Drs Seehra Lockyer Davis and Tanoe

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We previously carried out an announced comprehensive inspection at Drs Seehra, Lockyer, Davis and Tanoe on 22 October 2014. The practice was then rated as good for providing effective, caring and responsive services and requires improvement for providing safe and well led services. Overall the practice was rated as requires improvement. We carried out a focused inspection on 8 October 2015 and the practice was rated good for providing safe services and requires improvement for providing well led services. Overall the practice was rated as good. The full comprehensive reports on the 4 October 2014 and 8 October 2015 inspections can be found by selecting the 'all reports' link for Drs Seehra, Lockyer, Davis and Tanoe on our website at www.cqc.org.uk.

We carried out an announced comprehensive inspection at Drs Seehra, Lockyer, Davis and Tanoe on 20 September 2017. Overall the practice is now rated as inadequate.

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

- There was a system for reporting, recording and sharing the learning from significant events, however checks were not made to ensure identified learning had been actioned.
- A new process had been established so patient safety alerts were logged, shared, initial searches completed and the changes affected. This process needed to be embedded in practice as not all clinicians were aware of it.
- Arrangements were in place to keep patients safeguarded from abuse. However some information displayed in the practice was out of date. The practice could not evidence that all staff had received safeguarding training applicable to their role. Appropriate recruitment arrangements were in place; however one clinical staff member was still awaiting a Disclosure and Barring Service Check (DBS) and worked unsupervised with patients.
- Some arrangements were in place for infection control; however we found that policies and

Summary of findings

procedures needed to be updated, sharps bins were not dated and clinical waste was not stored securely. Identified actions from the infection control audit completed in April 2017 needed to be completed.
- Health and safety risks to patients and staff were not all assessed, which included legionella. This had been identified and an external company had been booked to undertake this work in November 2017.
- Staff assessed patients' needs and delivered care in line with current evidence based guidance. Staff had been trained to provide them with the skills, knowledge and experience to deliver effective care and treatment. A new programme of mandatory e-learning was being completed by staff. Not all staff had received an annual appraisal. Some staff we spoke with did not feel supported, although they reported this had improved since the new practice manager had come into post.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment. However, written consent was not obtained for minor surgery and verbal consent was not always documented.
- Information about services and how to complain was available and improvements were made to the quality of care as a result of complaints and concerns. Checks were not made to ensure identified learning had been actioned.
- Generally patients were able to get an appointment, although patients reported there could be a wait for the telephone to be answered, especially in the morning. Patients confirmed that urgent appointments were available the same day.
- The practice lacked effective clinical leadership and they did not have a clear and established governance framework.

The areas where the provider must make improvement are:

- Ensure that care and treatment of patients is only provided with the consent of the relevant person.
- Ensure care and treatment is provided in a safe way to patients.
- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.

The areas where the provider should make improvement are:

- Continue to improve the completion of e-learning and training deemed mandatory by the practice and that this is recorded effectively.
- Complete annual appraisals for all staff.
- Continue with plans to improve the identification of carers and provision of information to support carers.
- Encourage the uptake of annual health checks for patients with a learning disability.
- Check that learning identified from significant events and complaints had been actioned, and an annual analysis of trends for significant events is undertaken.

I am placing this service in special measures and while recognising that the Practice is on an improvement trajectory there needs to be clear vision and leadership cohesion for the Practice to continue to drive through the required improvements. 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 if needed could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service by adopting our proposal to remove this location or cancel the provider's registration. 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?

Requires improvement

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

- There was an effective system in place for reporting and recording significant events.
- Learning was shared and action was taken to improve safety in the practice. However, checks were not made to ensure the learning identified had been actioned.
- Patient safety alerts were logged, shared and initial searches were completed and the changes effected. This process needed to be embedded in practice as not all clinical staff were aware of this new system.
- Arrangements were in place to keep patients safeguarded from abuse. However some information displayed in the practice was out of date and the practice could not evidence that all staff had received safeguarding training appropriate to their role.
- Some arrangements were in place for infection control; however we found that policies and procedures needed to be updated, sharps bins were not dated and clinical waste was not stored securely. Identified actions from the infection control audit completed in April 2017 needed to be completed.
- Patients on high risk medicines were identified and reviewed.
- When things went wrong patients received reasonable support, detailed information, and a written apology. They were told about any actions to improve processes to prevent the same thing happening again.
- Health and safety risks to patients and staff were not all assessed, which included legionella. This had been identified and an external company had been booked to undertake this work in November 2017.
- Appropriate recruitment arrangements were in place; however one clinical member of staff was awaiting a Disclosure and Barring Service Check (DBS) and worked unsupervised with patients. We raised this with the practice manager, who stopped them undertaking unsupervised work with patients and confirmed that they would not be able to resume until the practice had received a DBS certificate.

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) showed patient outcomes were at or above average compared to the national average. The overall exception reporting rate was 29% which was 15% above the CCG average and 19% above 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 was able to demonstrate in their more recent, unverified data, that although overall performance had reduced slightly from 99% to 98%, the exception reporting had reduced more significantly, from 29% to 24%. However, the GP lead for QOF was unaware of their high exception reporting, so the improvement was not due to a targeted approach.
- Clinical audits demonstrated quality improvement with improved outcomes for patients.
- Staff assessed needs and delivered care in line with current evidence based guidance and had the skills, knowledge and experience to deliver effective care and treatment.
- Staff were completing a new programme of mandatory e-learning, which all staff were due to complete by March 2018.
- Evidence of appraisals and personal development plans were not in place for all staff.
- Staff worked with other health care professionals to understand and meet the range and complexity of patients' needs.
- Written consent for minor surgery was not obtained for all patients and verbal consent was not always documented.

Are services caring?

Good

The practice is rated as good for providing caring services.

- Data from the national GP patient survey, published in July 2017, showed patients rated the practice in line with other practices both locally and nationally for most aspects of care. The practice had an action plan in place to address the areas where their performance was below the local average.
- Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.
- Information for patients about the services available at the practice was easy to understand and accessible. The practice had written their practice leaflet in large print and copies were available for patients to take from the waiting room.
- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.

Summary of findings

- The practice had identified 41 patients as carers (0.3% of the practice list). The new patient registration form identified carers; however no information was available in the practice to support carers. The practice had identified this as an area for improvement.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services.

- Practice staff reviewed the needs of its local population and had more recently started to engage with the NHS England Area Team and Clinical Commissioning Group to secure improvements to services where these were identified.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- The practice accepted patients who had moved out of the practice area so that patients could keep their GP.
- Generally patients were able to obtain routine and urgent appointments when they needed them. A small number of patients reported that there was a wait for the telephone to be answered, particularly in the morning. Telephone consultations were offered and appointments for patients who found it difficult to attend during opening hours could be made at the request of the GP.
- Information about how to complain was available and easy to understand and evidence showed the practice responded quickly to issues raised. Learning from complaints was shared with staff; however there was no system to ensure the identified learning was completed.

Are services well-led?

Inadequate

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

- The aim of the practice was 'To provide primary healthcare to the best of our ability working in a partnership with you, the patients.' Staff we spoke with said the aim of the practice was to focus on patients.
- The GPs did not demonstrate that they had sufficient clinical and management oversight of the practice. The governance arrangements were insufficient. GPs were in lead roles although they were not always effective in these roles.
- Staff did not feel well supported or involved, however they did express that this had improved since the new practice manager had come into post.

Summary of findings

- The practice were in the process of reviewing their policies and procedures to ensure they were specific to the practice. These had not all been completed and shared with staff.
- The provider was aware of and complied with the requirements of the duty of candour. The partners encouraged a culture of openness and honesty. The practice had systems in place for notifiable safety incidents and ensured this information was shared with staff to ensure appropriate action was taken.
- The practice sought feedback from staff and patients, which it acted on.
- Previous inspection findings had not all been actioned to completion. The comprehensive inspection on 22 October 2014 found that the approach to significant event reporting and monitoring, the recording of safeguarding risks to children known by the practice and the system to assess and monitor the quality of the service provided needed improving. The focused inspection on 8 October 2015, found that the procedures for reviewing and learning from significant events and recording of safeguarding risks had improved However, improvement was still required to ensure that staff training was properly recorded, that potential risks to the practice were identified and that non-clinical audits were undertaken to assess the service provided to patients.

Summary of findings

The six population groups and what we found

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

Older people

Inadequate

The practice is rated as requires improvement for providing safe services and inadequate for effective and well led services. The concerns which led to these ratings apply to everyone using the practice including this group. However there were 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.
- GPs and nursing staff provided home visits to patients who lived in three care homes covered by the practice.
- Nationally reported data showed that outcomes for patients for conditions commonly found in older people, including rheumatoid arthritis, dementia and heart failure were in line with the local and national averages. However exception reporting was higher than the local and national averages.

People with long term conditions

Inadequate

The practice is rated as requires improvement for providing safe services and inadequate for effective and well led services. The concerns which led to these ratings apply to everyone using the practice including this group. However there were examples of good practice:

- The practice used the information collected for the Quality and Outcomes Framework (QOF) to monitor outcomes for patients (QOF is a system intended to improve the quality of general practice and reward good practice). Data from 2015/2016 showed that performance for diabetes related indicators was 94%, which was above the local and national average of 90%. Exception reporting for diabetes related indicators was 35% which was above the local average of 17% and the national average of 12% (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).
- Longer appointments and home visits were available when needed.

Summary of findings

- All patients had a named GP and regular reviews to check their health and medicines needs were being met. For those patients with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Inadequate

The practice is rated as requires improvement for providing safe services and inadequate for effective and well led services. The concerns which led to these ratings apply to everyone using the practice including this group. However there were examples of good practice:

- There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk.
- Immunisation rates were generally in line with the CCG and England averages for all standard childhood immunisations. They were below the recommended standard for one vaccination.
- Families were registered with the same named GP.
- Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this.
- Appointments were available outside of school hours and the premises were suitable for children and babies.
- We saw positive examples of joint working with midwives, health visitors and social workers.

Working age people (including those recently retired and students)

Inadequate

The practice is rated as requires improvement for providing safe services and inadequate for effective and well led services. The concerns which led to these ratings apply to everyone using the practice including this group. However there were examples of good practice:

- The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care.
- Telephone appointments were available for patients who required one and consultations were arranged by the GP outside of usual working hours if necessary.
- The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group.

Summary of findings

- The percentage of women aged 25-64 whose notes recorded that a cervical screening test had been performed in the preceding five years was 93%, which was above the local average of 83% and national average of 82%. The exception rate was 24%, which was 14% above the CCG average and 17% above the national average.

People whose circumstances may make them vulnerable

Inadequate

The practice is rated as requires improvement for providing safe services and inadequate for effective and well led services. The concerns which led to these ratings apply to everyone using the practice including this group.

- The practice held a register of patients living in vulnerable circumstances which included those with a learning disability.
- Annual health assessments for people with a learning disability were undertaken by the practice nurse and follow up undertaken by the GP, when necessary. The practice had 90 patients on the learning disabilities register. Only 26 of these patients had a health review in the previous 12 months.
- The practice offered longer appointments for patients with a learning disability.
- The practice worked with other health care professionals in the case management of vulnerable patients.
- The practice informed vulnerable patients about how to access various support groups and voluntary organisations.
- The practice could not evidence that all staff had received safeguarding training appropriate to their role. Some information was available for staff; however this was not always up to date. Staff knew how to recognise signs of abuse in vulnerable adults and children and were aware of the GP lead for safeguarding but were unclear how to contact relevant agencies in normal working hours and out of hours.
- The practice's computer system alerted GPs if a patient was also a carer. The practice had only identified 41 patients as carers (0.3% of the practice list). There was no carer's information available to these patients.

People experiencing poor mental health (including people with dementia)

Inadequate

The practice is rated as requires improvement for providing safe services and inadequate for effective and well led services. The concerns which led to these ratings apply to everyone using the practice including this group. However there were examples of good practice:

Summary of findings

- 66% of patients diagnosed with dementia had their care reviewed in a face to face meeting in the last 12 months, which was below the local average of 74% and national average of 78%. 2016 to 2017 unverified data from the practice showed that the practice had improved performance in this area to 85%.
- 36% of patients experiencing poor mental health had a comprehensive care plan, which was below the local average of 67% and the national average of 78%. 2016 to 2017 unverified data from the practice showed that the practice had improved performance in this area to 97%.
- The practice worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those with dementia.
- The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations.
- The practice hosted therapeutic art classes for patients with mental health needs.

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 was performing in line with local and national averages. 246 survey forms were distributed and 108 were returned. This represented a 44% response rate.

- 85% of patients found it easy to get through to this practice by phone compared to the CCG average of 77% and the national average of 71%.
- 86% 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 88% and the national average of 84%.
- 91% of patients described the overall experience of this GP practice as good compared to the CCG average of 87% and the national average of 85%.
- 82% 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 82% and the national average of 77%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 35 comment cards, 34 of which were positive about the standard of care received from staff at the practice. Patients reported positively about the clinical care received and that staff were caring and helpful. Seven patients expressed that there was a wait for the telephone to be answered, particularly in the morning and/or difficulty in obtaining an appointment.

We spoke with representatives from three care homes where residents were registered at the practice. The feedback was very positive, particularly in relation to communication, the responsiveness of the practice particularly in relation to urgent home visits and involving patients and families in their care.

We spoke with five patients during the inspection. All of the patients were complimentary of the care received from the clinical staff and said that they gave them time and did not feel rushed. The said that the non clinical staff were friendly and caring. Two patients reported that there was often a wait for the telephone to be answered in the morning, and one of these commented that there could be a wait to see a GP when they had arrived for their appointment. Patients with long term conditions confirmed their care and treatment was reviewed.

Areas for improvement

Action the service MUST take to improve

- Ensure that care and treatment of patients is only provided with the consent of the relevant person.
- Ensure care and treatment is provided in a safe way to patients.
- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.

Action the service SHOULD take to improve

- Continue to improve the completion of e-learning and training deemed mandatory by the practice and that this is recorded effectively.
- Complete annual appraisals for all staff.
- Continue with plans to improve the identification of carers and provision of information to support carers.
- Encourage the uptake of annual health checks for patients with a learning disability.
- Check that learning identified from significant events and complaints had been actioned, and an annual analysis of trends for significant events is undertaken.

Drs Seehra Lockyer Davis and Tanoe

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector and included a GP specialist adviser.

Background to Drs Seehra Lockyer Davis and Tanoe

The practice area covers the town of Lowestoft and extends into the outlying villages. The practice offers health care services to approximately 12,400 patients. The practice holds a General Medical Service (GMS) contract with the local Clinical Commissioning Group (CCG).

- There are four GP Partners at the practice (all male), two regular locums GPs (female), four practice nurses and one health care assistant.
- There is a team of eleven reception staff and five administration staff, which includes an information technology administrator, a practice administrator, a Quality and Outcomes Framework (QOF) administrator and two medical secretaries. The team support the work of the practice manager, who has been working at the practice for six months.
- The practice is open between 8am and 6.30pm Monday to Friday and appointments are available from 8.40am to 11am and from 3pm to 5.10pm. Appointments with the duty GP were available until 6.10pm.
- When the practice is closed Integrated Care 24 provides the out of hours service, patients are asked to call the NHS111 service to access this service, or to dial 999 in the event of a life threatening emergency.
- The practice has a larger number of patients aged over 65 than the national average. There are fewer patients between the ages of 35 to 45 than the national average. Male and female life expectancy in this area is slightly below the England average at 78 years for men and 82 years for women. Income deprivation affecting children is 29%, which is above the CCG average of 25% and national average of 20%. For older people, this is 22%, which is above the CCG average of 17% and the national average of 16%. The percentage of patients who are unemployed is 4% which is above the CCG average of 3% and the same as the national average.

Why we carried out this inspection

We previously carried out an announced comprehensive inspection at Drs Seehra, Lockyer, Davis and Tanoe on 22 October 2014. The practice was rated as good for providing effective, caring and responsive services and requires improvement for providing safe and well led services. Overall the practice was rated as requires improvement. We carried out a focused inspection on 8 October 2015 and the practice was rated good for providing safe services and requires improvement for providing well led services. Overall the practice was rated as good. The full comprehensive reports on the 4 October 2014 and 8 October 2015 inspections can be found by selecting the 'all reports' link for Drs Seehra, Lockyer, Davis and Tanoe on our website at www.cqc.org.uk.

Detailed findings

We undertook a comprehensive inspection of Drs Seehra, Lockyer, Davis and Tanoe on 20 September 2017. This inspection was carried out to review in detail the actions taken by the practice to improve the quality of care and to confirm that the practice was now meeting legal requirements.

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 20 September 2017. During our visit we:

- Spoke with a range of staff (GPs, practice nurses, reception and administration) and spoke with patients who used the service.
- Observed how patients were being cared for and talked with carers and 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.
- Spoke with representatives from care homes where residents were registered at the practice.

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

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

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

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

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

Requires improvement

Are services safe?

Our findings

Safe track record and learning

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

- Staff told us they would inform a GP or 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).
- The practice took necessary action immediately following a significant event. These were discussed at the weekly partners meetings and any actions and learning was also shared with the practice team at the practice meetings. There was no process in place to check that the identified learning had been actioned.
- We saw evidence that when things went wrong with care and treatment, patients were informed of the incident, received reasonable support, detailed information, a written apology and were told about any actions to improve processes to prevent the same thing happening again.
- The practice did not carry out an analysis of the significant events every year in order to identify trends.

We talked with staff and reviewed some safety records, incident reports, patient safety alerts and minutes of meetings where these were discussed. The practice had recently established a process for dealing with patient safety alerts. They were logged, shared and initial necessary searches were completed and the changes effected. This process needed to be embedded as not all the clinicians we spoke with were aware of this. We saw evidence that lessons were shared and action was taken to improve safety in the practice. For example, following a significant event, the practice had ensured that all staff were aware of the location of the panic button.

Overview of safety systems and processes

The practice had some systems, processes and practices in place to keep patients safe and safeguarded from abuse.

- Some arrangements were in place to safeguard children and vulnerable adults from abuse. The practice had completed an audit and updated patients' records to ensure that children with safeguarding needs were highlighted appropriately on the computer system and their social worker information was up to date. The practice had a safeguarding children and safeguarding adults policy, which reflected relevant legislation and local requirements, however the safeguarding adults policy did not provide the contact details for referral to other agencies. The safeguarding adults policy had been recently updated and had not been shared with all staff. Referral information was available in the safeguarding folder, however not all staff we spoke with were aware of this. Some of the safeguarding information displayed in the practice was out of date. All the staff we spoke with were aware of the safeguarding lead GP and advised they would discuss any concerns with the GP lead. The practice held quarterly safeguarding meetings with a social worker to review all children with safeguarding needs. The GPs provided reports where necessary for other agencies. We saw some evidence that staff had received training on safeguarding children and vulnerable adults relevant to their role; however the practice were not able to evidence that all staff had received this. We were told that all GPs and nurses were trained to level three but we did not see the evidence to confirm this.
- A notice in the waiting room, around the practice and in consultation rooms advised patients that chaperones were available if required. All staff who acted as chaperones had received a Disclosure and Barring Service (DBS) check. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable). The practice could not evidence that staff had attended recent chaperone training updates. A chaperone policy was in place but did not give guidance on where chaperones should be located during a procedure.
- Some arrangements were in place for infection control, however we found that policies and procedures needed to be updated, sharps bins were not dated, some chairs were damaged which made them difficult to clean, and clinical waste was not stored securely. One of the practice nurses was the infection control lead. They were aware that quarterly meetings were held by the infection prevention teams and although none had been attended at the time of our inspection, they planned to attend these, to keep up to date with

evidence based practice. Staff had received training appropriate to their role, as infection control training had been prioritised. The practice had undertaken an annual infection control audit, which had been completed with the Clinical Commissioning Group (CCG) in April 2017. Some identified actions had been completed, for example, examination couch cover rolls had been removed from the floor and most privacy screens had been replaced with disposable curtains. The practice were planning to complete the other identified actions. Body fluid spillage kits were available in the practice. There was a sharps injury policy and procedure available.

- 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. Blank prescription forms and pads were securely stored and there were systems in place to monitor their use. Patient Group Directions had been adopted by the practice to allow nurses to administer medicines in line with legislation. Healthcare assistants were trained to administer vaccines and medicines against a patient specific prescription or direction from a prescriber.
- We reviewed three personnel files and found appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service. We found that one member of clinical staff did not have a DBS check in place. We raised this with the practice manager, who stopped them undertaking unsupervised work with patients and confirmed that they would not be able to resume until the practice had received a DBS certificate. We checked and saw evidence that other nurses and non clinical staff who acted as chaperones had appropriate DBS checks completed.

Monitoring risks to patients

- The practice had a fire equipment service report undertaken by an external company which detailed that an up to date fire risk assessment was on site and that identified actions had been completed. The practice had documented a recent fire drill and had planned these every three months. All the electrical equipment had been checked in October 2016 to ensure the equipment was safe to use. Clinical equipment was checked to ensure it was working properly. Health and safety had been reviewed and work had been arranged for an external company to provide support, which was planned for November. The practice did not have a legionella protocol or risk assessment in place (Legionella is a term for a particular bacterium which can contaminate water systems in buildings).
- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system in place for all the different staffing groups to ensure enough staff were on duty.

Arrangements to deal with emergencies and major incidents

- There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency.
- All staff received annual basic life support training and there were emergency medicines available.
- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and stored securely.
- The practice had a defibrillator available on the premises and oxygen with adult and children's masks. A first aid kit and accident book were available.
- The practice had a comprehensive business continuity plan in place for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff and copies were kept off site.

Inadequate

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

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

- Staff had access to guidelines from NICE and used this information to deliver care and treatment that met patients' needs.
- The practice monitored that these guidelines were followed through risk assessments, audits and random sample checks of patient records.

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 from 2015/2016 showed the practice achieved 99% of the total number of points available. The overall exception reporting rate was 29% which was 15% above the CCG average and 19% above 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). 2016 to 2017 unverified data from the practice showed that the practice received 98% of the total number of points available and the exception reporting rate had reduced to 24%. However, the GP lead for QOF was unaware of their high exception reporting, so the improvement was not due to a targeted approach.

Data from 2015/16 showed:

- Performance for diabetes related indicators in 2015/2016 was 94%, which was above the local and national average of 90%. The exception reporting for diabetes related indicators was 35% which was above the local average of 17% and the national average of 12%. 2016/2017 unverified data from the practice showed that performance had reduced to 86%; however the exception reporting rate had also reduced to 29%.
- Performance for mental health related indicators was 99%. This was 9% above the CCG average and 6% above the England average. The exception reporting rate was 43% which was above the CCG average of 19% and national average of 11%. 2016/2017 unverified data from the practice showed that performance had improved to 100%, and the exception reporting rate had reduced to 39%.
- Performance for depression related indicators was 100% which was 5% above the CCG average and 8% above the national average. The exception reporting rate was 81% which was higher than the CCG average of 26% and national average of 22%. 2016/2017 unverified data from the practice showed that performance had maintained and the exception reporting rate had reduced to 43%.
- The prevalence of asthma was 7%, which was higher than the England average of 6%. The performance for asthma indicators was 100% which was above the CCG average of 98% and the national average of 97%. The exception reporting rate was 30% which was higher than the CCG average of 13% and national average of 7%. 2016/2017 unverified data from the practice showed that performance had maintained performance; however the exception reporting rate had increased to 35%.

There was evidence of some quality improvement including clinical audit.

- The practice participated in local audits, national benchmarking and peer review.
- Findings were used by the practice to improve services. For example, action taken as a result of a two cycle clinical audit demonstrated improved recording of patient information following home visits from 87% to 98%. One single cycle clinical audit showed that the treatment of three patients was changed, following a review of all patients taking a combined oral contraceptive pill, with a body mass index (BMI) over 35.
- The practice was ranked lowest of the practices in the CCG for poor prescribing, which included for example, high prescribing of hypnotic medicines and antibiotics. They met monthly with the CCG medicines management team to work to improve their performance.

Inadequate

Are services effective?

(for example, treatment is effective)

Four of the GPs at the practice undertook minor surgery and a process was in place to record complication and infection rates. We checked three patients who had histology samples sent in recently and found that they had all been actioned.

Effective staffing

- The practice had an induction programme for all newly appointed staff, including GP locum staff. This covered areas such as information about the practice, fire safety, dealing with emergencies, health and safety and confidentiality. We looked at the induction record for a member of staff who had recently started and found that this had not been fully completed.
- Following a review in March 2017, by the new practice manager, a programme of e-learning training was identified, which they deemed mandatory for staff to complete. This was split into training for clinical and non clinical staff. This included for example, safeguarding, fire safety awareness, health, safety and welfare and information governance. Training had not yet been completed by all staff, as they all needed an NHS email to access the training, which some staff did not have. Staff were now all able to access the e-learning and a plan was in place for this to be completed by all staff by March 2018. Staff had access to and made use of in-house training, workshops and conferences.
- 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 nurse meetings.
- The learning needs of staff were identified through meetings and a review of the practice development needs. The practice was working towards non clinical staff being multi-skilled, so that they could offer a more flexible service to patients. Staff had access to appropriate training to meet their learning needs and to cover the scope of their work. This included ongoing support for staff and for revalidating GPs. The appraisal system had been reviewed and appraisals had been undertaken with four of the fifteen non clinical staff who were due an annual appraisal. The practice manager was responsible for undertaking these with non clinical staff and wanted to get to know the staff before they undertook their appraisal. The appraisals of the four nurses had not yet been completed.

Coordinating patient care and information sharing

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

- This included care and risk assessments, care plans, medical records and investigation and test results.
- The practice shared relevant information with other services in a timely way, for example when referring patients to other services.

Staff worked together and with other health and social care professionals to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. This included when patients moved between services, including when they were referred, or after they were discharged from hospital. Meetings took place with other health care professionals on a three monthly basis when care plans were routinely reviewed and updated for patients with complex needs. The diabetes specialist nurse visited the practice on a quarterly basis, to review patients with complex diabetes.

Consent to care and treatment

Generally, 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.
- 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.
- When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance.
- Written consent for minor surgery, including excisions, was not obtained for all patients and verbal consent was not always documented.

Inadequate

Are services effective?

(for example, treatment is effective)

Supporting patients to live healthier lives

The practice identified patients who may be in need of extra support. This included patients receiving end of life care, carers, those at risk of developing a long-term condition and those requiring advice on their diet, exercise, smoking and alcohol.

The practice's uptake for the cervical screening programme was 93% which was above the CCG average of 83% and the national average of 82%. However, the exception rate was 24%, which was 14% above the CCG average and 17% above 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). 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.

- 59% of patients aged 60 to 69 had been screened for bowel cancer in the last 30 months compared to the CCG average of 60% and an England average of 58%.
- 76% of females aged 50 to 70 had been screened for breast cancer in the last 36 months compared to the CCG average of 72% and an England average of 73%.

Childhood immunisation rates for the vaccinations given were generally comparable to CCG averages. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 61% to 97% which was comparable to the CCG range of 67% to 96% and above the national range of 21% to 96%. In relation to five year olds, it ranged from 66% to 96% which was comparable to the CCG range of 70% to 96% and above the national range of 16% to 94%. The practice scored 61% which was lower than the expected 90% standard for the percentage of children aged two who had been vaccinated with the pneumococcal conjugate booster. The practice were not aware of their performance in this area. Childhood immunisations clinics were available one morning a week and to encourage attendance ad hoc appointments were also available. Patients were usually contacted before their appointment to maximise attendance.

The practice did not offer the NHS health checks for patients aged 40 to 74. They were considering offering these again once they had reviewed their capacity. Annual health assessments for people with a learning disability were available and were undertaken by the practice nurse and the GP where applicable. The practice had 90 people with a learning disability on their register and only 26 of these patients had received a health check in the previous 12 months.

Good

Are services caring?

Our findings

Kindness, dignity, respect and compassion

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

- Screens 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.

We spoke with representatives from three care homes who said they felt the practice offered a professional and friendly service. Patients told us they were very satisfied with the care provided by the practice and staff were helpful, caring and treated them with dignity and respect. 35 of the 34 patient Care Quality Commission comment cards we received were positive about the service experienced.

Results from the national GP patient survey published in July 2017 showed the practice was in line with local and national averages for its satisfaction scores on consultations with GPs and nurses. For example:

- 88% of patients said the GP was good at listening to them compared to the clinical commissioning group (CCG) average of 90% and the national average of 89%.
- 90% of patients said the GP gave them enough time compared to the CCG average of 88% and the national average of 86%.
- 93% 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%.
- 89% of patients said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 87% and the national average of 86%.
- 84% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 92% and the national average of 91%.
- 84% of patients said they found the receptionists at the practice helpful compared to the CCG average of 88% and the national average of 87%.

The practice displayed the results of the national GP patient survey in the waiting room and had an action plan in place to address the areas where they performed below the local average.

Care planning and involvement in decisions about care and treatment

Patients told us they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them. Representatives from three care homes advised that patients, care home staff and families were involved appropriately. Patient feedback from the comment cards we received was also positive and aligned with these views.

Results from the national GP patient survey, published in July 2017, showed results were in line with local and national averages for how patients responded to questions about their involvement in planning and making decisions about their care and treatment. For example:

- 86% of patients said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 89% and the national average of 86%.
- 81% of patients said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 85% and the national average of 82%.
- 83% of patients said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average of 88% and the national average of 85%.

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. We saw information was available on the practice's website and notices in the practice informing patients this service was available.
- The practice information leaflet was available in large print and copies were available in the waiting room for patients to take.

Good

Are services caring?

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.

The practice's computer system alerted GPs if a patient was also a carer and the practice had identified 41 patients as carers (0.3 of the practice list). There was no specific information for carers at the practice, although information for carers from NHS choices was available on the practice website. The practice were aware of this and planned to make improvements in this area.

Staff told us that if families had suffered bereavement, their usual GP contacted them. 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.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice reviewed the needs of its local population and had recently started to improve their engagement with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified.

- The practice had not identified any patients on an end of life care register until March 2017, when the new practice manager started in post. Since then, they have read coded these patients, have added 15 patients to the register and report this data to the CCG.
- The practice was ranked lowest of the practices in the CCG for poor prescribing, which included for example, high prescribing of hypnotic medicines and antibiotics. They met monthly with the CCG medicines management team to work to improve their performance.
- There was recognition from the CCG that the practice had improved in their engagement and collaboration with the CCG since the practice manager had commenced in post.
- Telephone appointments were available for patients if required. The practice used a text message appointment reminder service for those patients who had given their mobile telephone numbers. The practice were due to receive training in September on a two way text messaging system to further improve communication with patients.
- The practice had 90 patients on the learning disabilities register. Only 26 of these patients had a health review in the previous 12 months. The practice offered longer appointments and appointments 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.
- GPs and nursing staff undertook a weekly visit to three care homes to assess, monitor and review a large number of patients who were residents. Feedback was very positive particularly in relation to continuity of care and communication.
- All consultation rooms were on the ground floor and easily accessible. Translation services were available and information was clearly displayed in the practice to advise patients of this service.
- Patients were able to receive travel vaccinations available on the NHS.
- Alerts were recorded on the patient's record to ensure staff were aware of any particular needs. This included, for example for carers, where longer appointments were needed, where reminders were needed for patients who had a history of not attending their appointment or where there were known safeguarding concerns.

Access to the service

The practice was open between 8am and 6.30pm Monday to Friday. Appointments were available from 8.40am to 11am and from 3pm to 5.10pm. Appointments with the duty GP were available until 6.10pm. Appointments could be booked in person, by telephone or online. In addition to pre-bookable appointments that could be booked up to one month in advance, urgent appointments were also available for people that needed them. The practice offered online prescription ordering and access to the patient's own medical record.

Results from the national GP patient survey, published in July 2017, showed that patient's satisfaction with how they could access care and treatment was in line with and above the local and national averages.

- 81% of patients were satisfied with the practice's opening hours compared to the CCG average of 80% and the national average of 76%.
- 85% of patients said they could get through easily to the practice by phone compared to the CCG average of 77% and the national average of 71%.

People told us on the day of the inspection that they were generally able to get appointments when they needed them, which included urgent appointments although these were not with their named GP. Seven of the 35 comments cards we received detailed that there was a wait for the telephone to be answered, particularly in the morning and/or difficulty in obtaining an appointment.

The practice had a system in place to assess whether a home visit was clinically necessary and

the urgency of the need for medical attention. Requests for home visits were triaged by a GP who was allocated to undertake the home visit if necessary. Clinical and non-clinical staff were aware of their responsibilities when managing requests for home visits.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Listening and learning from concerns and complaints

The practice had an effective system in place for handling complaints and concerns. The complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. There was a designated person responsible who handled all complaints in the practice.

We saw that information was available to help patients understand the complaints system on the practice's website and in their information leaflet. The practice also had a 'Let us know what you think' leaflet which included information on complaints. Reception staff showed a good understanding of the complaints procedure and they had written information that they could give to patients if requested.

We looked at documentation relating to three complaints received in the previous year and found they had been fully investigated and responded to in a timely and empathetic manner. Complaints were discussed at the weekly partners meeting. Lessons were learnt from individual concerns and complaints. Complaints were shared with staff as appropriate, to encourage learning and development, although checks were not undertaken to ensure that learning had been embedded into practice. The practice completed an annual analysis of complaints.

Are services well-led?

Inadequate

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

Our findings

Vision and strategy

The aim of the practice as detailed in their Practice Charter was 'To provide primary healthcare to the best of our ability working in a partnership with you, the patients.' Staff we spoke with did not mention the Patient Charter although they said the aim of the practice was to focus on patients.

The practice manager had developed a work review and plan, five weeks after they had started work at the practice in March 2017. This identified a number of areas for review and action and included personnel, communication, CQC, patient services and suppliers.

Governance arrangements

The practice did not have a clear and established governance framework.

- The arrangements for identifying, recording and managing risks were insufficient. For example a Legionella risk assessment had not been completed, although this was identified in April 2017 in the infection control audit.
- GPs had lead areas of responsibility; however they were not effective in these roles. For example, the lead for the quality and outcomes framework was not aware of the practice's high exception reporting rate. The safeguarding lead did not ensure that safeguarding information in the practice was up to date.
- The practice was in the process of reviewing their policies to ensure they were practice specific and up to date. Not all the policies had been updated and some of those which had been updated were not sufficiently detailed. These had not all been shared with staff and some staff were not all aware of how to access them. This included, for example, the safeguarding adults and the chaperone policy.
- The GPs did not have a comprehensive understanding of the clinical and non clinical performance of the practice.
- The practice did use clinical and internal audit to monitor quality and to make improvements.

Previous inspection findings had not all been actioned to completion. The comprehensive inspection on 22 October 2014 found that the approach to significant event reporting and monitoring, the recording of safeguarding risks to children known by the practice and the system to assess and monitor the quality of the service provided needed improving. The focused inspection on 8 October 2015, found that the procedures for reviewing and learning from significant events and recording of safeguarding risks had improved. However, improvement was still required to ensure that staff training was properly recorded, that potential risks to the practice were identified and that non-clinical audits were undertaken to assess the service provided to patients.

Leadership and culture

On the day of inspection the partners did not demonstrate that they had the experience, capacity and capability to effectively manage the practice. The GPs were focused on the provision of clinical care to patients, and there was a lack of managerial oversight. For example, actions had been identified in April 2017 in relation to improvements for infection control. We spoke with one of the GPs who said this work had been delegated. However there was no monitoring process for work which had been delegated, to ensure this had been completed. There was a lack of oversight of the completion of staff training, including that which was deemed mandatory by the practice. For example, the practice were not able to evidence all the staff who had completed safeguarding training and to what level this had been completed.

Staff described a segregated culture between the GPs and the staff team. We saw examples of this in relation to the management of patient safety alerts, where the GPs we spoke with were not aware of the system in place. The practice meetings were occasionally attended by one of the GPs. Staff we spoke with did not feel well supported or involved, however they did express that they felt things had improved since the new practice manager had come into post and they hoped that this would continue.

Staff shared some examples of how their suggestions had been acted upon, since the new practice manager started in post. For example blood results could now be given to patients when requested, whereas previously, they were only given to patients in person, during a two hour time period on three days of the week.

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

Are services well-led?

Inadequate

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

requirements that providers of services must follow when things go wrong with care and treatment). The practice had systems in place to ensure that when things went wrong with care and treatment:

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

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

The practice sought feedback from patients and staff. The practice had gathered feedback from patients through events held at the practice, through surveys and complaints received. The practice engaged with the Friends and Family Test. We reviewed the data submitted since July 2016. However, due to the low number of responses, the data had not been published to protect against the possible risk of disclosure of patient identifiable information. The practice had displayed the results from the 2017 National GP patient survey in the waiting room. They had reviewed the results and identified the areas where they scored less than the Clinical Commissioning Group (CCG) average. Action for improvement had been identified, which included for example, increasing the percentage of appointments that could be booked online. Some actions had been completed, for example, discussing customer service at the practice meeting. The practice did not have Patient Participation Group (PPG) although they had identified the need to establish a virtual PPG to obtain feedback from a wider group of patients. Information about this was available to patients in the patient information newsletter.

Processes were being established to obtain the views of staff, for examples through appraisals, meetings and discussion. There were examples of staff feedback being listened to and acted upon.

Continuous improvement

The new practice manager had recognised areas where improvements could be made and discussed these with the partners. The partners had agreed to some of the suggestions, for example employing a nurse practitioner. The practice were also supporting one of the nurses in their training to be a nurse practitioner in order to improve the service received by patients. The practice also planned to employ a clinical pharmacist.

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 Surgical procedures Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent **Care and treatment of service users must only be provided with the consent of the relevant person.** • Written consent for minor surgery, including excisions, was not obtained for all patients and verbal consent was not always documented.

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **The registered persons had not done all that was reasonably practicable to mitigate risks to the health and safety of service users receiving care and treatment. In particular:** • Infection control policies and procedures needed to be updated, sharps bins were not dated and clinical waste was not stored securely. Identified actions from the infection control audit completed in April 2017 needed to be completed. • Health and safety risks to patients and staff were not all assessed, which included legionella.

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 Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **There were no systems or processes that enabled the registered person to assess, monitor and improve the quality and safety of the services being provided. In particular:** • Effective clinical and managerial oversight was not in place. • There was a lack of oversight of the completion of staff training, including that which was deemed mandatory by the practice. The provider was unable to evidence that safeguarding training was completed by all staff appropriate to their role and that staff who acted as chaperones had been trained for this role. • One member of staff who worked unsupervised with patients was awaiting a Disclosure and Barring Service check and worked unsupervised with patients. • Policies and procedures were not all up to date. Policies which had been updated were not detailed and shared with all staff. For example the safeguarding adults policy did not include referral information.