Five Elms Medical Practice

Quality Report

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

Ratings

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

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Five Elms Medical Practice on 5 April 2016. The practice was rated inadequate for safe, effective, caring, responsive and well led. The practice was given an overall inadequate rating and placed in special measures The full comprehensive report on the 20 April 2016 inspection can be found by selecting the 'all reports' link for Five Elms Medical Practice on our website at www.cqc.org.uk.

This inspection was undertaken following the period of special measures and was an announced comprehensive inspection on 14 February 2017. Overall the practice is rated as requires improvement.

Our key findings were as follows:

- Levels of patient satisfaction around access to the service and involvement in planning and making decisions about care and treatment were still significantly below local and national averages although there were improvements in all areas compared to the April 2016 inspection.
- The practice had been unable to make effective arrangements in place to cover periods of GP absence although there was evidence of actions taken to mitigate the impact of lost GP sessions.
- Although data from the Quality Outcomes Framework showed patient outcomes were generally comparable to the national average, there were areas where performance was significantly below the national average, including those for patients diagnosed with dementia.
- At our last inspection in April 2016 we found that the practice had not undertaken any completed clinical audit cycles and there was no clear audit strategy in place. At this inspection we found that the practice had developed an audit plan for 2016/17 and had undertaken four clinical audits, including one completed audit.
- The practice had recently begun to promote online access to services.

Summary of findings

- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. All opportunities for learning from internal and external incidents were maximised.
- The practice had good facilities and was well equipped to treat patients and meet their needs
- The practice actively reviewed complaints and how they are managed and responded to, and made improvements as a result.
- There was a clear leadership structure and staff said they felt increasingly supported by management. The practice had begun to seek feedback from staff and patients but processes had not been fully established.
- The provider was aware of and complied with the requirements of the duty of candour.

However, there were also areas of practice where the provider needs to make improvements.

Importantly, the provider must:

- Continue to seek and act on feedback from patients on the services provided, for the purposes of continually evaluating and improving such services, including improving access to the practice and patient satisfaction around involvement in planning and making decisions about care and treatment.
- Take action to ensure sufficient numbers of suitably qualified, competent, skilled and experienced persons are available to meet patient needs.

In addition the provider should:

- Ensure the practice business continuity plan is available to staff, including whilst off-site.
- Continue to monitor Quality Outcomes Framework performance to improve performance in relation to the management of long-term conditions and ensure exception reporting rates are closely scrutinized.
- Consider further ways of promoting online access to services, including a review of the practice website and leaflet.
- Continue to review how carers are identified and recorded on the clinical system to ensure information, advice and support is made available to them.
- Review arrangements to support patients with impaired hearing.

This service was placed in special measures in August 2016. Insufficient improvements have been made such that there remains a rating of inadequate for providing responsive services. The service will be kept under review and if needed could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within six months, and if there is not enough improvement we will move to 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.

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?

Good

The practice is rated as good for providing safe services.

- When we inspected in April 2016, we noted a limited use of systems to record and report safety concerns, incidents and near misses. When there were unintended or unexpected safety incidents, reviews and investigations were not thorough enough and lessons learned were not communicated widely enough to support improvement. People did not always receive a verbal and written apology
- At this inspection we noted that there was an effective system in place for reporting and recording significant events. For example, eleven significant events had been recorded since our April 2016 inspection and we saw evidence that lessons were shared and actions taken to improve safety in the practice.
- When things went wrong patients were informed as soon as practicable, received reasonable support, truthful information, and a written apology. They were told about any actions to improve processes to prevent the same thing happening again.
- At our April 2016 inspection, we found that the practice could not demonstrate that chaperoning arrangements kept patients safe. For instance, although the practice had a policy for chaperoning, this had not been reviewed since 2012 and staff who acted as chaperones had not received a Disclosure and Barring Service check (DBS check) and there was no evidence the practice had carried out a risk assessment to determine if this was needed.
- At this inspection we found that the chaperoning policy had recently been updated and all staff who undertook chaperoning duties had DBS checks and training on how to carry out the role.

Are services effective?

Requires improvement

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

- During our April 2016 inspection, we found that the practice did not have a system to review the training or personal development needs of staff and no system for staff to receive appraisals. At this inspection, we noted that an online training

Summary of findings

resource had been put in place and all staff had received training as appropriate to their role. We also found all staff had received an appraisal and these had included a review of individual training needs.

- When we inspected in April 2016, there was no evidence that quality improvement programmes including clinical audit were driving improvement in performance to improve patient outcomes. At this inspection, we saw that the practice had undertaken four clinical audits, including one completed audit.
- At our April 2016 inspection, we found that patient's outcomes were variable when compared to similar services. During this inspection, data from the Quality and Outcomes Framework (QOF) showed patient outcomes had improved and most were now comparable to the national average for most indicators. For instance, the percentage of patients with schizophrenia, bipolar affective disorder and other psychoses with a care plan documented in the record had improved from 65% in 2014/2015 to 87% in 2015/2016.
- Outcomes were still significantly lower than average for some clinical indicators. For instance, although the percentage of patients diagnosed with dementia whose care had been reviewed in a face-to-face meeting had improved from 25% in 2014/2105 to 48% in 2015/2016, this was significantly lower than the CCG average of 87% and national average of 84%. However, unpublished data for 2016/2017 showed that this had since improved further to 69%.
- The practice had a higher than expected exception reporting rating for patients whose blood sugar level was outside of the normal range. When we inspected in April 2016, the practice had excepted 18% of patients from this indicator but at this inspection, this had risen to 29%. However, we saw unpublished data for 2016/2017 and saw that the exception reporting rate for this indicator was currently at 7% which was comparable to local and national averages.
- When we inspected in April 2016, there was no clear process to ensure that national guidelines, clinical updates or safety alerts were consistently monitored and updated. At this inspection, we found that the practice had put systems in place to keep all clinical staff up to date and had undertaken audits to identify patients affected by updates.

Are services caring?

The practice is rated as requires improvement for providing caring services, as there are areas where improvements should be made.

Requires improvement

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- When we inspected in April 2016, we looked at data from the national GP patient survey published in January 2016 and this had shown that patients rated the practice lower than others for some aspects of care. The next set of results had been published in July 2016. Although this was just three months after the April 2016 inspection, these showed that satisfaction levels had improved in every area, but were still below local and national averages. For instance, data from the July 2016 results showed that 67% of patients had said the GP was good at listening to them compared to 54% in the results published in January 2016.
- The percentage of patients who said the last GP they spoke to was good at treating them with care and concern was 54%, compared to 44% at the time of the April 2016 inspection. This represented an increase of 10% against the results published in January 2016.
- At the April 2016 inspection, there was no evidence that staff had received information governance or confidentiality training. At this inspection, we saw evidence that all staff had received this training and that staff personnel files now included signed confidentiality agreements.
- When we inspected in April 2016, the practice did not have a process for identifying patients who were also carers. At this inspection, we saw that the practice had put a process in place to identify patients who were also carers. At the time of our inspection, the practice had identified 15 carers which was less than 1% of the practice list.

Are services responsive to people's needs?

Inadequate

The practice is rated as inadequate for providing responsive services.

- During our inspection in April 2016, results from the national GP patient survey showed that patient's satisfaction with how they could access care and treatment was significantly lower than local and national averages. At this inspection we saw that the practice had developed and begun to implement an action plan to bring about improvements. The most recent results had been published just three months after this inspection, which meant that it was not possible to fully assess the impact of the changes. However, there had been improvements in every area.
- When we inspected the practice in April 2016, results from the national GP patient survey showed that only 17% of patients said they could get through easily to the surgery by phone. The

Summary of findings

practice had since recruited two additional members to the reception team and data from the national GP survey published in July 2016 showed that 25% of patients now said they could get through easily to the surgery by phone.

- Patients reported considerable difficulty in accessing a named GP and poor continuity of care. Although the percentage of patients who said they always or almost always see or speak to the GP they prefer had increased from 5% to 17% since our inspection in April 2016, this was still significantly below the national average of 60%.
- At our April 2016 inspection, we noted that the practice did not have adequate arrangements for patients who did not have English as a first language. At this inspection, we saw that the practice had carried out an audit of the languages spoken by patients at the practice and had used this to bring about improvements to access for patients whose first language was not English.
- The practice had recently introduced online access to services including making and cancelling appointments and requesting repeat prescriptions.
- Patients could get information about how to complain in a format they could understand.

Are services well-led?

Requires improvement

The practice is rated as requires improvement for being well-led.

- The practice had a vision to provide high quality care and promote good outcomes for patients but did not always have effective supporting plans to deliver this vision. For instance, although the practice was aware of poor patient satisfaction with access to appointments with GPs, it had been unable to fulfil plans to provide appropriate GP cover during periods of annual leave.
- The practice had taken actions to address the major concerns identified at the April 2016 inspection but was not yet able to demonstrate the impact of these actions.
- During our April 2016 inspection we found that the delivery of high-quality care was not assured by the governance arrangements in place.
- At this inspection we found that practice management had developed a governance framework to support the practice in delivering its mission. This included updates of policies, procedures and training that drive effective processes and procedures. For example, the practice had reviewed and updated policies used to govern repeat prescribing and

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chaperoning services and staff had received mandatory training including information governance and infection control. However, it was not yet clear whether these improvements were fully embedded in the practice culture.

- When we inspected in April 2016, staff told us they had not received regular performance reviews and did not have clear objectives. At this inspection, we saw that staff had annual performance reviews, attended staff meetings and been provided with appropriate training opportunities. New staff had had documented induction programmes
- The practice had recently reviewed all policies and procedures to govern activity and had begun to hold and document regular governance meetings.

Summary of findings

The six population groups and what we found

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

Older people

Requires improvement

The provider was rated as inadequate for providing responsive services, requires improvement for providing effective, caring, and well-led services and good for providing safe services. The concerns which led to these ratings apply to everyone using the practice, including this population group. However, we did find examples of good practice.

- The practice offered proactive, personalised care to meet the needs of the older people in its population.
- The practice was responsive to the needs of older people, and offered home visits and urgent appointments for those with enhanced needs.
- The practice worked closely with lead professionals such as the integrated care management team to review care plans for the most vulnerable patients identified by the practice.

People with long term conditions

Requires improvement

The provider was rated as inadequate for providing responsive services, requires improvement for providing effective, caring, and well-led services and good for providing safe services. The concerns which led to these ratings apply to everyone using the practice, including this population group. However, we did find examples of good practice.

- Performance for diabetes related indicators was comparable to local and national averages. For instance 74% of patients had well controlled blood sugar levels (CCG average of 67%, national average 78%).
- Outcomes for patients with asthma were comparable to CCG and national averages. For instance, 77% had had an asthma review in the preceding 12 months using a nationally recognised assessment tool compared to the CCG average of 74% and the national average of 76%. The exception reporting rate for this indicator was 7% (CCG average 3%, national average 8%).
- Nursing staff had lead roles in long-term disease management and patients at risk of hospital admission were identified as a priority.
- Staff had knowledge of national guidelines and we saw evidence that processes were in place to ensure that these were followed.

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Families, children and young people

Requires improvement

The provider was rated as inadequate for providing responsive services, requires improvement for providing effective, caring, and well-led services and good for providing safe services. The concerns which led to these ratings apply to everyone using the practice, including this population group. However, we did find examples of good practice.

- There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances.
- The practice's uptake for the cervical screening programme was 76%, which was comparable to the CCG average of 73% and the national average of 74%.
- Appointments were available outside of school hours and the premises were suitable for children and babies.

Working age people (including those recently retired and students)

Requires improvement

The provider was rated as inadequate for providing responsive services, requires improvement for providing effective, caring, and well-led services and good for providing safe services. The concerns which led to these ratings apply to everyone using the practice, including this population group. However, we did find examples of good practice.

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- Telephone appointments were available for patients who were unable to attend in person or who were unsure if their condition required attention.
- Health checks were available for new patients and those aged over 40.
- The practice had recently begun to promote online services including the facility to make and cancel appointments as well as request repeat prescriptions.
- The practice did not offer any extended opening hours to support those who worked or had other commitments during the day.

People whose circumstances may make them vulnerable

Requires improvement

The provider was rated as inadequate for providing responsive services, requires improvement for providing effective, caring, and well-led services and good for providing safe services. The concerns which led to these ratings apply to everyone using the practice, including this population group. However, we did find examples of good practice.

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- The practice offered longer appointments for patients with a learning disability.
- The practice had recently undertaken an audit of languages spoken amongst the practice population and had use this to review its interpreting and translation provision. Practice leaflets had been printed in the four most prevalent community languages and arrangements had been put in place to ensure that interpreters for these languages were available when needed.
- The practice worked with multi-disciplinary teams in the case management of vulnerable people.

People experiencing poor mental health (including people with dementia)

Requires improvement

The provider was rated as inadequate for providing responsive services, requires improvement for providing effective, caring, and well-led services and good for providing safe services. The concerns which led to these ratings apply to everyone using the practice, including this population group. However, we did find examples of good practice.

- There was evidence of close working with multi-disciplinary teams in the case management of people experiencing poor mental health.
- Performance data for patients experiencing mental health indicated that most patients had received an annual review but individual care plans were not always produced. For instance, data showed that 87% of patients with schizophrenia, bipolar affective disorder and other psychoses had an agreed care plan in the record compared to the CCG average of 90% and national average of 89%.
- Performance data indicated that only 48% of patients diagnosed with dementia had a care plan documented in the record compared to the CCG average of 87% and national average of 84%. However, we looked at unpublished data for 2016/2017 and found that this had improved to 69%. We looked at patient records and saw that those care plans that had been agreed were comprehensive.
- The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations.
- The practice had a system in place to follow up patients who had attended accident and emergency where they may have been experiencing poor mental health.

Summary of findings

What people who use the service say

The national GP patient survey results were published in July 2016. The results showed the practice was performing significantly below local and national averages although there improvements in all areas when compared with the results of the preceding national GP survey which had been published in January 2016. Two hundred and sixty two survey forms were distributed and 99 were returned. This represented 2% of the practice's patient list.

- 25% found it easy to get through to this surgery by phone compared to a national average of 73%. This represented an improvement of 8% against the survey published in January 2016.
- 58% were able to get an appointment to see or speak to someone the last time they tried (national average 76%). This was an improvement of 23% compared to the previous survey.
- 48% described the overall experience of their GP surgery as fairly good or very good (national average 85%), an improvement of 11% compared to January 2016.
- 30% said they would definitely or probably recommend their GP surgery to someone who has just moved to the local area (national average 79%), compared to 22% in January 2016.

We received three patient Care Quality Commission comment cards. Comments included some views which were positive and some which were negative about the service experienced. Patients expressed frustration with difficulties getting through to the practice by telephone and long delays waiting for appointment times. Positive comments referred to improvements in online access and the helpful nature of administration and reception staff.

We spoke with five patients during the inspection. Patients had mixed views about the care they received. Some patients also spoke about difficulties contacting the practice by telephone and problems accessing appointments at times that were convenient. These views aligned with results from the GP National Survey published in July 2016. General satisfaction levels were also reflected in the national friends and family test (FFT) results. (The FFT is a tool that supports the fundamental principle that people who use NHS services should have the opportunity to provide feedback on their experience that can be used to improve services. It is a continuous feedback loop between patients and practices). The most recent results from the FFT showed that 13 forms had been completed and returned and 85% of these had recommended this practice.

Areas for improvement

Action the service MUST take to improve

- Continue to seek and act on feedback from patients on the services provided, for the purposes of continually evaluating and improving such services, including improving access to the practice and patient satisfaction around involvement in planning and making decisions about care and treatment.
- Take action to ensure sufficient numbers of suitably qualified, competent, skilled and experienced persons are available to meet patient needs.

Action the service SHOULD take to improve

- Ensure the practice business continuity plan is available to staff, including whilst off-site.
- Continue to monitor Quality Outcomes Framework performance to improve performance in relation to the management of long-term conditions and ensure exception reporting rates are closely scrutinized.
- Consider further ways of promoting online access to services, including a review of the practice website and leaflet.
- Continue to review how carers are identified and recorded on the clinical system to ensure information, advice and support is made available to them.
- Review arrangements to support patients with impaired hearing.

Five Elms Medical Practice

Detailed findings

Our inspection team

Our inspection team was led by:

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

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Background to Five Elms Medical Practice

Five Elms Medical Practice is a single location practice providing GP primary care services to approximately 4,200 people living in Dagenham in the London Borough of Barking and Dagenham. The practice has a General Medical Services (GMS) contract. A GMS contract is the contract between general practices and NHS England for delivering primary care services to local communities.

Information published by Public Health England rates the level of deprivation within the practice population group as two on a scale of one to ten. Level one represents the very highest levels of deprivation and level ten the lowest. This information also shows that Income Deprivation Affecting Older People (IDAOPI) is 30% which is comparable to the clinical commissioning group (CCG) average of 28% but significantly higher than the national average of 16%. Income Deprivation Affecting Children (IDACI) is 32% (CCG average 32%, national average 20%). The proportion of patients on the register aged 65 or over is significantly higher than the CCG average. Data from Public Health England shows that 17% of the practice population falls into this age group compared to the CCG average of 9%.

The practice is located in a purpose built health centre which is shared with a dental practice and a team of health visitors. The practice shares reception and waiting areas with these services.

There is one full time GP who provides nine sessions per week and one long term part-time locum who provides eight sessions per week. There is one part time nurse (0.5 Full Time Equivalent), a full time practice manager and six staff who share reception and administration duties. A healthcare assistant employed by a local hospital is hired on an ad hoc basis to undertake NHS health checks.

The practice is registered with the Care Quality Commission to provide the regulated activities of diagnostic and screening procedures, treatment of disease, disorder and injury and maternity and midwifery services.

The practice opening hours are:

Monday 8:30am to 6:30pm

Tuesday 8:30am to 6:30pm

Wednesday 8:30am to 6:30pm

Thursday 8:30am to 1:30pm

Friday 8:30am to 6:30pm

Saturday Closed

Sunday Closed

On the first Tuesday of each month, the practice is closed for protected learning time when the opening hours are 8:30am to 1:30pm. Surgery times are from 8:30am to 11:30am, Monday to Friday and from 3:30pm to 6:30pm on every weekday except Thursday. There is no surgery on Thursday afternoons or the afternoon of the first Tuesday

of each month. Between 8am - 8.30am every weekday and 1:30pm to 6:30pm every Thursday (and first Tuesday of every month) telephone calls are answered by the out of hours (OOH) provider.

Patients who are unable to make an appointment at the practice can make appointments at a local hub where same day GP appointments are available every weekday evening between 6.30pm and 10pm, and 8am and 8pm on weekends. These appointments are available to everyone registered with a GP in Barking and Dagenham.

The practice does not open at weekends, having opted out of providing OOH services, between 6.30pm and 8am and at weekends patients are directed to the OOH provider for Barking & Dagenham CCG. The details of the out of hours service are communicated in a recorded message accessed by calling the practice when it is closed and details can also be found on the practice website.

We inspected Five Elms Medical Practice as part of our new comprehensive inspection programme on 5 April 2016. At that time the practice was rated overall as inadequate and placed into special measures in August 2016 for a period of for six months.

Why we carried out this inspection

We undertook a comprehensive inspection of Five Elms Medical Practice on 5 April 2016 under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The practice was rated as inadequate for providing safe, effective, caring, responsive and well led services and was placed into special measures for a period of six months.

We also issued requirement notices to the provider in respect of safe care and treatment, good governance, staffing issues and concerns around the employment and fitness of proper persons. We undertook a further announced comprehensive inspection of Five Elms Medical Practice on 14 February 2017. This inspection was carried out following the period of special measures to ensure improvements had been made and to assess whether the practice could come out of special measures.

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked NHS England to share what they knew. We carried out an announced visit on 14 February 2017.

During our visit we:

- Spoke with a range of staff (one GP, a practice nurse, practice manager and two members of the administration team) and spoke with patients who used the service.
- Observed how patients were being cared for in the reception area and talked with carers and/or family members
- Reviewed an anonymised sample of the personal care or treatment records of patients.
- Reviewed comment cards where patients and members of the public shared their views and experiences of the service.
- Visited all practice locations
- 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).

Detailed findings

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.

Good

Are services safe?

Our findings

At our previous inspection on 5 April 2016, we rated the practice as inadequate for providing safe services as the arrangements in respect of learning from events or action to improve safety, safety systems and processes, monitoring of risks to patients such as cleanliness and infection control and arrangements to deal with emergencies were not adequate.

These arrangements had significantly improved when we undertook a follow up inspection on 14 February 2017. The practice is now rated as good for providing safe services.

Safe track record and learning

When we inspected in April 2016, we saw evidence which showed the practice recorded significant events however, there were no records to demonstrate that these had been discussed with staff or that lessons learned had been used to update procedures or protocols. We asked the provider to take action to improve this.

At this inspection we saw that there was now an effective system in place for reporting and recording significant events. We reviewed safety records, incident reports, patient safety alerts and minutes of meetings where these were discussed. The practice had recorded 12 significant events since the April 2016 inspection and we saw evidence that lessons were shared and action taken to improve safety in the practice.

- Staff told us they would inform the practice manager of any incidents and there was a recording form available on the practice's computer system. The incident recording form supported the recording of notifiable incidents under the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).
- We saw evidence that when things went wrong with care and treatment, patients were informed of the incident, received reasonable support, truthful information, a written apology and were told about any actions to improve processes to prevent the same thing happening again.
- The practice carried out a thorough analysis of the significant events.

Staff told us that openness and transparency about safety was encouraged; they understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. For example, we saw a record which referred to an occasion when a patient had been referred to secondary care but was issued with a referral letter in the name of a different patient with a similar name. The error was identified by the secondary care provider who brought it to the attention of the practice. The practice had contacted the patients, including the patient whose name had been incorrectly printed on the letter and provided a full explanation of the incident and an apology had been given to both patients. The incident had been discussed at a practice meeting and an additional step had been added to the referral process to ensure that staff double checked details before printing referral letters.

Overview of safety systems and processes

At our inspection in April 2016 systems, processes and practices in place to keep patients safe and safeguarded from abuse were not effective and many of these had not been reviewed since 2012. Not all policies were understood by staff and processes were not routinely followed.

The practice had since put in place, clearly defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from abuse. For example:

- When we inspected in April 2016, the practice had written policies for safeguarding children and adults but these had not been reviewed since 2012 and the practice was unsure if these reflected relevant legislation and local requirements. At this inspection, we saw that these policies had been reviewed and contained up to date information, including details of local safeguarding contacts and these were accessible to all staff. There was a lead member of staff for safeguarding. The GPs attended safeguarding meetings when possible and always provided reports where necessary for other agencies. Staff demonstrated they understood their responsibilities and all had received training on safeguarding children and vulnerable adults relevant to their role. GPs and the practice nurse were trained to child protection or child safeguarding level three, the health care assistant was trained to level two and all other members of staff were trained to level one. All staff, including non-clinical staff had also received formal training on safeguarding adults.

Good

Are services safe?

- At the April 2016 inspection we noted that staff members who acted as chaperones had not received a Disclosure and Barring Service (DBS) check. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable). We also found that the practice had not conducted a risk assessment to assess the risks associated with staff undertaking the role of a chaperone to determine who should have a DBS check in place. Staff who undertook this role were unable to describe how they had carried out this role were unsure of the practice's chaperone policy. During this inspection we found that all staff working at the practice had received a DBS check to ensure they were all safe to act in the capacity as a chaperone. All these staff had received updated training and were confident describing how to carry out the role properly. A notice in the waiting room advised patients that chaperones were available if required.
- When we inspected in April 2016, we noted that staff had not received training around infection prevention and control and that the practice did not have an infection control protocol in place had not undertaken an infection audit since 2012. At this inspection, we saw that all staff had now received appropriate training and an infection control audit had recently been undertaken and an infection prevention and control protocol was now in place. We observed the premises to be clean and tidy.
- The arrangements for managing medicines, including emergency medicines and vaccines, in the practice kept patients safe (including obtaining, prescribing, recording, handling, storing, security and disposal). Processes were in place for handling repeat prescriptions which included the review of high risk medicines. The practice carried out regular medicines audits, with the support of the local CCG pharmacy teams, to ensure prescribing was in line with best practice guidelines for safe prescribing. Blank prescription forms and pads were securely stored. Patient Group Directions (PGDs) had been adopted by the practice to allow nurses to administer medicines in line with legislation. PGDs are written instructions for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment.
- During our inspection in April 2016, we found that appropriate recruitment checks had not been undertaken for all employees. For example, one file did not contain proof of identification, three had no record of references being collected, and four had no record of appropriate checks through the Disclosure and Barring Service and this included the practice nurse. At this inspection, we reviewed eight personnel files and found appropriate recruitment checks had been undertaken prior to employment for all new members of staff and checks for existing employees which had been outstanding at the time of the inspection in April 2016, had also now been completed. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service.

Monitoring risks to patients

When we inspected in April 2016, we found that risks to patients were not always well assessed or well managed. This included concerns around fire safety procedures and risk assessments.

At this inspection, we found that these concerns had been addressed and actions had been taken to assess and mitigate risks.

- At our April 2016 inspection, there was no health and safety information available and we were told that a fire risk assessment had not been carried out since 2011. There was no record of a recent fire drill and there was no system in place for checking that fire extinguishers had been serviced. At this inspection we found that fire procedures had been reviewed shortly after our inspection visit. The practice had conducted a fire risk assessment and recommendations were being implemented. For example, all fire extinguishers had been serviced and fire safety training had been undertaken. In addition, immediately following our 2016 inspection, a fire drill had taken place. We saw that there was now a health and safety policy available with a poster in the reception office which identified local health and safety representatives. All electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly.
- When we inspected in April 2016, the practice had not undertaken a risk assessment for Legionella (Legionella

is a term for a particular bacterium which can contaminate water systems in buildings). At this inspection, we saw that this risk had now been assessed and we saw evidence of preventative maintenance taking place which included the emptying and refreshing of water tanks and a recent legionella culture test which had provided a negative result.

- We looked at arrangements for planning and monitoring the number of staff and mix of staff at the practice and were told that there was a system in place to review staff numbers. However, during this inspection we noted that the long term locum GP was on a period of annual leave but the practice had not recruited a locum GP to cover this absence. When we asked about this, the practice told us that repeated attempts to recruit locum GPs had been unsuccessful and that on this occasion, they had not been able to make arrangements to cover this absence. The practice also told us that they had attempted to mitigate the reduced capacity by extending the length of existing sessions to provide 43 additional telephone appointment slots with the lead GP. We asked the practice how they would deal with this situation the next time it arose and were told that there were ongoing plans to recruit a GP partner or sessional GP to the practice. The practice also told us they were seeking to recruit an additional part time practice nurse; however we were unable to see any evidence of how these plans were being implemented.

Arrangements to deal with emergencies and major incidents

- During our inspection in April 2016, we found that the practice did not have an instant messaging system on their computers that alerted staff to any emergency. At this inspection there was now an instant messaging system in place.
- At our April 2016 inspection three staff had not received basic life support training. Our findings at this inspection were that all staff had received appropriate basic life support training and were able to describe how to respond to various emergency scenarios put to them.
- The practice had a defibrillator available on the premises and oxygen with adult and children's masks. A first aid kit and accident book were available.
- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and stored securely.
- At our April 2016 inspection, we found that although the practice had a business continuity plan in place for major incidents, this had not been reviewed since 2009. Staff were unsure whether emergency contact details were current and the plan included the names of GP partners who had retired several years previously. At this inspection, we found that the business continuity plan had been rewritten and now included up to date contact details for staff and emergency services and included details of an arrangement with a neighbouring practice which involved sharing that practice's building in an emergency. However, arrangements had not been made to keep copies of the plan off-site which meant that if a major incident occurred which rendered the practice inaccessible, there was risk that staff would not have access to the plan.

Requires improvement

Are services effective?

(for example, treatment is effective)

Our findings

At our previous inspection on 5 April 2016, we rated the practice as inadequate for providing effective services as the arrangements in respect of the management, monitoring and improving of patient outcomes, clinical audits and appraisal needed improving.

These arrangements had improved when we undertook a follow up inspection on 14 February 2017. However, it was not yet clear whether these improvements were fully embedded in the practice culture and there were areas where further improvements were needed, for instance outcomes for some patients, including those diagnosed with dementia, were still below local and national averages. The practice is now rated as requires improvement for providing effective services.

Effective needs assessment

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

- When we inspected in April 2016, we found that clinical staff were responsible for arranging to receive updated guidance individually but here was no system in place to ensure these were actually being received. At this inspection, we saw that the practice manager now received and distributed each update to ensure that clinical staff had access to guidelines from NICE and used this information to deliver care and treatment that met patients' needs. We reviewed these systems and saw examples of recent NICE guidelines that had been forwarded to clinical staff.
- The practice monitored that these guidelines were followed through risk assessments, audits and random sample checks of patient records. For example, following a published guideline on the appropriate use of preventative antiviral medicines during the annual flu season the practice conducted a search to identify patients who would benefit from using these medicines.
- The practice used a risk stratification tool to identify and support high risk patients (patients who were at risk of unplanned admissions).

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent published results were 89% of the total number of points available compared to a local average of 93% and national average of 95%. Exception reporting rate overall was 14%, compared with CCG average of 5% and the national average of 6%. We looked at data from 2014/2015 and noted that the exception reporting rate had been 14% for that period also. (Exception reporting is the process by which practices are not penalised where, for example, patients do not attend for review, or where a medication cannot be prescribed due to a contraindication or side-effect).

Data from 2015/2016 showed:

- Performance for diabetes related indicators was comparable to local and national averages. For instance, 74% of patients had well controlled blood sugar levels (CCG average of 67%, national average 78%). This was the same as the outcome for 2014/2015. The exception reporting rate for this indicator was 29% (CCG average 14%, national average 13%). The practice exception reporting rate for 2014/2015 was 19%. We looked at unpublished data for 2016/2017 and saw that the exception reporting rate for patients whose blood sugar levels were outside of the normal range was currently at 7%.
- The percentage of patients on the diabetes register in whom the last blood pressure reading (measured in the preceding 12 months) was 140/80 mmHg or less was 97% (2014/2015, 88%) (CCG average 91%, national average 78%). The exception reporting rate for this indicator was 7% (CCG average 6%, national average 9%).
- Performance for some mental health related indicators was comparable to the national average. For example, 87% of patients diagnosed with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive, agreed care plan documented in the record (CCG average 90%, national average 89%). The practice exception reporting rate for this indicator was 5% (CCG average 5%, national average 13%) Data for 2014/2015 showed the practice had achieved 65% for that period. Exception reporting data for 2014/2015 was not available.

Requires improvement

Are services effective?

(for example, treatment is effective)

- Performance for dementia indicators was still significantly below that national average although higher than the previous year. When we inspected in April 2016, data from 2014/2015 had shown that only 25% of patients diagnosed with dementia had had their care reviewed in a face to face review. At this inspection, we found that this had increased to 48% compared to the CCG average of 87% and national average of 84%. We looked at unpublished data for 2016/2017 and saw that this had increased to 69%. We looked at patient records and saw that those care plans that had been agreed were comprehensive. Staff told us that there was an active recall programme in place for patients in this category and we saw evidence that appointments were scheduled to improve this performance further.
- 87% of patients with hypertension had well controlled blood pressure compared to the CCG average of 81% and the national average of 83%. The exception reporting rate for this indicator was 2% (CCG average 4%, national average 4%). Practice performance for this indicator was comparable to the 88% achieved in 2014/2015 when the exception reporting rate had also been 2%.
- Outcomes for patients with asthma were comparable to CCG and national averages. For instance, 77% had had an asthma review in the preceding 12 months using a nationally recognised assessment tool compared to the CCG average of 74% and the national average of 76%. The exception reporting rate for this indicator was 7% (CCG average 3%, national average 8%). Practice performance for this indicator was comparable to the 82% achieved in 2014/2015 when the exception reporting rate had been 9%.

Exception reporting rates at the practice were generally comparable to other practices. However, we asked the practice about the higher than average QOF exception reporting specifically for diabetes related indicators. When we inspected in April 2016, it was not clear that the practice management fully understood exception reporting. For instance, the practice told us that an incorrectly low level of HBA1c (a measure of blood glucose levels) had been used to report 'difficult to manage' cases and consequently some patients were excepted who should not have been and that this would also impact performance for 2015/2016. Since the April 2016 inspection, the newly appointed practice manager had received mentoring and training around QOF from an experienced practice manager at a different practice and had updated the processes used to exception report patients. They were now able to explain the criteria considered when excluding patients from the indicator calculation. For example, patients who have been recorded as refusing to attend review having been invited on at least three occasions during the financial year, or patients for whom it is not appropriate to review the chronic disease parameters due to particular circumstances, including diagnosis of terminal illness or patients who were extremely frail. In addition, patients newly diagnosed or who have recently registered with the practice who should have measurements made within three months and delivery of clinical standards within nine months e.g. blood pressure or cholesterol measurements within target levels, or patients for whom prescribing a medication is not clinically appropriate. We looked at unpublished data for 2016/2017 and saw that the exception reporting rate for patients whose blood sugar levels were outside of the normal range was currently at 7% which was comparable to local and national averages.

At our last inspection in April 2016 we found that the practice had not undertaken any completed clinical audit cycles and there was no clear audit strategy in place. At this inspection we found that the practice had developed an audit plan for 2016/17.

- At the time of our inspection in April 2016, the practice had not undertaken any clinical audits for two years. At this inspection, we found that there had been four clinical audits completed in the last year and one of these was a completed audit where the improvements made were implemented and monitored. The clinical audits undertaken concerned audits of palliative care, diabetes, cancer and chronic obstructive pulmonary disorder (COPD). (COPD is the name for a collection of lung diseases including chronic bronchitis, emphysema and chronic obstructive airways disease).
- There was evidence of collaborative working on audits. For instance, the audit of patients with COPD had been completed jointly by a GP and the practice nurse, whilst an audit of patients diagnosed with cancer had been undertaken by a GP and the practice manager.
- The practice had also undertaken audits of non-clinical aspects of the service provided, including an audit of the appointment system, of languages spoken amongst the practice population and an audit of patients who did not attend appointments.

Requires improvement

Are services effective?

(for example, treatment is effective)

Information about patients' outcomes was used to make improvements. For instance, the practice had undertaken an audit of the care provided to patients diagnosed with COPD. The first cycle had identified that of the 99 patients diagnosed with the condition; only 8% had had a structured annual review of their condition in the previous 12 months and of these only 3% had been instructed on inhaler technique. The practice had revised its processes for recalling patients and had invited patients diagnosed with COPD to appointments to have their condition reviewed. The practice repeated the audit one year later and had identified that the percentage of patients who had had a structured review had risen from 8% to 71%. The audit also showed that the percentage of patients who had been given instruction on inhaler technique had risen from 3% to 67%.

Effective staffing

- When we inspected in April 2016, there was no induction programme for newly appointed staff and there was no evidence that they had been provided with training or information on practice policies including infection control, confidentiality or health and safety. At this inspection, the practice had developed an induction programme for all newly appointed staff and we saw records which showed this had been used to induct new staff on topics including safeguarding, infection prevention and control, fire safety, health and safety and confidentiality. Staff told us they had been able to spend time with the practice manager during their induction period as well as shadowing more experienced colleagues.
- At our inspection in April 2016, staff told us they had not received annual appraisals for at least two years. At this inspection, we saw that all staff had received an appraisal within the previous six months and this had involved a review of individual training needs. Staff told us the appraisal system was a positive experience which had improved their personal morale.
- When we inspected in April 2016 we found that staff did not always receive training that included: safeguarding, fire safety awareness, information governance. During this inspection we reviewed eight training files and found that all members of staff had received the appropriate training. Staff had access to and had begun to make use of e-learning training modules, in-house training and external training.
- When we inspected in April 2016, we saw that some members of had difficulty using the practice computer system. We spoke with the same members of staff during this inspection and were told that training had since been provided. We could see that these staff were now more confident and were able to use the computer system to carry out a wide range of tasks including updating patient registers and undertaking searches.
- The practice could demonstrate how they ensured role-specific training and updating for relevant staff. For example, for those reviewing patients with long-term conditions.
- Staff administering vaccines and taking samples for the cervical screening programme had received specific training which had included an assessment of competence. Staff who administered vaccines could demonstrate how they stayed up to date with changes to the immunisation programmes, for example by access to on line resources and discussion at practice meetings.

Coordinating patient care and information sharing

The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practice's patient record system and their intranet system.

- This included care and risk assessments, care plans, medical records and investigation and test results. We reviewed examples of care plans and saw that these were detailed and up to date. We also reviewed processes for managing incoming test results and looked at examples of recently received correspondence. We noted that these were handled in a timely manner and updates to patient records were accurate.
- The practice shared relevant information with other services in a timely way, for example when referring patients to other services. We reviewed referral processes including those used to refer patients for urgent reviews and saw that the practice had failsafe steps in place to ensure that patients received and attended appointments.

Staff worked together and with other health and social care professionals to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. This included when patients moved between services, including when they were

referred, or after they were discharged from hospital. Meetings took place with other health care professionals on a monthly basis when care plans were routinely reviewed and updated for patients with complex needs. We saw one set of minutes from a meeting with the palliative care team and saw that the findings of the practice audit of its palliative care had been discussed and areas for improvement had been identified. For instance, although the results of the audit indicated that patients who had deceased during the period of the audit had died in their preferred place of death, one patient who had passed away and should have been added the palliative care register had not. The practice told us this had been discussed in a clinical governance meeting and clinicians had been reminded to consider adding patients to the palliative care register when reviewing care plans.

Consent to care and treatment

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

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

Supporting patients to live healthier lives

The practice identified patients who may be in need of extra support. For example:

- Patients receiving end of life care, carers, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol. Patients were signposted to the relevant service and we saw examples of when this had happened. For instance we saw details of information that was provided to younger carers showing where specialised support was available.
- Dietary and smoking cessation advice was available from a local support group.

When we inspected in April 2016, the practice's uptake for the cervical screening programme was 70%. At this inspection we noted that this had increased to 76%, which was the same as the national average and comparable to the CCG average of 73%. There was a policy to offer telephone reminders for patients who did not attend for their cervical screening test. The practice demonstrated how they encouraged uptake of the screening programme by using information in different languages and for those with a learning disability and they ensured a female sample taker was available. There were failsafe systems in place to ensure results were received for all samples sent for the cervical screening programme and the practice followed up women who were referred as a result of abnormal results. The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening.

Childhood immunisation rates for the vaccinations given were comparable to CCG/national averages. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 86% to 93% and five year olds from 74% to 87%.

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

Requires improvement

Are services caring?

Our findings

At our previous inspection on 5 April 2016, we rated the practice as inadequate for providing caring services. Data from the National GP Patient Survey showed patients rated the practice significantly below others for many aspects of care. There was insufficient information available to help patients understand the services available to them and the practice did not have a process for identifying patients who were also carers.

When we undertook a follow up inspection of the service 14 February 2017, we saw that actions had been taken to bring about improvements. The most recent national GP patient survey results had been published just three months after the April 2016 inspection which meant the impact of these improvements could not be accurately measured so it was not clear whether these improvements were fully embedded in the practice culture yet. We saw evidence that the practice had undertaken a simple patient survey but this had only received eight responses from 50 survey forms issued and even though the majority of responses were positive, it had not been possible to draw any useful information from the survey. The practice is now rated as requires improvement for providing caring services as there were some areas where further improvements were needed and patient satisfaction levels were still lower than CCG and national averages.

Kindness, dignity, respect and compassion

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

- Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- We noted that consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- Reception staff knew when patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.
- When we inspected in April 2016, the practice could not provide evidence that staff had received Information Governance or confidentiality training and only one member of staff had signed a confidentiality agreement. At this inspection, we found that all staff had received training in confidentiality and information governance since our inspection in April 2016. We saw that all staff personnel files now included signed confidentiality agreements.

We received three patient Care Quality Commission comment cards. Comments included some views which were positive and some which were negative about the service experienced. Patients expressed frustration with difficulties getting through to the practice by telephone and long delays waiting for appointment times. Positive comments referred to improvements in online access and the helpful nature of administration and reception staff.

When we inspected in April 2016, results from the national GP patient survey showed that patients rated the practice significantly lower than average for its satisfaction scores on consultations with GPs and nurses.

Staff told us that positive changes introduced by the Practice Manager, including annual appraisals and improved access to training had contributed to an improved atmosphere at the practice and this had subsequently influenced a positive change in patient satisfaction levels. The changes had not yet been measured as some of them had taken longer to put into effect. The practice told us that GPs had reviewed their consultation style and were now using techniques to demonstrate attentiveness including recapping conversations and waiting until the end of the consultation before typing consultation notes into the computer system.

At this inspection, we found that there had been improvements in every area although these improvements were limited and levels of satisfaction were still lower than average for all indicators. For instance, data from the national survey published in July 2016 showed:

- 67% of patients said the GP was good at listening to them which was an increase of 13% compared to the results published in January 2016 (54%). (CCG average 81%, national average 87%).
- 58% of patients said the GP gave them enough time which was an increase of 18% compared to the test results published in January 2016 (40%). (CCG average 78%, national average 87%).
- 80% of patients said they had confidence and trust in the last GP they saw (CCG average 86%, national average 92%) which was an increase of 15% on the previous survey results.

Requires improvement

Are services caring?

- 79% of patients said the last nurse they spoke to was good at treating them with care and concern. (CCG average 84%, national average 91%). This represented an increase of 21%.
- 61% of patients said they found the receptionists at the practice helpful which was an improvement of 9% compared to the results published in January 2016 (52%). (CCG average 84%, national average 87%).

Care planning and involvement in decisions about care and treatment

When we inspected in April 2016, results from the national GP patient survey showed patients rated the practice significantly lower than average for its satisfaction scores about their involvement in planning and making decisions about their care and treatment compared to other practice. Results were significantly below local and national averages.

At this inspection, we found that there had been improvements in every area although these improvements were limited and levels of satisfaction were still lower than average for all indicators.

- 62% said the last GP they saw was good at explaining tests and treatments which was an increase of 18% compared to the results published in January 2016 (44%). (CCG average 78%, national average 86%).
- 54% of patients said the last GP they saw was good at involving them in decisions about their care which was an increase of 15% compared to the results published in January 2016 (39%). (CCG average 73%, national average 82%).
- 78% of patients said the last nurse they saw was good at involving them in decisions about their care compared to 60% at the time of the April 2016 inspection which was an increase of 18%. This was comparable to the CCG average of 80% and the national average of 85%.

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

- Staff told us that interpreter and translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patients this service was available.
- Information leaflets were available in easy read format.

Patient and carer support to cope emotionally with care and treatment

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

When we inspected in April 2016, the practice did not have a process in place to proactively identify patients who were also carers. At this inspection, we were told the newly appointed practice manager had reviewed how carers were identified and had arranged for the reception team to receive in-house training about how this could be done. Reception staff we spoke with told us this training had helped them to understand why identifying carers was important and that they had started to work together to increase the number of carers on the register. For instance, staff told us they would notice when a repeat prescription was routinely collected by someone other than the patient themselves, or that they would ask someone who regularly made appointments on someone else's behalf, if they were a carer. The practice had identified 15 patients as carers (less than 1% of the practice list). Written information was available to direct carers to the various avenues of support available to them.

Staff told us that if families had suffered bereavement, their usual GP contacted them or sent them a sympathy card. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service.

Inadequate

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

At our previous inspection on 5 April 2016, we rated the practice as inadequate for providing responsive services as the arrangements for accessing the service, and the recording, investigating and learning from complaints needed improving. The practice did not have adequate arrangements for patients who did not have English as a first language and patients were unable to access online services at the practice.

We issued a requirement notice in respect of these issues and when we undertook a follow up inspection of the service 14 February 2017, we saw that actions had been taken to bring about improvements. However, as the most recent national GP patient survey results had been published just three months after the April 2016 inspection, the impact of these improvements could not be accurately measured and it was not clear whether these improvements were fully embedded in the practice culture yet. The practice is rated as inadequate for providing responsive services as patient satisfaction levels were still significantly lower than CCG and national averages.

Responding to and meeting people's needs

The practice had recently taken steps to review the needs of its local population and since being placed in special measures, had engaged with the NHS England Area Team and clinical commissioning group (CCG) to secure improvements to services where these were identified.

- When we inspected in April 2016, patients were unable to access services online. At this inspection, we found the practice had introduced online access to services including arranging and cancelling appointments and requesting repeat prescriptions. The practice told us this was being actively promoted using notes attached to prescriptions, posters and special leaflets.
- At our inspection in April 2016, we noted that the practice had not made arrangements to support patients who did not speak English as a first language. At this inspection, we found that the practice had undertaken an audit of the practice population to identify the range of languages spoken by patients and had used this as a baseline to review its provision for patients who did not speak English as a first language. The audit had identified that twenty one different languages were represented amongst the practice population and that Romanian and Lithuanian had displaced Bengali and Urdu the most common non-English languages spoken by patients. The practice had made arrangements to provide interpreter and translation services and the practice had worked with their translation provider to produce practice leaflets in the four most prevalent community languages.
- There were longer appointments available for patients with a learning disability.
- Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice.
- Same day appointments were available for children and those patients with medical problems that require same day consultation.
- Patients were able to receive travel vaccinations available on the NHS and were referred to other clinics for vaccines available privately.
- There were disabled facilities and translation services available although the practice did not have a hearing loop.
- The practice had disabled parking facilities, a front door which opened automatically and there was step free access to all consulting rooms.

Access to the service

The practice opening hours for the surgery were:

Monday 8:30am to 6:30pm

Tuesday 8:30am to 6:30pm

Wednesday 8:30am to 6:30pm

Thursday 8:30am to 1:30pm

Friday 8:30am to 6:30pm

Saturday Closed

Sunday Closed

GP appointments were available between 8:30am and 11:30am and between 3:30pm and 6:30pm every weekday except Thursday. Nurse appointments were available every weekday between 8:30am to 1:30pm.

Patients who were unable to make an appointment at the practice could make appointments at a local hub where

Inadequate

Are services responsive to people's needs?

(for example, to feedback?)

same day GP appointments were available every weekday evening between 6.30pm and 10pm, and 8am and 8pm on weekends. The appointments were available to everyone registered with a GP in Barking and Dagenham.

Pre-bookable appointments could be booked up to six weeks in advance and urgent appointments were also available for people that needed them. The practice had opted not to provide out of hours services (OOH) to patients and these were provided on the practice's behalf by NHS Barking and Dagenham .The details of the how to access the OOH service were communicated in a recorded message accessed by calling the practice when it is closed and details could also be found on the practice website.

Results from the national GP patient survey published in July 2016 showed that although patient's satisfaction with how they could access care and treatment had improved since our inspection in April 2016, this was still significantly lower than local and national averages. The practice had undertaken a two cycle audit of appointment demand but it was unclear how this was being used to bring about improvements. However, we were shown documents which showed that the practice had recently reviewed how it calculated the number of appointments provided and we saw evidence which showed that starting in March 2017, the practice would be increasing the number of appointments provided per 1,000 patients from 67 appointments to 72 appointments and would be increasing the number of telephone consultations provided.

- When we inspected in April 2016, we reviewed results from the national GP patient survey published in January 2016 which showed that 41% of patients were satisfied with the practice's opening hours. The practice told us that since the previous inspection, staff shift patterns had been revised so that the practice no longer closed between 12:30pm and 2:30pm daily; however, this change had occurred after the publication of the most recent survey results in July 2016 which meant that the impact of this change had not yet been measured although data from the July 2016 survey results showed that patient satisfaction with opening hours had risen to 46%.
- When we inspected in April 2016, results from the national GP patient survey published in January 2016 showed that just 17% of patients were satisfied with telephone access to the practice. At this inspection, the practice told us they had recently recruited two additional staff to the administration and reception team. We were also told that online access was being actively promoted in order to relieve pressure from the telephone service and that over 120 patients (3% of the practice list) had already registered to use this service. Results from the national GP patient survey published in July 2016 showed that satisfaction with telephone access to the practice had increased to 25%. (CCG average of 68%, national average 73%).
- During our April 2016 inspection, national GP survey results showed that only 5% of patients always or almost always saw or spoke to the GP they preferred. The practice told us the lead GP now provided an additional session each week and the number of telephone consultations available had been increased. Data from the national GP patient survey published in July 2016 showed that 17% of patients always or almost always saw or spoke to the GP they preferred (CCG average 50%, national average 60%).

Listening and learning from concerns and complaints

When we inspected in April 2016, we saw that the practice had a system for handling complaints and concerns but this was not widely publicised and there was no evidence that the practice was recording verbal complaints. At this inspection, we found that information about how to complain was advertised in the waiting area and in the practice leaflet.

- Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England.
- There was a designated responsible person who handled all complaints in the practice.

We looked at 10 written complaints and seven verbal complaints which had been received in the last 12 months and found that these were handled in line with practice procedure. Lessons were learnt from individual concerns and complaints and also from analysis of trends and action was taken to as a result to improve the quality of care. For example, we reviewed a complaint from a patient who had been unable to attend an appointment because transport arrangements which they believed the practice had arranged on their behalf had not worked on the day of their appointment. The practice had investigated the complaint and had identified a shortcomings in the procedure used to book patient transport. The procedure had been revised to

Inadequate

Are services responsive to people's needs?

(for example, to feedback?)

include a step which meant that the member of staff who received such a request from a patient would arrange the booking immediately and note the details of the booking on the computer system before closing the record.

Are services well-led?

Requires improvement

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

Our findings

At our previous inspection on 5 April 2016, we rated the practice as inadequate for providing well-led services as there was a lack of involvement, oversight and leadership from the GP and little evidence of an overarching governance structure.

We issued a requirement notice in respect of these issues and found arrangements had improved when we undertook a follow up inspection of the service 14 February 2017. However, although actions had been taken to address the major concerns identified at the April 2016 inspection, the practice was not yet able to demonstrate the impact of these actions. The practice is now rated as requires improvement for providing well-led services.

Vision and strategy

When we inspected in April 2016, we found that the practice did not have a clear vision to deliver high quality care and promote good outcomes for patients and we did not see documented values, a mission statement or objectives.

At this inspection the practice had a vision to deliver high quality care and promote good outcomes for patients and had a mission statement which was displayed in the waiting areas and which was understood by staff. However, we found that the practice did not always have supporting plans to deliver this vision. The practice had engaged with support offered by NHS England and the Barking and Dagenham CCG and had begun to develop business plans and strategies which reflected the vision and values of the practice.

Governance arrangements

Since our inspection in April 2016, the practice had put in place, a governance framework which supported the delivery of the emerging strategy and good quality care.

- There was a clear staffing structure and staff were aware of their own roles and responsibilities.
- Policies to govern activities at the practice had been reviewed and updated and were available to all staff. Staff were able to demonstrate that they had access to policies and were confident in describing how they applied these policies when carrying out their duties.
- A programme of continuous clinical and internal audit had been developed. The practice had recently completed its first completed audit cycle for several years and this was used to monitor quality and to make improvements. Three further audits had had single cycles completed with second cycles planned for two of these.
- There were arrangements for identifying, recording and managing risks, issues and implementing mitigating actions.

Although there was evidence of improvements in practice performance, these improvements were limited and outcomes were still below CCG and national averages in most areas. Levels of patient satisfaction had also improved, however, results from the most recent national GP patient survey had been published just three months after our inspection in April 2016. This meant the practice had not yet been able to measure the impact of actions taken to improve satisfaction and it was not yet clear whether these improvements were fully embedded in the practice culture.

Leadership and culture

During the inspection of April 2016, we found leaders did not have the necessary capacity to lead effectively. There was a lack of involvement, oversight and leadership from the GP. There was no effective system for managing issues and risks arising from inadequate arrangements for chaperoning, safeguarding, fire safety and infection control. This indicated that quality and safety were not a priority for the leadership.

At this inspection, we found that the practice had put systems in place to improve patient safety. For instance, chaperoning and safeguarding arrangements had been reviewed and staff had received training around fire safety and infection prevention and control.

Staff told us the leadership had become more approachable since the practice had been inspected in April 2016 and the practice manager was always able to find the time to listen to all members of staff. We were also told that although staff had not always felt appreciated in the past, this had recently started to improve, particularly since the practice manager had ensured that all staff had had a meaningful annual appraisal.

During this inspection, the long term locum GP was away from the practice for a period of annual leave. Despite repeated attempts to recruit sessional GPs, the practice had not been able to arrange a replacement GP for the

Are services well-led?

Requires improvement

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

majority of this time. We noted that the practice had attempted to mitigate the reduced clinical capacity by extending the length of surgery times provided by the lead GP and had offered six additional telephone consultations every weekday whilst the locum GP was away from the practice. The practice told us it was planning to recruit a GP partner or additional sessional GP to the practice but we were unable to see any evidence which showed when this plan would be realised.

The provider was aware of and had systems in place to ensure compliance with the requirements of the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).This included training and support and training for all staff around communicating with patients about notifiable safety incidents. The partners encouraged a culture of openness and honesty. The practice had systems in place to ensure that when things went wrong with care and treatment.

- The practice gave affected people reasonable support, truthful information and a verbal and written apology.
- The practice kept written records of verbal interactions as well as written correspondence.

There was a clear leadership structure in place and staff felt supported by management. However, although staff told us they felt supported by management, they weren't always sure who to approach with issues.

- When we inspected in April 2016, we were told that staff meetings were infrequent and were not attended by all members of staff. At this inspection, we found that the practice now held regular team meetings and used these to review serious incidents, patient complaints and practice development.
- Staff told us the culture within the practice had improved since the previous inspection and they had the opportunity to raise any issues at team meetings and felt increasingly confident and supported in doing so.
- Staff said they felt respected, valued and supported, particularly by the practice manager in the practice. All staff were encouraged to identify opportunities to improve the service delivered by the practice.

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

During our inspection in April 2016, we found no evidence that regular feedback was gathered from staff or patients and that when feedback was provided, it not always acted upon. For examples, staff told us that concerns had been raised about workload but no action had been taken as a result.

At this inspection, staff told us since the introduction of regular staff meetings and annual appraisals, they felt more engaged in how the practice was run. The practice could also provide recent evidence of encouraging feedback from patients. Following the CQC inspection carried out in April 2016, it had undertaken a survey of patients in an attempt to further understand patient dissatisfaction with aspects of the service provided at the practice. Survey forms had been distributed to 50 patients but only eight had been returned, however, the practice told us they had learned from the process and were developing the processes used to seek further feedback from patients.

- The practice had recently taken steps to re-invigorate the patient participation group (PPG) which had become inactive. We were told that a number of patients had agreed to join the group and that a meeting was planned for March 2017.
- The practice had gathered feedback from staff through staff meetings, appraisals and discussion. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they now felt more involved and engaged to improve how the practice was run than had previously been the case.

Continuous improvement

We saw evidence that the practice had sought support from the NHS to bring about improvements following the April 2016 inspection. For instance, the practice had worked with NHS management to ensure plans to improve fire safety arrangements at the premises were followed through and we also saw that the practice manager had sought support to put practice specific policies in place to govern activities.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **How the regulation was not being met:** The provider had failed to act on feedback from relevant persons and other persons on the services provided in the carrying on of the regulated activity, for the purposes of continually evaluating and improving such services. This was in breach of regulation 17 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **How the regulation was not being met:** The provider had failed to ensure sufficient numbers of suitably qualified, competent, skilled and experienced persons were available to meet patient needs. There was not sufficient staff to provide the care and appointments that the patient population required in a timely way. This posed a risk to the health and wellbeing of patients. This was in breach of regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.