- The practice participated in the electronic prescription scheme, so that patients could collect their medicines from their preferred pharmacy without having to collect the prescription from the practice.
- The practice provided contraceptive advice and services, including intra-uterine devices (coils) fittings and removals.
- The practice's uptake rate for cervical cancer screening was below local and national averages. We did not see any clear evidence that attendance was being actively promoted with female patients.

People whose circumstances may make them vulnerable

Inadequate

We rated the practice as inadequate for providing safe, effective, responsive and well-led services, and as good for being caring. The concerns which led to these ratings apply across all the population groups we inspected.

- The practice had identified 0.5% of their registered patients as being carers. There was no evidence that carers were being offered ongoing support, and the practice had not identified a carers' champion.
- The practice informed us that none of the 18 patients on the learning disability register had received an annual review of their health needs in the last 12 months. This meant the practice could not be assured that the health needs of patients with a learning disability were being met.
- Longer appointments were available for patients with a learning disability and for those who required them.
- Palliative care patients were reviewed with community staff at a monthly meeting to ensure their needs were met.
- Feedback from care home staff was positive regarding the service provided to their residents.

People experiencing poor mental health (including people with dementia)

Inadequate

We rated the practice as inadequate for providing safe, effective, responsive and well-led services, and as good for being caring. The concerns which led to these ratings apply across all the population groups we inspected.

- 84% of patients diagnosed with dementia had their care reviewed in a face to face meeting in the last 12 months, and this was in line with the CCG and national averages. The exception reporting rate for this indicator was also in alignment with local and national averages.

Summary of findings

- Performance for mental health related indicators was 72% which was 25% below the CCG average and 22% below the national average. Performance had decreased from a 100% achievement in the previous two years. The exception reporting rate for mental health related indicators was higher than local and national percentages.
- 83% of patients with severe and enduring mental health problems had a comprehensive care plan documented in the preceding 12 months. This was lower than the CCG average of 92%, and above the national average of 90%. Exception reporting for this indicator at 33% was significantly above local (17%) and national (12%) figures.
- Patients experiencing poor mental health were provided with information about how to access various support groups and voluntary organisations.

Summary of findings

What people who use the service say

The national GP patient survey results were published on 6 July 2017. The results showed the practice had mixed feedback and although they were performing in line with many local and national averages, a number of areas still highlighted the need for significant improvement. In total, 239 survey forms were distributed and 99 of these (41%) were returned. This represented approximately 2.8% of the practice's patient list.

- 78% of patients described the overall experience of this GP practice as good compared with the CCG average of 91% and the national average of 85%. This was an increase from 72% at the previous survey.
- 68% of patients described their experience of making an appointment as good compared with the CCG average of 84% and the national average of 73%.
- 48% 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 84% and the national average of 77%.

As part of our inspection we also asked patients to complete a patient experience questionnaire, and we received 27 completed responses. Patients said that they were mostly satisfied with the care and treatment they had received at the practice. However, a number of adverse comments were received which included: lengthy waits beyond the allocated appointment times; difficulties in accessing a preferred GP and inconsistencies in care due to locum cover; and access to GP appointments was highlighted by a number of patients as being problematic.

West End Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Over the two days of our inspection, the inspection team consisted of a CQC Lead Inspector, two GP specialist advisors, two nurse specialist advisors, a practice manager specialist advisor, and a CQC Inspection Manager.

Background to West End Surgery

West End Surgery is a GP practice within NHS Nottingham West Clinical Commissioning Group's area. It provides primary medical services to approximately 3,600 patients via a general medical services (GMS) contract. The list size has showed a continual decline over recent years, and the CCG informed us that the list size had reduced by 40% (approximately 2,500 patients) since 2013.

West End Partnership has been registered with the CQC as the provider of this service since 25 August 2017. The partnership consists of three GPs although only one of the GPs works at the practice, the other two partners have no regular input at the practice. These two partners are also part of the IMH group, and the partnership contracts all its support functions through IMH. Practice staff are now employed through IMH.

The practice is located close to Beeston town centre on the outskirts of Nottingham and is easily accessible by public transport, including the tram which runs directly in front of the building. The premises are within an old converted three floor town house property, which has recently been sold by the new provider and the space is rented back to them. There is only staff car parking available on site, but patients can park in an adjacent local car park. Accessible parking is available within the car park, and there is a designated practice accessible parking space on a side road across the street from the practice. All patient services are provided on the ground floor.

The practice age profile demonstrates lower numbers of younger people compared to local and national averages, and higher numbers of patients aged over 65 compared to national averages, but in line with local averages. The patients are predominantly white British at approximately 90% of those who are registered with the practice.

The clinical team is comprised of a part-time female GP partner, two salaried GPs (one full-time male GP, and one part-time female GP), and one part-time female healthcare assistant. A new practice nurse is due to commence their role at the practice in October 2017, following a period of several months without a dedicated practice nurse. The clinical team is supported by a practice manager, and an assistant practice manager. The practice manager covers two practices (the other being a separately registered practice in a neighbouring CCG area) and rarely attends the site. A reception manager heads a team of five reception staff, and there are also two medical secretaries. A CCG pharmacist is based in the practice for two and a half days each week, funded through a successful CCG bid to place clinical pharmacists in primary care. The CCG is negotiating longer term funding for this post with the practice.

The practice manager is identified as the registered manager. This is the person who is registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Detailed findings

The practice opens between 8am and 6.30pm Monday to Friday. GP consulting times are variable but are generally from 8.50am to 11.10am each morning and from 3pm to 5.20pm each afternoon.

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, following concerns that were highlighted to the CQC, to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations, including NHS Nottingham West CCG and NHS England, to share what they knew. We carried out an unannounced inspection visit on 2 October 2017 due to information of concern which had been received; a further visit was undertaken on 13 October 2017 to follow up on areas of concern identified on the initial visit. During our visits we:

- Spoke with a range of staff including GPs, operational managers, the pharmacist, the healthcare assistant, visiting nursing staff, and members of the reception and administrative team. We also spoke with patients who used the service, including the chair of the practice participation group.
- Reviewed a sample of the personal care or treatment records of patients.
- Observed how patients were being cared for in the reception area and talked with carers and/or family members
- Reviewed patient questionnaires where patients and members of the public shared their views and experiences of the service.
- Looked at information the practice used to deliver care and treatment plans.

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

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

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

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

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

Inadequate

Are services safe?

Our findings

The provider is rated as inadequate for providing safe services following our comprehensive inspection on 2 and 13 October 2017.

Safe track record and learning

- Some systems were in place to enable staff within the practice to report and record significant events.
- Staff could either record details of significant events or incidents directly onto the IMH intranet, or complete a paper form and forward this onto the practice manager. When logged, the incidents were listed as 'recorded events' which included complaints, and this made an overall analysis of incidents difficult to assess, and the recorded description of the incident lacked detail.
- The significant events were reviewed with clinical staff and managers at monthly meetings. We did not see that lessons learned were generally shared and applied across the whole practice team.
- Whilst events were discussed and learning was considered, there was greater scope for learning opportunities. For example, when a serious incident occurred due to language barriers with a patient's relative, the outcome had not been effective in addressing the issues that had arisen.
- Evidence of how any learning had been embedded within the practice was not apparent, and we saw that some issues had recurred. This included finding consumable stock which had gone out of date when treating patients.
- Near misses were not recorded. A member of the team told us that there was no formal mechanism to review these, although there may be an informal discussion in passing.
- When things went wrong with care and treatment, we were told that patients were informed of the incident, provided with support, information and apologies where appropriate. However, we found that two of the three GPs did not fully understand the duty of candour (this is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment), and we saw evidence that this obligation was not being fulfilled. For example, an incident involving the incorrect medicines being prescribed for a patient with dementia was not discussed with the patient as it was felt they did not understand. No action had been taken to document the rationale as to why this had not been discussed. Additionally, this issue was not discussed with the patient's relatives.

The process in place to deal with alerts from the Medicines and Healthcare products Regulatory Agency (MHRA) and some other alerts related to patient safety was not being operated effectively. MHRA alerts were received via email and disseminated to relevant staff within the practice. We saw that a CCG pharmacist working within the practice reviewed some of the alerts, however there was no clear audit trail to indicate that all alerts had been reviewed, patient searches undertaken, and patients recalled for review when appropriate. Not all GPs were able to demonstrate an awareness of the MHRA alerts process.

We reviewed a MHRA alert issued in April 2017 for female patients who may become pregnant being prescribed sodium valproate, due to the riskof developmental disability and birth defects. This affected two patients in the practice, and neither patient had been recalled to discuss the alert. However, the practice took action after our inspection to follow up the patients and review their status.

The absence of a robust system for the review of medicines alerts raised concerns that patient safety could be affected as the effective follow up to potential risks could not be assured.

Following our inspection on 2 October 2017, the practice provided us with an alert log template which would be implemented to record receipt and document the actions taken in respect of these. They told us that alerts log would also be added to their intranet for ease of reference and including details of any actions taken. When we went back to the practice on 13 October, there had been no progress in populating the template, although the provider informed us that they were following up the patients prescribed sodium valproate.

Overview of safety systems and processes

- The practice had some arrangements in place to help to safeguard children and vulnerable adults from abuse. Safeguarding policies were in place although the salaried GPs were unclear about how to access policies. The policies mostly reflected relevant legislation and outlined who to contact for further guidance if staff had concerns about the welfare of a patient. The practice

had a GP safeguarding lead in place, but no safeguarding meetings had been held with the health visitor or school nurse to discuss children at risk of harm since February 2017. We were told that this was because there had been a reconfiguration of the health visiting team, and the allocation of a school nurse as the main point of contact for safeguarding concerns. The practice told us they had tried to arrange a meeting with the school nurse but had only had one informal telephone conversation with the nurse since February. Staff mostly demonstrated knowledge of their responsibilities and had previously received training on safeguarding children and vulnerable adults relevant to their role. The practice informed us that GPs were trained to child protection or child safeguarding level 3, but were unable to produce evidence that all practice staff were up to date with their safeguarding training. GPs were unable to provide any examples of current child safeguarding issues that were subject to monitoring. The use of safeguarding alerts on the computer system were not utilised to ensure that clinicians were fully aware where concerns were known. A GP told us that the practice did not have a register of vulnerable adults.

- Information was displayed in the practice which advised patients that they could request a chaperone if required. However, on the day of our inspection we observed that a GP requested a member of the reception team to act as a chaperone, but they were unable to assist at the time as they working alone on reception. When discussing how chaperones worked with a GP, it was apparent that their knowledge of the chaperoning process was not adequate as the GP informed us that a chaperone could stand behind a curtain if the patient wished. It is necessary for the chaperone to be able to see the procedure being undertaken. We were told that staff who acted as chaperones had received some training for the role, but this could not be evidenced by the practice. When we visited the practice on 13 October, the Head of Clinical Operations told us they had arranged to deliver chaperone training to all staff at the end of October 2017. Staff who undertook chaperoning duties had not received an enhanced 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). Following our inspection, the provider informed us that staff would no longer act as chaperones until they had received appropriate DBS clearance. Feedback received from patient questionnaires indicated that a number of patients did not understand the chaperoning procedure.
- Effective arrangements were not in place to ensure the practice maintained appropriate standards of cleanliness and hygiene. During our inspection we observed the practice was not cleaned to a high standard. Cleaning was undertaken via an external contractor. There were no cleaning schedules in place when we inspected on 2 October 2017. A tick-list schedule had been placed on the wall in each room when we returned to the practice on 13 October. However, we still found that cleaning standards remained insufficient. A practice nurse who worked at another IMH GP practice was the infection control clinical lead for West End Surgery in the absence of their own practice nurse. This nurse attended the practice once a week. An initial audit by the local infection prevention and control team (IPCT) on 28 September 2016 had identified a significant number of concerns and developed an extensive action plan for the practice. The practice had suspended providing minor surgical procedures on site due to infection control concerns. The action plan had been reviewed by the IPCT on 22 May 2017, and again on 6 October 2017 but a number of issues still required action, some of which were part of a longer-term refurbishment proposal, but other issues remained as the practice had not acted to resolve them. For example, infection control policies and protocols were available but these had been shared from a local community trust provider and had not been customised to the practice's individual requirements. Staff had not received infection control training relevant to their roles although they were issued with training folders, containing some basic information, following our inspection on 2 October. Waste bins were not being emptied daily. In addition, we found other infection control concerns including a large number of overfilled and unlabelled sharps boxes in the practice cellar, and some of the sharp bins in use in clinical areas were open or full. This included an open bin containing cytotoxic waste (cytotoxicmedicines have a toxic effect on cells). The cleaning schedules of medical equipment were not maintained in accordance with manufacturer's instructions.
- The arrangements for managing medicines (including emergency medicines and vaccines, in the practice)

needed to be improved. We found some out of date medicines, and observed that vaccines were not always managed in accordance with recommended guidance. It was observed that no vaccine fridge temperatures had been recorded manually in April 2017. The provider produced a data logger print out after our inspection covering this period, but as the practice had two fridges it was not possible to be fully assured that the reading related to the fridge without any manual recording. It was highlighted that the provider did not have any cool bags to ensure the safe transportation of vaccines outside of the practice (for example, if giving flu vaccines in patients' homes or care homes), despite this issue having previously been raised as a concern with them by the CCG. Following our inspection, the provider showed us they had purchased this equipment. The most recent infection control audit on 6 October 2017 which was undertaken after our first inspection visit still identified areas of non-compliance with safe vaccine management, including storage arrangements, servicing of the fridges and calibration of thermometers, and the daily monitoring of temperatures. We observed that the practice cold chain policy was out of date and required a review.

- The practice did not adhere to the IMH Prescription Security Protocol. For example, this indicated that boxes of incoming prescriptions were recorded by number on arrival by the practice manager or responsible person using a hand written log. It also did not conform to the requirement to strictly control and record authorisation of those given access to the secure storage of prescriptions. There were some systems in place to store blank prescription forms and pads securely and to monitor their use. However, there was not a procedure to record the serial numbers of prescriptions when these were distributed and returned from printers. Named prescription pads for GPs who had left the practice were kept in the safe. When highlighted to a member of the practice team, they suggested that they would shred these, indicating a need for staff training and better oversight of the management of controlled prescription stationary. The IMH protocol did not contain reference to the safe disposal of prescription documents.
- There were processes in place for handling repeat prescriptions which included the ongoing review of high risk medicines. However, we saw that there were a number of uncollected prescriptions awaiting collection at reception on October 2, and these dated back to June 2017. This included some medicines which could be detrimental to the patient's condition if not taken such as medicines for the control of asthma and mental health conditions. When we returned to the practice on 13 October, these patients had been reviewed and followed up. The practice had implemented a system to log and regularly review uncollected prescriptions.
- We also observed that a patient prescribed a high-risk medicine had not attended for regular blood tests. The last direct contact with the patient had been in January 2017. The practice was contacted by the hospital consultant to highlight this, and the patient was recalled for a blood test. The patient failed to attend for the test but no follow up action was taken by staff. Following our inspection, the practice contacted the patient again who subsequently attended for the blood test. At our second visit on 13 October the practice provided us with a list of medicines that required regular monitoring including the tests to be undertaken and the timescales for review; this was to be introduced from October 2017.
- We were informed that Patient Group Directions (PGDs) had been adopted by the practice to allow nurses to administer medicines in line with legislation but these could not be located during our inspection on 2 October. When we returned to the practice on 13 October, the practice had found the PGDs to support a locum practice nurse and whilst these had been completed by the senior GP, there was no signed sheet completed by the agency nurse.
- The healthcare assistant was not administering medicines against a patient specific prescription or direction from a prescriber. We found that the healthcare assistant, who largely worked unsupervised, was seeing patients without a patient specific direction (PSD) in place. We observed that this included seeing patients opportunistically for their annual flu vaccination. The healthcare assistant completed patient templates for PSDs but these were incorrectly completed and unauthorised. This did not adhere to IMH's guidance on PSDs. We observed that patient notes did not always include details of the site administered, or batch number/expiry date of the vaccine. We highlighted this to the practice on the day of our inspection as a significant concern, however when we returned to the practice on 13 October, we saw that the procedure had only been corrected the day before our return visit.

Inadequate

Are services safe?

- On 2 October, we observed a backlog of approximately 800 patient letters dating back to March 2017 requiring clinical coding. When we visited on 13 October, this number had been reduced to 211, and the practice told us they were putting additional support in place to clear the backlog by 31 October 2017.
- In addition, it was observed on 13 October that two GPs had a backlog of incoming patient letters to review going back four weeks. One GP had 99 letters dating back to 20 September 2017 that needed to be viewed and followed up as appropriate. A review of the six oldest letters indicated that no action was required. The other GP had 55 letters awaiting viewing dating back to 18 September 2017. We also viewed the six oldest letters, and found that three of these letters did require the GP to undertake some form of action.
- We reviewed six staff files and found that evidence of appropriate recruitment checks could not be demonstrated. No paper records were available on site as all records were processed for electronic filing by IMH's Human Resources (HR) department. However, when we reviewed the electronic staff records, most supporting recruitment information was unavailable. For example, proof of identification, evidence of conduct in previous employment or character references, proof of qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service were missing from some, or all, of the six files viewed. The provider told us that the paperwork was with their HR team awaiting upload onto the system. Some additional information was provided throughout our inspection, for example, for the most recent employee, but there were still many gaps demonstrating that all the required recruitment checks had not been undertaken. Additionally, there was no evidence to support that the annual registration status of GPs and nurses was being undertaken following their employment.
- A Health Professional Alert Notice (HPNA) had been issued by the National Clinical Assessment Service (NCAS) in October 2016. The surgery had signed a declaration to the CCG that they adhered to the HPAN web checking service, but still proceeded to appoint an individual who had been identified via this system, and failed to inform the relevant persons that they had done so. We observed that the pre-recruitment checks for this individual were largely absent, including previous references and interview notes.
- We did not see documented evidence that all clinical staff had received the appropriate health clearance including Hepatitis B vaccination to undertake their role safely. Reception and domestic staff had not been offered vaccination, and there was no risk assessment available to explain this.
- There was a system in place to monitor electronic pathology results, but there was not a clear buddy system in operation. The full-time GP usually covered these but we observed that when this GP was not at work on one day the previous week, the incoming results had not been checked.

Monitoring risks to patients

- Risks to patients, staff and visitors were not appropriately assessed and managed.
- No fire risk assessment was available for the site. We did not see evidence of regular checks of fire safety systems and equipment being undertaken and recorded, and we saw no evidence that fire evacuation procedures had been tested.
- The practice could not produce other risk assessments used to monitor safety of the premises such as control of substances hazardous to health (COSHH), an asbestos site survey or general health and safety risk assessments. COSHH assessments were provided when we went back to the practice on 13 October, but all sheets were out of date with no evidence that they had been reviewed.
- We found numerous examples of poor health and safety management. For example, we found an unlocked door opposite the consulting rooms which led to a steep descent into a cellar. The cellar contained piles of broken and out of date equipment, as well as being a cramped workspace for a handyman with tools and various items which required proper storage and supporting COSHH paperwork. We found papers which included patient information in torn black bin liners, overfilled sharps bins, and old computer equipment amongst quantities of other discarded items. The cellar was very damp and there were two grills at the end of the cellar at ground level where old leaves had blown down into the cellar, creating a potential fire risk as well as a potential point for unauthorised access into the premises.
- A room marked as a child's room was located on the ground floor. This was unlocked and crammed with old and out of date equipment, which included a

defibrillator. This had been serviced in the last 12 months and although we were informed this was unused as pads could not be purchased for it, there was no label on it indicating it had been taken out of use. There was an unused third floor which was not accessible to the public. We saw that old patient notes were stored in one room, some in unlocked metal cabinets and many others stored in cardboard boxes. An unused fridge was switched on in an old kitchen area which contained a disconnected gas cooker and boiler.

- We found that blind cords had not been secured despite previous safety alerts being distributed about the potential risk of ligation. This was raised with the provider on 2 October. When we returned on 13 October, this had not been actioned and no risk assessment or temporary control measure had been considered. We were told there had been a mix up in the order for blind safety hooks and the provider then showed us evidence that the safety hooks had been ordered that day.
- We saw that electrical equipment had been tested as part of the portable appliance testing (PAT) schedule. However, we found that a light situated above an examination couch was marked as having failed the test, but was plugged into the wall and assumed to be still is use. The provider removed this equipment after our inspection on 2 October.
- The annual calibration of some medical equipment was overdue. For example, we saw a spirometer machine and an ECG machine which were last marked as tested in November 2012.
- The provider had commissioned an external company to undertake a legionella risk assessment in July 2017 (Legionella is a term for a particular bacterium which can contaminate water systems in buildings). The report identified a number of actions required to mitigate areas of potential risk. This included eight recommendations that required rectification as soon as possible. However, the provider was unable to provide any evidence of progress in the form of an ongoing action plan. When we returned to the practice on 13 October, the provider was able to show that arrangements had been implemented to ensure actions were being completed and control measures, for example, the monitoring of water temperatures, was being monitored and kept under review.
- Limited arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We were told that rota systems were operated to ensure there were enough staff on duty and staff provided cover for each other in the event of absence or annual leave. However, we found that management presence on site was minimal as both the practice manager and assistant practice manager were based at the other local IMH practice. Only one person was on duty on reception on our inspection on 2 October in the early morning. We saw that this person was under pressure to answer incoming calls and deal with patients at reception and requests from GPs. The practice had not had a practice nurse in post for several months and relied on regular agency cover, and input from the visiting practice nurse from another practice on one day a week, although we were informed this nurse did not work clinically.

Arrangements to deal with emergencies and major incidents

The practice had insufficient 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.
- Not all staff were up to date with annual basic life support training. Update training had been booked for November 2017.
- The practice had a defibrillator available on the premises and oxygen with adult and children's masks. The practice only had one cylinder of oxygen available, and there was no sign available to highlight where the oxygen was stored in line with health and safety requirements. We observed that the resuscitation kit did not contain an adult ambu bag (a hand-held device used to aid resuscitation), and a child airway had just gone out of date, although we were informed that the contents were checked regularly.
- Emergency medicines were available to staff in a secure area of the practice, and staff were aware of their location. However, a sign indicating where these were kept related to the previous location they were stored and there was no sign indicating the current location. The present location was locked within a locked room, making access difficult in an emergency. Some emergency medicines we checked were out of date,

Inadequate

Are services safe?

including two ampules of one medicine which had expired in October 2016 and there were excessive quantities of stock which meant it would be difficult to find a particular item quickly.

- The practice had a business continuity plan in place covering major incidents such as power failure or building damage. We found that the GP's knowledge about the plan was insufficient.
- There was only one full time GP at the practice. If this GP was not at work, reception staff told us they had mobile numbers for the part-time GPs in case of an emergency or significant problem, although a locum GP may be available on site. There were no protocols for reception staff to follow in case of an emergency.

Inadequate

Are services effective?

(for example, treatment is effective)

Our findings

The provider is rated as inadequate for providing effective services following our comprehensive inspection on 2 and 13 October 2017.

Effective needs assessment

- We were informed that relevant and current evidence based guidance and standards were used to assess the needs of patients and deliver care; these included National Institute for Health and Care Excellence (NICE) best practice guidelines and local guidelines. However, GPs were unable to give any examples of any recent NICE guidance and how this had been applied within the practice.
- We were informed that new and updated guidance was discussed amongst clinical staff. We reviewed minutes from recent clinical meetings but none of these made reference to NICE. Following our inspection, we were informed that a shortcut to NICE guidance would be created on all clinical desktops to facilitate easy access to information.
- The head of clinical operations for IMH showed us copies of corporate newsletters. These contained useful and up to date information including the latest NICE guidance. It also contained other useful clinical updates, and some information on learning from incidents. The head of clinical operations informed us that this was sent onto the practice manager and the senior partner. We asked to see evidence that this was distributed to all staff but this was not produced, and there was no evidence that this was referenced within clinical meetings.

Management, monitoring and improving outcomes for people

The practice used information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). The most recently published results for the year 2016-17 showed the practice had achieved 92% of the total number of points available. This was 7% below the CCG average and 4% below the national average. This was a reduction in performance from a 96% overall achievement in 2015-16.

The clinical exception reporting rate within QOF was 9% which was 0.4% below the CCG average and 1% below the national average. (Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects). The practice had reduced its level of exception reporting from 14% in 2014-15, and 12% in 2015-16.

This practice QOF data from 2016/17 showed the practice was an outlier in a number of areas:

- Performance for diabetes related indicators 88% which was 10% below the CCG average and 3% below the national average. The practice had attained 85% for diabetes in 2015-16, and had achieved 96% in 2014-15.
- Performance for indicators related to chronic obstructive pulmonary disease was 88% which was 11% below the CCG average and 9% below the national average. Data from 2015-16 showed the practice had achieved 100%. In 2014-15, the achievement had been 71%, and the practice had instigated arrangements to improve performance, and whilst this had made an impact the following year, this had not been sustained.
- Performance for mental health related indicators was 72% which was 25% below the CCG average and 22% below the national average. The exception reporting rate for mental health related indicators was significantly higher than local and national averages, with practice data indicating this to be 24%. The previous two years had both demonstrated a 100% achievement for mental health.
- The practice achieved 80% of patients with hypertension in whom the last blood pressure reading (measured in the preceding 12 months) was 150/90 mmHg or less. This was 7% below the local average and 3% below the national average. The practice had a higher prevalence of hypertension than local and national averages.
- The practice achieved 92% for indicators related to patients with dementia which was 7% below the local average, and 5% below the national average. It was noted that 56% of patients with a new diagnosis of dementia recorded in the preceding year had a record of recommended investigations recorded between 12 months before, or 6 months after, entry onto the practice register. This was 32% below local and national averages.

Inadequate

Are services effective?

(for example, treatment is effective)

- The practice had also attained a lower achievement against local and national percentages for osteoporosis (67%), stroke (89%) and coronary heart disease (82%).

There was limited evidence of quality improvement including clinical audit.

- There was some evidence of quality improvement work including audits within the practice. We were provided with two clinical audits. One was a first cycle audit on patients who had a splenectomy (removal of the spleen). This was not available on October 2, but the GP agreed to write this up and provide it as evidence the day after our inspection. The aim of the audit was to ensure that patients had received appropriate vaccinations to reduce the risk of infection associated with patients who do not have a spleen. The audit identified four patients, all of whom required at least one vaccination or booster to comply with recognised standards, and all needed to be informed about the new guidelines. Patients were being followed up with a second audit planned in the future. The other audit from July 2017, and prior to the registration of this provider, was undertaken to discover what proportion of patients had been identified as having symptoms of pre-diabetes, and check these had been correctly coded and received appropriate follow up. The audit showed that only 35% of patients had been coded correctly, and 64% of the 136 patients identified had received an HbA1c or plasma glucose test within the last 12 months in line with guidance. Eight patients were followed up immediately as their results had exceeded the range for pre-diabetes and five were diagnosed as having diabetes, the other patients had left the practice. The audit aimed to improve the coding of patients with pre-diabetes and establish a recall system for an annual review. The new provider planned to repeat the audit in six months' time. One GP told us they had not undertaken any audit work.
- The CCG maintained a quality dashboard giving an overview of the performance of each of their practices. West End Surgery was the only practice in the three south Nottinghamshire CCGs to have achieved an overall red rating since the introduction of the dashboard. In the latest data for the first quarter of 2017-18, the practice was showing an amber rating on the dashboard, with ten of the other eleven practices in their own CCG being rated as green

Effective staffing

- We saw an example of IMH's detailed corporate induction programme to support newly appointed clinical and non-clinical staff. However, the practice was unable to provide any documentation of a completed and signed induction for any staff working at West End Surgery.
- Access to role-specific training and updates was unclear. For example, the provider showed us an example of a competency assessment used for the healthcare assistant to administer B12 injections. The assessment required the healthcare assistant to observe the procedure performed by a competent person five times, and then be observed and signed as being competent by the assigned mentor. The form produced on the day of our inspection only contained one entry that the healthcare assistant had observed the procedure on one occasion. However, the visiting practice nurse later provided a signed sheet dated 1 September 2017 indicating that the health care assistant had been observed on at least five occasions administering the B12 injection and flu vaccine, and could administer these under the direction of a registered nurse using a PSD.
- We observed that the health care assistant was undertaking spirometry (a test to help diagnose and monitor certain lung conditions by measuring how much air a person can breathe out in one forced breath). However, there was no evidence of training available to support this, and the individual informed us they had undertaken their training overseas. It was noted that the timescale that patients were being seen for did not give sufficient time for the test to give a conclusive result. We reviewed some patients' notes regarding spirometry tests and observed that entries were poorly documented. For example, there were no results or no details of the test undertaken. The provider later informed us that they had suspended undertaking this test until it could be done correctly, but they gave no indication as to how patients would be provided with access the test in the interim, or how patients who had already been assessed would be reviewed.
- The provider was unable to provide evidence of the health care assistant's training to perform ear syringing or ECGs.
- A new practice nurse was due to commence their role at the practice in October 2017. As this individual had not

previously worked in a primary care setting, we did not see evidence that the practice was planning the appropriate training and support for the induction of this individual. When we returned to the practice on 13 October, we saw the provider was looking to source appropriate training and establish mentoring arrangements.

- The provider was unable to provide training records for their staff, apart from a few individual certificates. We were informed that the provider had changed their online training provider recently and the training history had been lost. Work was planned to upload some of the previous information onto the company intranet, but a lot of this depended on individual staff. On 13 October 2017, the IMH intranet system showed practice training to be 7% complete.
- Not all staff had received regular appraisals. The healthcare assistant had not had an appraisal or review of performance since commencing employment. Salaried GPs did not receive an in-house appraisal. The reception manager had received an appraisal but we were told that this had not been written up and would need to be repeated. The assistant practice manager told us they had received an appraisal in August but this had not been written up by the time of our inspection. Reception staff had received an appraisal but these were essentially lists of training to be done with no reference to clear objectives or performance review.
- The practice had worked with the support of a local CCG pharmacist since April 2016 who attended the practice for three days each week. This post was funded until March 2018 as part of a national pilot. We saw that the pharmacist undertook a lot of work to oversee medicines issues and review individual patients' prescribed medicines.

Coordinating patient care and information sharing

Staff mostly had access to the information they required to support them to plan and deliver care and treatment, although this was not always updated in a timely manner due to the backlog in reviewing letters and coding. Information was accessible though the practice's electronic patient record system and included medical records and investigation and test results. Relevant information was shared with other services, for example when referring patients to other services. We found that care plans were not widely completed, other than for palliative care patients.

There was evidence of some co-ordination to the delivery of care for patients who had more complex needs. We saw evidence that the practice worked with community based health care professionals to understand and meet the needs of patients and to assess and plan ongoing care and treatment. Meetings took place with other health care professionals on a monthly basis to discuss any vulnerable patients including those with palliative care needs. This meeting was attended by the GP partner, although when we spoke with one of the salaried GPs, there appeared to be limited evidence that outcomes from the meeting were more widely shared. Following our inspection, the community team told us that the salaried GP had started to attend these meetings. The absence of an established recall system did not provide co-ordinated care for patients requiring long-term condition management.

Consent to care and treatment

- Consent for care and treatment was usually sought from patients in line with legislation and guidance.
- Some clinicians did not fully understand 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, some clinicians were not aware of assessments of capacity to consent in line with relevant guidance.
- We observed that patient consent was obtained for procedures such as joint injections and family planning. However, this was not recorded sufficiently and the documentation of associated risks and safety netting was not always apparent. It was also observed that the documentation associated with joint injections did not record medicine batch numbers or expiry dates as required.

Supporting patients to live healthier lives

The practice identified some patients who may be in need of extra support. For example patients receiving end of life care, or support with smoking and alcohol cessation.

Inadequate

Are services effective?

(for example, treatment is effective)

Patients were usually signposted or referred to relevant services. However, one patient told us that they had been told to lose weight but was not presented with any options for support.

The practice told us that it encouraged patients to attend national screening programmes, although uptake was generally below local and national averages.

The percentage of women aged 25-65 who had attended the practice for a cervical screening test to be performed in the preceding five years was 74%, which was below the CCG average of 84% and the national average of 81%. Exception reporting levels were higher at 8.5% than local and national averages of 4% and 7% respectively.

The uptake rate for bowel cancer screening in 60-69 year olds in the last 30 months was 54% which was below the CCG average of 63% and below the national average of 58%.

Performance for breast cancer screening was better with the uptake rate for females aged 50-70 in the last three years at 75% which was slightly below the CCG average of 78% and marginally above the national average of 73%.

Data provided from the practice indicated that there were 18 patients on their learning disability register. However, none of these patients had received a review in the year 2016-17. This meant the practice could not be assured that the health needs of patients with a learning disability were being met. The provider informed us that they would ensure that all of these patients would receive a review before 31 October 2017.

The practice had a recent history of low uptake rates for childhood immunisation rates and had the lowest performance rates of all 12 practices within the CCG. In the absence of a designated practice nurse, the surgery had been reliant on locum nurses to perform child immunisations. We viewed the latest data provided by the practice which showed that 70% of immunisations had been delivered by the mid-year stage. We observed that the numbers of children due immunisations were very low. When we completed our inspection on 13 October, an agency nurse was seeing children to administer their immunisations. We spoke with two parents, one told us they were attending because they had initiated the appointment themselves in the knowledge that the immunisation was due, and had not received a recall from the practice. The other parent told us that their child had been unable to receive a particular vaccination as they had not been recalled in the permitted timescale for this to be administered.

Good

Are services caring?

Our findings

The provider is rated as good for providing caring services following our comprehensive inspection on 2 and 13 October 2017.

Kindness, dignity, respect and compassion

During our inspection we saw that members of staff behaved in a polite and helpful manner towards patients and treated them with respect.

Measures were in place within the practice to help maintain the privacy and dignity of patients. These included:

- Curtains were provided in consulting rooms to maintain the privacy and dignity of patients during examinations and treatments.
- Consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- The layout of reception made it difficult to maintain patient confidentiality. Patients could be moved to a quieter area within the practice for more private discussions.

We received feedback from patients during our inspection; this included 27 patient questionnaires completed by patients on 2 October 2017 and speaking with the chair of the patient participation group (PPG). The majority of patients said they felt the practice offered a caring service and staff were helpful, and treated them with dignity and respect.

Results from the national GP patient survey showed that most patients felt they were treated with compassion, dignity and respect. The practice satisfaction scores for interactions with GPs, nurses and reception staff were mostly in line with local and national averages. Some questions showed higher levels of satisfaction than had been achieved 12 months earlier. For example:

- 88% of patients said the GP was good at listening to them compared to the clinical commissioning group (CCG) average of 91% and the national average of 89%.
- 89% of patients said the GP gave them enough time compared to the CCG average of 89% and the national average of 86%. This was an improvement from 81% at the previous survey.
- 97% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 96% and the national average of 95%.
- 87% of patients said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 88% and the national average of 86%. The practice had achieved 78% at the previous survey 12 months earlier.
- 92% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 93% and the national average of 91%.This was an improvement from 85% at the previous survey.

However,

- 79% of patients said they found the receptionists at the practice helpful compared to the CCG average of 90% and the national average of 87%. This showed a reduction from 84% at the last survey in July 2016.

Care planning and involvement in decisions about care and treatment

The majority of patients indicated that they felt listened to and supported by staff and had sufficient time during consultations to make informed decisions about treatment available to them.

Results from the national GP patient survey showed patient experience had improved across these indicators for consultations with both GPs and nurses. The results were in line with local and national averages. For example:

- 87% of patients said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 88% and the national average of 86%.
- 80% of patients said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 84% and the national average of 82%. This showed an increase from a score of 71% in the 2016 survey.
- 91% 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% and the national average of 85%. This was an increase from 76% in the 2016 survey.

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

- Translation services were available for patients who did not have English as a first language.

Good

Are services caring?

Patient and carer support to cope emotionally with care and treatment

Patient information leaflets were available in the patient waiting area which told patients how to access a number of support groups and organisations.

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 19 patients as carers; this was equivalent to 0.5% of the practice's patient list. The practice did not have a nominated member of the team to act as a carers' champion, or have a plan with regards to increasing the identification of carers. Some information was available within the practice to direct carers to the support available to them.

Staff told us that if families had suffered bereavement, their usual GP would speak to family members/carers as deemed necessary. This contact was either followed by the offer of a consultation at a flexible time and location to meet the family's needs or by giving them advice on how to find a support service if required.

Inadequate

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

The provider is rated as inadequate for providing responsive services following our comprehensive inspection on 2 and 13 October 2017.

Responding to and meeting people's needs

- There had not been a practice nurse in post for several months. This impacted on a range of services including childhood immunisations, long-term condition management, and cervical screening. At the time of our inspection, the practice had recruited a new practice nurse who was due to commence employment on 23 October 2017. The practice had used a locum nurse one day per week on most weeks to cover the nursing service.
- In the absence of a practice nurse, the provider was unable to offer travel vaccinations. Patients planning an overseas holiday were advised to contact Nottingham Travel Clinic for advice on travel vaccinations.
- Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice.
- Urgent appointments were available for children and those patients with medical problems that required same day consultation.
- Notes from meetings indicated that there had been issues with medical equipment working properly and needing testing. The last practice meeting minutes from November 2016 indicated that the ECG machine was not giving out a correct reading and was not calibrated. No follow up action was recorded. The same minutes indicated that the spirometry machine was not working properly and had not been PAT tested or calibrated since 2014 and had been 'faulty for a while'. The action was to have the machine PAT tested and when it failed to buy a new one with a suggestion to approach the PPG to fund this. The notes then state that any new machine would need to be calibrated by reception staff on a regular basis. The meeting notes also highlighted that there were very few blood pressure monitoring machines available to loan to patients, as some patients had not returned them. An action was agreed to introduce an equipment loan book. It was then highlighted in the same meeting that there were a number of blood pressure machines available in a clinic room, but it was not known if these were working and so would need to be PAT tested and calibrated.
- The practice provided primary care medical services to the majority of residents in two local care homes for older patients. Each home was allocated a named GP who visited weekly to review residents, and any urgent requests for a GP visit were undertaken as required. We received positive feedback from managers at the care homes, although one stated that reception staff were sometimes unhelpful.
- The premises did not provide fully accessible facilities for patients with a disability. Work was needed to ensure the site was fully complaint with the Equality Act 2010. For example, wheelchair access was problematic in the corridor areas and at reception. The provider told us that they had applied to the CCG for funding to achieve better compliance with Act, but had not received a response. However, the CCG told us that the practice was not able to submit three bids within the permitted timescale to have their plan supported. There was no current plan in place to address the issues. Automatic doors were in situ at the entrance but these were out of order on the day of our inspection, and we discovered that this had been an issue on previous occasions. A hearing loop was available for those with a hearing impairment.
- A range of online services were provided including appointment booking and requests for repeat prescriptions. The practice operated the electronic prescription service which meant that any approved requests for repeat prescriptions could be directed to the patient's preferred pharmacy for collection.
- The practice had temporarily ceased providing minor surgery clinic (for small operations such as the removal of warts, and joint injections) for patients further to concerns regarding compliance with infection control standards. Joint injections were still provided for patients.
- Contraceptive services were offered to patients including coil fittings and removals.
- There were some patient information leaflets available in the waiting area. There was limited information on display and we were told that this was due to some refurbishment work being undertaken as part of the infection control action plan.

Inadequate

Are services responsive to people's needs?

(for example, to feedback?)

- A TV screen in the waiting area acted as a patient calling system to go in and see the GP or nurse. This also displayed a range of health related information to patients.
- A text reminder service was being introduced in November 2017 to remind patients about their appointments and help to reduce wasted appointments.

Access to the service

The practice opened from 8am to 6.30pm Monday to Friday. There were no extended opening hours in operation at the time of our inspection. GP consulting times were generally from 8.50am to 11.30am each morning and from 3pm to 5.20pm each afternoon. In addition to some pre-bookable appointments (8.50am to 10.10am) that could be booked in advance, same day access appointments were also available for people that needed them (10.30am to 11.10am). The same day appointments were released every day at 8am and then at 2pm. When appointments reached full capacity, there was an option for a GP telephone consultation if this was necessary, and patients could be added as extras at the end of the list to ensure they were seen if this was clinically indicated.

Results from the national GP patient survey showed that patient's satisfaction with how they could access care and treatment was mostly lower than local and national averages. However, there was improved patient satisfaction in getting through to the practice by phone.

- 69% of patients were satisfied with the practice's opening hours compared to the CCG average of 83% and the national average of 76%. This showed a reduction from 74% achieved at the July 2016 survey.
- 87% of patients said they could get through easily to the practice by phone compared to the local average of 88% and the national average of 71%. This showed an increase from 78% achieved at the July 2016 survey.
- 73% 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 90% and the national average of 84%.
- 80% of patients said the last appointment they got was convenient. This compared to the CCG average of 89% and national average of 81%.
- 38% of patients usually got to see or speak to their preferred GP. This compared against a CCG average of 65% and a national average of 56%

On October 2, there was one available GP appointment in three working days' time, and after this the next appointment was in seven working days. The practice informed us that pre-bookable appointments were usually available up to eight weeks in advance but this was presently four weeks due to the lead partner reviewing the days of the week they worked at the practice. Feedback from patients received from returned questionnaires, indicated that generally people found it difficult to access a routine appointment, but could usually be seen on an urgent basis. Patients told us they had to ring the surgery at either 8am or 2pm to try and access newly released GP appointments, and that they did not like this system. Of the 27 returned questionnaires, 70% of patients said that appointments did not run to time, with delays reported of up to an hour.

Listening and learning from concerns and complaints

The practice had some systems in place to handle complaints and concerns.

- The practice's written complaints policy and procedure for managing complaints was in line with contractual obligations for GPs in England.
- There was a designated responsible person who handled all complaints in the practice.
- A complaints information leaflet was available on request from reception, but there was nothing displayed in the waiting area to help patients understand the complaints system. The practice website did not contain any information about the practice complaints procedure, apart from some basic information about complaints under a Patient Advice and Liaison Service (PALS) link. This included a hyperlink for more information which was not active.

We looked at how complaints were managed within the practice, and found systems were disorganised. The practice procedure indicated that complaints would be acknowledged in writing in two working days. However, we found a complaint received in July 2017, with no evidence that this had been acknowledged. The practice manager informed us that this had been acknowledged verbally and that they had drafted a response letter, but this was on the computer at another practice and so could not be

Inadequate

Are services responsive to people's needs?

(for example, to feedback?)

accessed. This raised concerns over the management of patient information as well as the management of the complaint. Another patient provided feedback in one of our questionnaires that they had made a complaint approximately four months earlier and was still waiting for a response. When we spoke with a member of staff, they informed us that they would record the details of the complaint on the patient's record, demonstrating that staff were not adequately trained in how to manage patient complaints. There was not a clear system to record verbal complaints. Complaints were logged centrally and reviewed and discussed at clinical meetings. We did not see any evidence of learning from complaints in the minutes of clinical meetings which we viewed.

Are services well-led?

Inadequate

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

Our findings

The provider is rated as inadequate for providing well-led services following our comprehensive inspection on 2 and 13 October 2017.

The partnership had registered with the CQC on 25 August 2017. Although this was a new registration as a partnership, the practice had been operating under these managerial arrangements since August 2016. There had been delays in finalising the new partnership's registration with the CQC and this had led the commissioners to issue a remedial breach notice in March 2017 for operating as an unregistered service. The previous registration was with a single-handed GP, and this GP was now part of the new partnership.

Two of the three GP partners did not work at the practice, and were part of the IMH Group, which is a network of primary care sites across the country whose aim is to help the NHS to deliver its five year plan. The group manages over 50 sites, including GP practices, walk-in centres, and urgent care centres.

The partnership contracted IMH, a multi-speciality care provider to provide the practice's support services including finance, recruitment, human resource management and information technology. The aim was to reduce the pressure of practice management, allowing clinical decision making to be made by GPs and enabling them to spend more time caring for their patients.

Responsibility for compliance with legal requirements was retained by the partnership as the provider registered with the CQC.

Vision and strategy

- IMH had a strategy to deliver the NHS five-year plan. However, we did not find any evidence of how this was being applied at practice level.
- The practice manager informed us that a 'visions and values day' was planned for 31 October 2017 involving other IMH led practices. The intention was to develop a clear strategic direction accompanied by a mission statement. This would then be shared with staff and progressed. Therefore, at the time of our inspection, we did not observe any evidence of a clear vision or specific objectives for the practice.
- There was no evidence of any specific management meetings between the partners and practice manager. The GP partner on site told us that partnership meetings did not happen often.

Governance arrangements

There were a number of areas where governance structures and procedures needed to be improved to support the delivery of care.

- There was a staffing structure but some staff were unclear about their own roles and responsibilities.
- The practice manager reported to the IMH regional lead, rather than to the registered partnership. The practice manager fulfilled the role of registered manager. We were not assured that there were effective governance systems in place to ensure the registered manager of the service retained oversight of the running of the practice.
- We found limited evidence of clear and directive clinical leadership and oversight within the practice. The GP partner based on site was designated as the clinical lead. Another GP informed us they had been assigned as the lead for referrals. However, they told us they had not agreed to do this and had not been told what to do.
- There were very limited arrangements in place to identify, record and manage risks effectively within the practice.
- Systems were not working effectively to protect patient and support the delivery of high quality care. This included the effectiveness of the management of medicines alerts to ensure patients were kept safe.
- During our inspection we identified an issue with the processing of letters and clinical coding. There was a large back log of clinical coding required and some GPs had letters requiring action dating back over four weeks.
- This practice did not have effective managerial oversight on the submission of accurate information to commissioners within designated timescales.
- A range of policies and protocols were available to govern activities within the practice. These were available to staff, but not all members of the team could explain how they could access them. We observed that the practice did not always adhere to its own policies/ protocols, for example in relation to prescription management and patient specific directions.

Are services well-led?

Inadequate

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

- We observed that the practice team struggled to provide us with information when requested. This indicated that further training may be required to be able to maximise the use of practice systems.
- There had been five clinical meetings in 2017 at the time of our inspection. We saw that minutes were recorded and agenda items included significant events and complaints. There was no reference to prescribing issues, NICE and local guidance, or MHRA alerts.
- We met with the Head of Clinical Operations on 13 October. They were able to show us some good examples of how the company infrastructure supported the practice. This included the electronic system for staff records, and a plan to facilitate clinical audit. However, the corporate level had not been applied to the practice level and therefore the evidence which should have been readily accessible was not available.

Leadership and culture

- The practice staff told us that the GPs working on site were approachable and took the time to listen and support members of staff. However, practice management was based at another IMH practice and did not visit the surgery regularly. We were told that the practice manager usually visited twice a week and the assistant practice manager was there for two or three days each week. However, staff told us that the visits were much less frequent and they generally received communication in the form of tasks or mails. Following our inspection on 2 October, the provider told us they would guarantee management cover through the week at the practice, and to ensure more visible and active leadership on site. On 13 October, we discovered this had not changed, and staff informed us that managers had been less accessible and asked not to be disturbed. However, staff were being sent jobs to do via email and the task system during this period. Following our second visit, the provider told us that the clinical operations manager for all of their 54 GP practices would be based within the practice with immediate effect to ensure that all remedial work was addressed.
- Feedback from staff indicated a lack of support by the management team. For example, rotas were changed earlier in the year without any wider consultation or internal meeting. Following our inspection on 2 October, staff had been sent a letter and given jobs to do but had not received any face to face meeting to discuss this.
- We saw that the practice did not hold regular staff meetings; the last meeting had taken place in November 2016. We were informed that a staff meeting had been arranged for October 2017.
- The practice had not established effective working relationships with local practices to facilitate joint working. Buddying arrangements had been organised with a nearby practice, but this had not achieved the desired outcomes to share best practice. The practice manager did not participate in the local practice managers' forum, and GPs did not generally participate in any local GP networking meetings although the GP partner did attend the CCG Clinical Development Committee. Practice staff would generally attend the monthly CCG protected time learning events.
- The CCG and NHS England had met with the provider on several occasions to discuss concerns and offer support, but this had not resulted in the delivery of any sustained improvements.
- This was a history of the practice failing to respond to requests for information or feedback from service commissioners. For example, the practice did not respond to a recent request to jointly fund the practice pharmacist post. Despite this post having added a significant impact for the practice, they had not responded by the designated deadline. Consequently, the input would revert back to the general CCG medicines management level of support from April 2018.

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

The practice sought patients' feedback although we found limited evidence that this was being used proactively to influence the delivery of the service.

- The practice had a patient participation group (PPG) who were keen to work with and support the practice. Meetings were planned to take place monthly, but had been postponed or cancelled by the practice on four occasions so far in 2017. The assistant practice manager attended the PPG meetings, and for the last few months, one of the medical secretaries had assisted the group by taking minutes. The PPG had lost some of their members and now had a group of five regular attendees. The PPG had continued to work with the practice despite a turbulent period in which there had been changes in practice management, and the

Are services well-led?

Inadequate

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

relationship with the PPG had been difficult. The PPG were hopeful that the new arrangements from August 2016 would be positive following their initial meetings with the new management team. However, the PPG explained their frustration in being able to influence change. For example, offers to get involved in patient surveys and a review of the practice website had not been pursued. The practice had changed its appointment system earlier in 2017, but the PPG were not aware of this until two weeks after its introduction. The PPG also repeatedly raised concerns about problems with disabled access due to problems with the automatic entrance doors, which took several months to resolve.

- An internal patient survey had been undertaken in 2017. At the time of our inspection, the survey had finished but the results had not been collated. We did see a patient survey action plan from 2016 which aimed to respond to concerns raised including the availability of urgent appointments.
- There had also been an annual CCG led patient survey that was completed between March-April 2017. The results, which included 'Mystery Shopper' feedback, were sent to the practice on 2 June 2017. The expectation was for practices to work with their PPGs to complete the survey and then discuss the results as a practice, and separately with the PPG to note the areas of improvement already achieved, agree areas to target for improvement this year, and inform the patient information including a 'You Said, We Did' display in the waiting area. However, the PPG told us they had not been involved in these discussions and there was no patient information on display about the results as required.
- The practice had repeatedly failed to provide their CCG with NHS Family and Friends returns, and had not provided any feedback on the results to their patients. The practice had identified that this was an area they needed to improve in their own patient survey from 2016.
- We reviewed patient feedback on the NHS choices website. The practice had a rating of 2 stars (out of a maximum of 5). There had been three comments added in the last 12 months, one of which was positive about the care provided. The other two comments reported negative experiences including unhelpful and rude staff, poor access and a lack of care. The practice manager had responded to the comments on the website and offered an apology and explanations as to how the service would be improved.
- A suggestion box was available in the reception area. There was no information on display about how the practice listened to patient feedback and acted on this to make improvements.
- Staff told us they supported to raise any concerns for discussion, although the absence of regular full staff meetings did not encourage this. Staff told us that they weren't always listened to effectively. For example, reception staff had highlighted that they needed training in systems such as the procedure to follow for downloading results and allocating results to clinicians. Whilst the training was agreed, it was not provided.

Continuous improvement

We did not find any examples of continuous improvement

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 Care and treatment must be provided in a safe way for service users to ensure compliance with the requirements of the fundamental standards as set out in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 **How the regulation was not being met** We found that the registered provider had not ensured safe systems were in place. This included insufficient recruitment information being produced; limited evidence of reviews for patients' prescribed medicines in response to safety alerts; the maintenance of safe and accessible emergency medicines (including equipment) and vaccines; the internal control and security of blank prescriptions ; adherence to infection control standards; the management and oversight of PSDs and PGDs which included administration of medicines without authorisation from a prescriber; the oversight of patients prescribed high risk medicines; the maintenance of sufficient staffing levels (both managerial and clinical); the effective oversight of safeguarding with regular designated meetings and up to date training; and the application of appropriate learning from incidents and near misses. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment **How the regulation was not being met**

This section is primarily information for the provider

Enforcement actions

Treatment of disease, disorder or injury	We found that the registered provider was not maintaining the premises to a safe and high standard. This included upholding standards of hygiene and ensuring the property was properly maintained and compliant with health and safety regulations, supported by regular site and environmental reviews to assess and control risk. This was a breach of regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Systems or processes must be established and operated effectively to ensure compliance with the requirements of the fundamental standards as set out in the Health and Social Care Act 2008 (Regulated Activities)Regulations 2014 **How the regulation was not being met** We found that the registered provider did not ensure that staff training was up to date; awareness of issues including the application of the mental capacity act and consent were insufficient; the induction and oversight of new staff could not be evidenced by appropriate completed and signed documentation; the appraisal system did not operate effectively; there was insufficient clinical leadership and distant practice management; the duty of candour was not fully understood and routinely applied when things went wrong; internal governance systems were ineffective including systems to monitor risk including health and safety and responding to MHRA alerts; the management of complaints was not responsive and staff did not adhere to the practice policy; and a process for learning disability reviews was not in place. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.