Hadley Health Centre

Quality Report

The Health Centre
High Street
Hadley
Telford
TF1 5NG
Tel: 01952 249251
Website: No website

Date of inspection visit: 10 July 2015
Date of publication: 17/09/2015

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

Ratings

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

Summary of findings

Contents

Summary of this inspection

Page

Overall summary 2

The five questions we ask and what we found 4

The six population groups and what we found 8

What people who use the service say 11

Areas for improvement 11

Detailed findings from this inspection

Our inspection team 13

Background to Hadley Health Centre 13

Why we carried out this inspection 13

How we carried out this inspection 13

Detailed findings 15

Action we have told the provider to take 31

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Hadley Health Centre on 10 July 2015. Overall the practice is rated as inadequate.

Specifically, we found the practice inadequate for providing safe, effective, and well led services. It required improvement in providing a responsive and caring service. There were aspects of practice which were inadequate and related to all population groups, it was also therefore inadequate for providing services for the all population groups.

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

• Patients were at risk of harm because systems and processes were not in place to keep them safe. For example appropriate recruitment checks on staff had not been undertaken prior to their employment and no recruitment records were held by the practice.

• Staff were clear about reporting incidents, near misses and concerns but the systems in place were not robust and there was no evidence of learning and communication with staff.

• There was insufficient assurance to demonstrate people received effective care and treatment.

• Patients were positive about their interactions with staff and said they were treated with compassion and dignity.

• There was a leadership structure with named members of staff in lead roles, but limited formal governance arrangements.

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

Importantly, the provider must:

- Ensure recruitment arrangements include all necessary employment checks and that appropriate records are held for all staff. Ensure there is a robust recruitment policy in place for staff to follow.

Summary of findings

- Put systems in place to ensure all clinicians are kept up to date with national guidance and guidelines.
- Ensure audits of practice are undertaken, including completed clinical audit cycles.
- Ensure there are formal governance arrangements in place including systems for assessing and monitoring risks and the quality of the service provision.
- Ensure staff have appropriate policies and guidance to carry out their roles in a safe and effective manner which are reflective of the requirements of the practice.
- Ensure the availability of medicines required in the event of an emergency are available such as oxygen. Oxygen is considered essential in dealing with certain medical emergencies. Ensure where there is an absence of emergency medicines, such as those used to treat suspected meningitis and seizures that an appropriate risk assessment is carried out to identify why they are not suitable for the practice to stock, and how this is kept under review.
- Complete a review of staffing sufficiency to ensure there are sufficient numbers of suitably qualified skilled and experienced staff.
- Complete an Infection Prevention and Control audit as the last audit took place in 2012.
- Ensure that all products subject to Control of Substances Hazardous to Health (COSHH) requirements are stored appropriately.

In addition the provider should:

- Consider equality and diversity training for all staff.
- Consider a practice website to improve patient access to information regarding the services it provides.
- Set up a patient participation group to assist the practice in gaining meaningful patient feedback.
- Ensure there is leadership capacity to deliver all improvements.

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

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Inadequate

The practice is rated as inadequate for providing safe services and improvements must be made. Staff were clear about reporting incidents, near misses and concerns. The reporting and recording mechanisms however were not robust. For example, staff did not take individual responsibility for recording first-hand the incident or significant event. They reported to the administrator/practice manager who had taken on this responsibility. Staff were not aware of their own responsibilities for both reporting and recording significant events. Gaps were found whereby two incidents said to have been reported, had not been recorded. Therefore incident and event records were not complete and the practice had not investigated, mitigated risks or provided any shared learning in these instances. Although there was some evidence that the practice carried out investigations when things went wrong, lessons learned were not widely communicated and so safety was not improved. Significant events/incident reports in a folder had been recently lost from previous years and could not be located by practice staff. Patients were at risk of harm because the systems and processes were either not in place, had weaknesses or were not implemented in a way to keep them safe. Areas of concern included; recruitment, fire training and drills, lack of a practice policies for example health and safety, management of unforeseen circumstance and dealing with emergencies. There was insufficient information to enable us to understand and be assured about safety because staff did not have appropriate policies and guidance to carry out their roles in a safe and effective manner which are reflective of the requirements of the practice.

Are services effective?

Inadequate

The practice is rated as inadequate for providing effective services, as there are areas where improvements should be made. Data showed patient outcomes were at or below average for the locality. Knowledge of and reference to national guidelines were inconsistent. For example, there were 218 patients at the practice with a diagnosis of diabetes. The percentage of patients with diabetes at the practice whose last specific blood test result was less than a specific level in the preceding 12 months was 59.79%. This was lower than the local CCG average of 77.72%. There were four quality outcome framework (QOF) indicators which had resulted in lower outcome percentages than the national average. For example, the percentage of women aged 25-64 whose notes record that a cervical screening test had been performed in the preceding 5 years

Summary of findings

was 69.97% which was lower than the national average of 81.88%. We saw that only 25% of patients with dementia had been reviewed in a face-to-face review in the preceding 12 months, compared with the national average of 83.82%. There was no evidence of completed clinical audit cycles or that audit was driving improvement in performance to improve patient outcomes. Multidisciplinary working was taking place but was generally informal and record keeping was limited or absent. There was no documented evidence of appraisals seen for staff. Staff could not recall their last appraisal. We found that staff had not received chaperone training, some staff could not recall their adult safeguard training and not all staff could recall when they last attended fire safety awareness training. Records had not been kept of staff training.

Are services caring?

Requires improvement

The practice is rated as requires improvement for providing caring services. Data showed that patients rated the practice similar to others for several aspects of care and lower in some areas. For example, 57% said the last GP they spoke to was good at treating them with care and concern which was lower than the local CCG average of 83% and national average of 85%. The national GP patient survey information showed how patients had responded to questions about their involvement in planning and making decisions about their care and treatment and only 55% said the last GP they saw was good at explaining tests and treatments, which was lower than the CCG average of 84% and national average of 86%, and 62% said the last GP they saw was good at involving them in decisions about their care, which was lower than the CCG average of 79% and national average of 81%.Information for patients about the services available was easy to understand and accessible. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Are services responsive to people's needs?

Requires improvement

The practice is rated as requires improvement for providing responsive services. It was aware of the needs of its local population and where required engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day. The practice had good facilities and was well equipped to treat patients and meet their needs, with the exception of the availability of oxygen. Information about how to complain was available and

easy to understand. However, there were few complaints recorded and some complaints within the file were incomplete as they had been referred to professional bodies and the outcome was not recorded in the practice file.

The practice had higher than the national average proportion of patients aged 18 years and younger (46.3%). The practice average across England was 32.2%. There was no specific plan in place to respond to their needs for example there was no active practice website or on-line booking. There were few complaints recorded and notes about some complaints within the file were incomplete as they had been referred to professional bodies and the outcome was not recorded. Staff told us that not all verbal complaints were documented as there was not enough time to do this and they were immediately acted upon.

We spoke with the registered managers at two local learning disability care homes. They praised the practice and found the staff to be helpful in the arrangements of patient appointments to minimise stress and patients gained prompt access to appointments on the same day. Staff had a good rapport with patients as they were known to each other and the registered managers reported that patients with capacity had requested and chosen to stay with practice. The relationships and communication between the services was said to be exceptionally good.

Are services well-led?

Inadequate

The practice is rated as inadequate for being well-led. It did not have a clear vision and strategy. Staff we spoke with were not clear about their responsibilities in relation to the vision or strategy. Staff did not always feel supported by management. The practice had few policies and procedures to govern activity. The chaperone policy was dated 2004 and had not been reviewed since. The practice did not hold regular governance meetings and issues were discussed at informal meetings that were not minuted. The practice had some measures in place to seek feedback from patients and had audited patients' views on whether patients felt they would benefit from an ethnic minority link-worker. However, there was no evidence of any subsequent action taken in response to the findings. They did not have a patient participation group (PPG) and had yet to take part in the Friends and Family Test. Staff told us they had not received regular performance reviews, no whole staff meeting were in place, and they did not have clear objectives. One staff member said that the culture at the practice did not lend itself to open reporting of concerns. Another told us they had discussed concerns regarding work pressures, a lack of policy and procedures, lack of time to produce policies and procedures and staffing but there had been no

Summary of findings

action taken. There were no formal minutes held of any meetings other than that of the health visitor meetings available. The practice had a leadership structure, but insufficient leadership capacity and limited formal governance arrangements.

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

People with long term conditions

Inadequate

The practice is rated as inadequate for the care of people with long-term conditions. There were aspects of the practice which were inadequate and these related to all population groups. The Advanced Nurse Practitioner had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. All these patients had a named GP and a structured annual review to check that their health and medication needs were being met. For those people with the most complex needs, the named GP communicated with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Inadequate

The practice is rated as inadequate for the care of families, children and young people. There were aspects of the practice which were inadequate and these related to all population groups. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. Immunisation rates were relatively high for all standard childhood immunisations. Patients told us that children 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. Every month the practice held a meeting with the health visitor. The agenda included children registered at the practice who were subject to protection plans.

Summary of findings

Working age people (including those recently retired and students)

Inadequate

The practice is rated as inadequate for the care of working-age people (including those recently retired and students).There were aspects of the practice which were inadequate and these related to all population groups. The age profile of patients at the practice is mainly those under 18 years old and of working age, students and the recently retired but the services available did not reflect the needs of this group. Appointments could only be booked by telephone or in person and there were no early or extended opening hours for working people. There was a low uptake for both health checks and health screening.

People whose circumstances may make them vulnerable

Inadequate

The practice is rated as inadequate for the care of people whose circumstances may make them vulnerable. There were aspects of the practice which were inadequate and these related to all population groups. The practice told vulnerable patients about how to access various support groups and voluntary organisations. The practice held a register of patients living in vulnerable circumstances including those with a learning disability. It had carried out opportunistic annual health checks for patients with a learning disability, longer appointments and they had received a follow-up. Staff at two local learning disability care homes praised the practice and found the relationships and communication between the practice and these services to be exceptionally good. The practice was not involved in regular meetings with multi-disciplinary teams in the case management of vulnerable patients.The practice had no adult safeguarding policy or contact numbers available for staff to refer to. Non-clinical staff were unaware as to whether they had received safeguarding adults training and could not readily access adult safeguarding information or contact numbers. During the course of the inspection, the Advanced Nurse Practitioner (ANP) sourced the adult safeguarding team contact numbers for staff to refer to and placed the local authority safeguarding policy into the practice policy file.

People experiencing poor mental health (including people with dementia)

Inadequate

The practice is rated as inadequate for the care of people experiencing poor mental health (including people with dementia). There were aspects of the practice which were inadequate and these related to all population groups. The practice told patients experiencing poor mental health about how to access various support groups and voluntary organisations including MIND and SANE. It had a system in place to follow up patients who had attended accident and emergency (A&E) where they may have been

experiencing poor mental health. The clinical staff said they had received training on how to care for people with mental health and dementia needs, however there were no accessible staff training records held at the practice to review. Staff described the dementia tool they were trained to use and that they referred patients to a local memory clinic. Of the 33 patients experiencing poor mental health their electronic systems showed that 27% had a care plan agreed. There were seven patients registered as living with dementia and only 25% had had a face to face review, however the practice systems demonstrated that 100% of those assessed as requiring a blood test had been completed. The Advanced Nurse Practitioner was unsure of why their systems suggested these figures and thought it could be due to a practice coding error. Dementia screening was undertaken and patients would be followed up with a referral to the memory clinic.

Summary of findings

What people who use the service say

We spoke with two patients during the inspection and four following it. We received 39 completed Care Quality Commission (CQC) comments cards in total. All of the patients we spoke with said they were happy with the service they received. Two patients remarked on a GPs lack of bedside manner, and two others felt they were not always listened to.

The National GP patient survey July 2015 results for this practice found that 68% of patients who responded said the last GP they saw or spoke to was good at giving them enough time compared to the CCG average of 86% and national average of 87%, and 69% said the last GP they saw or spoke to was good at listening to them compared to the CCG average of 87% and national average of 89%. This was based on findings from the 97 surveys returned out of the 448 surveys sent out, giving a 22% completion rate. The survey found that 80% of respondents found it easy to get through to the practice by phone, which was higher than both the local Clinical Commissioning Group (CCG) average of 71% and the national average of 73%. The percentage of patients that would recommend their practice was 49% which was lower than the CCG average of 73% and national average of 78%. Seventy-five per cent of patients in the survey described their overall experience of this practice as good which was lower than both the CCG average of 83% and national average of 85%.

Patients we spoke with said staff were helpful and treated them with dignity and respect. We were told that the GPs, nurses and reception staff explained processes and procedures and were available for follow up help and advice. They were given printed information when this was appropriate.

Areas for improvement

Action the service MUST take to improve

Ensure recruitment arrangements include all necessary employment checks for all staff and a recruitment policy in place for staff to follow.

Put systems in place to ensure all clinicians are kept up to date with national guidance and guidelines.

Ensure audits of practice are undertaken, including completed clinical audit cycles.

Ensure there are formal governance arrangements in place including systems for assessing and monitoring risks and the quality of the service provision.

Ensure staff have appropriate policies and guidance to carry out their roles in a safe and effective manner which are reflective of the requirements of the practice.

Ensure the availability of medicines required in the event of an emergency are available such as oxygen. Oxygen is considered essential in dealing with certain medical emergencies. Ensure where there is an absence of emergency medicines, such as those used to treat suspected meningitis and seizures that an appropriate risk assessment is carried out to identify why they are not suitable for the practice to stock, and how this is kept under review.

Complete a review of staffing sufficiency to ensure there are sufficient numbers of suitably qualified skilled and experienced staff.

Complete an Infection Prevention and Control audit as the last audit took place in 2012.

All products subject to Control of Substances Hazardous to Health (COSHH) requirements to be stored appropriately which includes the staff toilet used by patients after 5pm.

Action the service SHOULD take to improve

Consider equality and diversity training for all staff.

Consider a practice website to improve patient access to information regarding the services it provides.

Set up a patient participation group to assist the practice in gaining meaningful patient feedback.

Summary of findings

Ensure there is leadership capacity to deliver all improvements.

Hadley Health Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a GP, a specialist advisor and an Expert by Experience. Experts by Experience are members of the inspection team who have received care and experienced treatments from a similar service.

Background to Hadley Health Centre

Hadley Health Centre is located in Hadley, Telford. It is part of the NHS Telford and Wrekin Clinical Commissioning Group. The total practice patient population is 3,565. The practice has a higher proportion of patients aged 18 years and younger (46.3%) than the practice average across England (32.2%). Approximately 53% of the practice's patients are of Asian descent. The practice is a tenant at the Health Centre and NHS Property Services are responsible for the maintenance of the building.

The staff team comprises of a full time male lead GP providing eight sessions per week and a female long term locum GP providing six sessions per week. The practice team includes an Advanced Nurse Practitioner/prescriber working 32 hours per week, an administrator/practice manager working 30 hours per week, and three reception staff working a variety of part time hours. In total there are seven staff employed at the practice.

Hadley Health Centre opening times are 8:30am to 6pm Monday to Friday. The practice closes for lunch but the practice staff answer phone calls between 1-2pm.The practice does not provide an out-of-hours service to its own patients but has alternative arrangements for patients to be seen when the practice is closed through Shropdoc, the out-of-hours service provider. During the period between 8am and 8.30am when the out-of-hours service is transferred to the practice calls are directed through to the GP.

The practice telephones switch to the out of hours service at 6pm each weekday evening and at weekends and bank holidays.

The practice provides a number of clinics, for example long-term condition management including asthma, diabetes and high blood pressure. It also offers child immunisations, travel vaccinations and minor surgery.

The practice has a General Medical Services (GMS) contract with NHS England. This is a contract for the practice to deliver general medical services to the local community or communities. It also provides some Direct Enhanced Services, such as the childhood vaccination and immunisation scheme, minor surgery, and in facilitating a timely diagnosis and support for patients with dementia.

Why we carried out this inspection

We carried out an inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act

2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Please note that 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.

Detailed findings

How we carried out this inspection

Prior to our inspection we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. This included NHS Telford and Wrekin Clinical Commissioning Group, Healthwatch and NHS England Area Team. Clinical Commissioning Groups (CCG) are groups of General Practices that work together to plan and design local health services in England. They do this by 'commissioning' or buying health and care services.

We carried out an announced inspection on 10 July 2015. During our inspection we spoke with a range of staff including the Lead GP, Advanced Nurse Practitioner, administrator/practice manager and reception staff. We observed how patients were communicated with and how the practice supported patients with health promotion literature. We reviewed 39 CQC comment cards where patients and members of the public were invited to share their views and experiences of the service. The CQC comment cards had been made available to patients at Hadley Health Centre prior to the inspection. We also spoke with staff at two learning disability care homes whose patients receive care and support from Hadley Health Centre.

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 are provided for specific groups of people and what good care looks like for them. The population groups are:

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

Inadequate

Are services safe?

Our findings

Safe track record

The practice had some systems in place for reporting, recording and monitoring significant events and incidents, which were all via the administrator/practice manager. However, we found there was no accident book or log, there was no incident log and the file which we were told held copies of the significant events from previous years could not be located. We saw a file which held records of five events from 2014.

The staff we spoke with were generally aware of their responsibilities to raise concerns, and knew who to contact to report any incidents and near misses. However we found that the reporting and recording mechanisms were not robust. For example, staff did not take individual responsibility for recording first-hand the incident or significant event. They reported to the administrator/ practice manager who had taken on this responsibility. There were no measures in place in the absence of this designated staff member. Staff were not aware of their own responsibilities for both reporting and recording significant events. Gaps were found whereby two incidents, said to have been reported, had not been recorded. Therefore incident and event records were not complete and the practice had not investigated, mitigated risks or provided any shared learning in these instances. The GP and administrator/practice manager told us that they had a file which held all their previous significant events but this could not be located on the day of the inspection. The GP told us records of significant events were also reported through the GP appraisal system so could be verified via their yearly appraisals, should the significant event file not be located.

We found that the practice did not have its own health and safety policy or awareness of the person responsible for health and safety procedures within the practice. Staff were aware that the building landlord inspected the premises and completed fire equipment and alarm systems checks.

We asked to review safety records, incident reports and minutes of meetings where these were these were discussed. We found that the practice had not held any formal meetings and there were no records of minutes to review.

Learning and improvement from safety incidents

We reviewed records of four significant events that had occurred during the last 12 months. The outcomes of the reported significant events we saw in the 2014 to 2015 file were shared with staff. For example, we spoke with staff who were aware of the changes made to repeat prescribing on disease modifying medicines and that the lead GP reviewed patient's blood test results in this regard. The action and learning points from this event had included improved checks and protocol changes. However, we found following discussions with staff that this system was not always followed appropriately. Staff informed us of two events which had occurred and been reported but not recorded. The administrator/practice manager informed us that they did not have sufficient time available to write up the events immediately they were reported. The administrator/practice manager was aware of one of the two events we described but not both. It was clear that gaps in recording and reporting were present. Timely and accurate records were not well maintained in respect of significant events and there were delays in the mitigation of any associated risks and in any learning derived. There were no regular team meetings, no minutes kept regarding the sharing of incidents/significant event outcomes, updates on protocols, or evidence that learning from events was routinely shared with staff. There was some evidence of ad hoc informal sharing processes in place with some staff.

Staff, including receptionists, administrators and nursing staff, knew how to raise concerns for consideration but also said they could discuss issues with the Advanced Nurse Practitioner (ANP) or with the lead GP. The administrator/ practice manager made notes in various notebooks none of which had been transcribed or shared with staff. The practice did not maintain minutes of any staff meetings held.

The administrator/practice manager used a template on the practice intranet which she completed printed off and held in a file of the significant events or incidents. Staff were aware of the location of these forms. Of those we reviewed we saw records were completed in a comprehensive and timely manner. We saw evidence of action taken as a result and that the learning had been shared. For example, were a patient had fallen outside the premises, this was reported to NHS property services. However, as the risk was not mitigated other than through appropriate reporting a second patient slipped and fell.

Inadequate

Are services safe?

Following the reporting of the second incident warning cones were set up to highlight the risk and remedial repairs were completed. Where patients had been affected by something that had gone wrong they were given an apology and informed of the actions taken to prevent the same thing happening again.

The ANP said alerts such as the National patient safety alerts were discussed with the GPs during informal practice discussions to ensure clinical staff were aware of any that were relevant to the practice and where they needed to take action. The ANP was able to give examples of recent alerts that were relevant to the care they were responsible for. We raised concerns about the audit trail the practice had and how they could be reassured that these were being seen by the necessary staff.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to children, young people and vulnerable adults. The administrator/practice manager told us that staff had received role appropriate training within the past three years and that the expectation was that administrative and reception staff received an update every three years and clinical staff annually. Staff we spoke said they had attended safeguarding training in the previous three year period. Clinical staff told they had received annual training. The ANP could not confirm the level of training achieved in adult and child safeguarding. The practice held no copies of staff training records. We were unable to verify that staff were up to date with safeguarding adults and children training. The administrator/practice manager did not hold a record of the actual date of when staff had received relevant role specific training on safeguarding and subsequently when they were due for refresher training.

Staff knew how to recognise signs of abuse in children. Staff were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding children concerns and how to contact the relevant agencies in working hours and out of normal hours for children. Contact details were easily accessible. Non clinical staff could not recall whether their training had included vulnerable adults. There was no vulnerable adult's policy for staff to access or contact details. The ANP during the inspection sourced a copy of the local authority safeguarding adults policy and contact details and made these accessible for all staff.

The practice had a dedicated GP lead for safeguarding children and safeguarding adults. We were told the GPs had been trained to the appropriate level. We were unable to evidence this level of training. Every month the practice held a meeting with the health visitor. The agenda included children who were registered at the practice and were subject to protection plans. There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments; for example children subject to child protection plans.

The chaperone policy was dated 2004 and had not been reviewed. There was no visible information in the waiting room, noticeboards or consulting rooms on the availability of chaperones. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). Staff had not received chaperone training. This is needed in order for staff to understand their responsibilities when acting as chaperones. The administrator/practice manager told us they acted as a chaperone in the absence of clinical staff when a chaperone was requested. Reception staff did not act as chaperones. The administrator/practice manager told us that all staff undertaking chaperone duties had received Disclosure and Barring Service (DBS) checks. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable). We found that there were no staff personnel files holding records such as DBS checks, so we could not verify that staff had a DBS in place. The ANP informed us that she had been subject to DBS checks with her other NHS employer.

GPs appropriately used the required codes on their electronic case management system to ensure risks to children and young people who were looked after or on child protection plans were clearly flagged and reviewed.

Medicines management

We checked medicines stored in the minor surgery treatment room and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There were processes in place to ensure that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. The ANP told us the practice policy was in the process of review with the Clinical Commissioning

Group (CCG) prescribing advisor. Clinical Commissioning Groups (CCG) are groups of General Practices that work together to plan and design local health services in England. They do this by 'commissioning' or buying health and care services. Records showed that fridge temperature checks were carried out which ensured medication was stored at the appropriate temperature.

Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms for use in printers were handled in accordance with national guidance and kept securely. The reception staff said that hand written prescription pads were held securely within a lockable drawer. The medicines were dispensed according to the patients' choice of pharmacy.

The practice was supported by a CCG prescribing advisor who reviewed with the practice their prescribing data. For example, patterns of antibiotic, hypnotics and sedatives and anti-psychotic prescribing within the practice. This included ensuring that all clinicians had access to a copy of the local prescribing guidelines and evidenced change in prescribing habits in line with the guidelines. There was a system in place for the management of high risk medicines such as disease modifying drugs, which included regular monitoring in accordance with national guidance. Appropriate action was taken based on the results. The practice had clear systems in place to monitor the prescribing of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse). Staff were aware of how to raise concerns around controlled drugs with the controlled drugs accountable officer in their area.

The ANP used Patient Group Directions (PGDs) to administer vaccines and other medicines that had been produced in line with legal requirements and national guidance. The ANP accessed these via their electronic systems to the CCG medicines management website to ensure they were current. The ANP said they had been informed by the CCG not to download the PGD information as this was regularly updated on-line. The practice had not put in place a signature and authorisation sheet for these PGDs. During the course of the inspection the ANP ensured these were completed, signed and appropriately authorised by the GP. We were not able to see evidence that the ANP had received appropriate training or been assessed as competent to administer the medicines referred to under a PGD from the prescriber as no records of staff training were held. The ANP said they would ensure their training records, including sight of any original training certificates, were maintained and a file held at the practice.

Staff informed us of a prescribing error which we case tracked. The prescriber prescribed in error a medicine for lowering blood pressure rather than an antibiotic. The patient had felt unwell and had returned to the practice, which was when the medicine error was noticed. The patient's medicine was promptly changed. Staff informed us this was reported to the administrator/practice manager but they had not taken responsibility themselves to document the incident. We found that this incident had not been documented or recorded as a medicines incident or significant event. The staff member recalled that the prescribing error had been dismissed as not having taken place, although the electronic systems evidenced that it had. We discussed the event with the GP. The GP told us they vaguely recalled something about it but acknowledged this had not been recorded as an incident or event. We found that incidents were not always logged efficiently or reviewed promptly to make sure appropriate actions were taken to minimise the chance of similar errors occurring again.

Cleanliness and infection control

We observed the premises to be clean and tidy. Cleaners were employed by the landlord at the health centre, who held the cleaning records. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, personal protective equipment such as disposable gloves were available for staff to use and staff were able to describe how they would use these to comply with the practice's infection control policy There was also a policy for needle stick injury and staff knew the procedure to follow in the event of an injury.

The practice had a lead for infection control who told us they had undertaken further training to enable them to

provide advice on the practice infection control policy and carry out staff training. The ANP told us all staff received infection control training specific to their role at induction. The ANP told us the last Infection and Prevention of Infection audit was completed by the community infection control team in November 2012. The practice demonstrated that any improvements identified for action were completed. The ANP assured us that they would conduct an audit in August 2015 and implement any improvements accordingly.

Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms. The staff toilet however had cleaning products subject to Control of Substances Hazardous to Health (COSHH) requirements on the floor. The floor covering was damaged and the sink plug hole area was a rust colour. The practice had a policy for the management, testing and investigation of legionella (a bacterium which can contaminate water systems in buildings) which lay with the building landlord, NHS estates.

Equipment

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

Staffing and recruitment

The practice did not have a recruitment policy that set out the standards it should follow when recruiting clinical and non-clinical staff. No staff personal files were kept. There was therefore no evidence to show that appropriate recruitment checks had been undertaken prior to employment. The practice had no systems in place to ensure staff maintained their registration with their appropriate professional body. The ANP told us they maintained their own indemnity insurance. There was no record kept of this at the practice and this system relied on the staff member providing this information. The administrator/practice manager said that the appropriate checks through the Disclosure and Barring Service had been completed for clinical staff but no records were maintained. (These 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). Staff said they did not have job descriptions.

We asked how the practice monitored if there were enough staff on duty to ensure patients were kept safe.There was an arrangement in place for members of administrative and reception staff to cover each other's annual leave. The GP partner ensured there was locum GP cover and covered the work of the ANP in the event of holidays. In the event of long term sickness/absence the GP told us they would arrange for a nurse to cover either from a local practice who they had an arrangement with or from an agency. The long term locum GP could not be present on the day of the inspection they wrote to the inspection team. This letter included that practice staff went out of their normal working patterns to help patients.

Staff said they did not have enough time to complete their delegated tasks. They told us they had discussed this with management but there had been no action taken. There were no records held at the practice of practice meetings, so this could not be verified. The ANP had reported that an additional HCA or nurse was needed to support them in the long term condition management and vaccination and immunisation programmes. The administrator/practice manager said their role included receptionist, administration and practice manager with insufficient time to complete tasks. The GP felt the practice was, if anything, overstaffed based on their observations.

Monitoring safety and responding to risk

The practice had some systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included regular checks of the practice environment, medicines management, staffing, dealing with emergencies and equipment. The practice did not have a health and safety policy. Health and safety information was not displayed for staff to see and there was no identified health and safety representative at the practice. The building was maintained by a landlord, NHS Property Services. Staff told us that this arrangement worked well and there were no problems with maintenance being carried out.

Inadequate

Are services safe?

The practice had a disaster recovery plan which was a plan of where to relocate to in the event of a disaster but no specifics, such as contact numbers for services and electronic systems support, risks associated with the service and staffing changes (both planned and unplanned), fire risk assessments and the safety of medical electrical equipment.

We saw that staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies. For example, there were emergency processes in place for patients with long-term conditions; referrals were made for patients whose health deteriorated suddenly and the practice monitored repeat prescribing for patients receiving medication for mental ill-health. Staff we spoke with told us that children were always provided with an on the day appointment if required.

Arrangements to deal with emergencies and major incidents

The practice had some arrangements in place to manage emergencies. Staff told us they had all received training in basic life support, however there were no records held regarding when this last took place and staff could not recall the training dates when asked. Emergency equipment was available including an automated external defibrillator (used in cardiac emergencies). However, we found that the expiry date on the practice's oxygen was 2010, and a valve was broken so it could not be operated. The ANP said that this had been reported and made attempts at contacting oxygen suppliers during the course of the inspection. When we asked members of staff, they all knew the location of the emergency equipment and records confirmed that it was checked regularly; however the date of the oxygen had clearly been missed. We checked and the pads for the automated external defibrillator were within their expiry date.

Emergency medicines were accessible to staff in a secure area of the practice and staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use. However, we found an absence of some medicines such as those used to treat suspected meningitis and seizures. The ANP told us that these had gone out of date and had not been replaced. There was no appropriate risk assessment in place to identify why they there was an absence of emergency medicines, or why they may not be suitable for the practice to stock.

The practice landlords carried out a fire risk assessment but the practice did not hold a copy which might include actions required to maintain fire safety. There were no staff records showing that that staff were up to date with fire training or that they practised regular fire drills. Some staff could not recall attending a fire drill and others said it had been more than two years.

Inadequate

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The Advanced Nurse Practitioner (ANP) was familiar with current best practice guidance. They accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from meetings with other practitioners through forums and local protected learning time events with the local Clinical Commissioning Groups. The ANP told us that NICE guidance could be downloaded from the website and disseminated to staff. They said that all clinical staff held their own responsibility for ensuring they remained up to date with best practice.

Informal clinical meetings were said to take place which were informal between the GP lead and the long term locum GP but minutes of these meetings were not available. We were told that during these meetings implications for the practice's performance and patients were identified and required actions agreed. For example, complex cases and palliative care patients. Through discussion we found that the GP was unaware of who received updates from NICE and that they were unaware for example of the latest NICE guidance in respect of blood thinning medicine prescribing in a specific a heart condition.. The GP said they maintained their clinical professional development through external courses and journals.

The ANP described how they carried out comprehensive assessments which covered all health needs and was in line with these national and local guidelines. They explained how care was planned to meet identified needs and how patients were reviewed at required intervals to ensure their treatment remained effective. For example, patients with diabetes were having regular health checks and were being referred to other services when required. Feedback from patients confirmed they were referred to other services or hospital when required.

The ANP told us that they had insufficient time to maintain the number of patient checks required as they were the only nurse at the practice. For example there were 218 patients at the practice with a diagnosis of diabetes. The percentage of patients with diabetes at the practice whose last specific blood test result was less than a specific level in the preceding 12 months was 59.79%. This was lower than the local CCG average of 77.72%. This measure demonstrated that some diabetic patients at the practice had higher blood sugar levels and their diabetes could be less well controlled. However, this was the only one out of the six indicators for diabetes within the Quality and Outcomes Framework data which was significantly lower than the national average, the remainder were similar to that expected. (QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). The GP informed us that many patients of Asian descent went out of the country for a period of time and potentially did not maintain compliance with their medicines which could impact on their blood results. However, we saw no evidence to support this and no audit had been completed. The ANP told us they worked closely with the diabetic nurse specialist in the management and monitoring of patients with diabetes. The nurse was able to demonstrate positive individual patient's results. For example, one patient who was on medicines for diabetes was now diet controlled and had made significant improvements to their weight with lifestyle changes, such as walking.

The practice used computerised tools to identify patients who were at high risk of admission to hospital. We saw that after patients were discharged from hospital they were followed up to ensure that all their needs were continuing to be met if clinically necessary.

Discrimination was avoided when making care and treatment decisions. Interviews with the GP and ANP showed that the culture in the practice was that patients were cared for and treated based on need and the practice took account of patients' age, gender, race and culture as appropriate.

Management, monitoring and improving outcomes for people

The practice did not use audits effectively to improve quality. On the day of our inspection the practice could not provide evidence that there was a formal system for clinical audit. We saw two audits that had been undertaken in the last 12 months, but the practice had not completed the audit cycle for either by carrying out a repeat of the audit to demonstrate the changes resulting since the initial audit.

We saw an example of where improvements had been made in referral practice by the GP following an audit of referrals made between January 2015 and March 2015. Each referral was assessed and a score made according to

whether the referral guidance as advised by the Telford Referral and Quality Service (TRAQS) had been followed. (TRAQS manage all GP referrals for a first outpatient consultant appointment with some noted exceptions). During this audit the GP found that the rejection of referrals responses had been fewer, which in turn led to quicker patient access to consultant appointments. The learning derived from the audit was to continue to use and refer to the referral guidance when completing referrals. There was no evidence that this audit had been shared with other clinical staff at the practice.

Information about patients' care and treatment, and their outcomes, was routinely collected and monitored and this information used to improve care. Staff across the practice had roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, and managing child protection alerts and medicines management. The information staff collected was then collated by the administrator/practice manager and to support the practice in identifying areas of good practice and any areas for improvement. We found for example that the practice had achieved comparable results and in some cases higher uptakes in their childhood immunisation programme.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. There were four areas which had resulted in lower outcome percentages than the national average. For example, the percentage of women aged 25-64 whose notes record that a cervical screening test had been performed in the preceding 5 years was 69.97% which was lower than the national average of 81.88%. The practice were aware of the results and had focused on implementing improvements. For example, they had approached the local mosque to see whether health promotion may be best considered in the community. They had carried out an audit to identify whether it would be beneficial for ethnic minority patients to have access to an Asian link-worker to provide screening and education regarding chronic disease management in the community. The outcome from this survey was that all those surveyed felt they would benefit from a link-worker. The GP suggested they had reported their findings to the local CCG for consideration however we saw no outcome from this action. Both the clinical and non-clinical staff were aware of the practice audit on the benefits of an Asian link-worker.

We saw that only 25% of patients with dementia had been reviewed in a face-to-face review in the preceding 12 months, compared with the national average of 83.82%. The ANP was unsure of why the figure was so low when the records also demonstrated that 100% of these patients had received routine blood tests. The practice had seven patients living with dementia. The practice used a screening tool for cognitive impairment designed for the primary care setting and referred patients to attend a memory clinic. The ANP was unaware of these figures which suggested that best use was not being made of the clinical audit tools available and that the informal clinical meetings to assess the performance of clinical staff were ineffective. Clinical coding (the translation of medical terminology as written by the GP to describe a patient's complaint, problem, diagnosis, treatment or reason for seeking medical attention, into a coded format which is nationally recognised) and data quality from clinical narratives (a first person history written by a GP that describes a specific clinical event or situation) was also thought to be impacting on the practice QOF results.

The practice's prescribing rates were similar to national figures. Staff regularly checked patients receiving repeat prescriptions had been reviewed by the GP. They also checked all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines.

We saw there was a system in place that identified patients at the end of their life and staff at the practice told us that there were two patients on the palliative care register. The ANP said they completed joint home visits with the Macmillan nursing team. There were alerts within the clinical computer system making clinical staff aware of their additional needs.

The practice also kept a register of patients identified as being at high risk of admission to hospital and of those in various vulnerable groups such as learning disabilities. The practice were aware of the patients with a learning disability who were registered with the practice and that six of the 17 patients resided at two local care homes. Structured annual reviews were also undertaken for patients with long term conditions.

Inadequate

Are services effective?

(for example, treatment is effective)

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. There were no centrally held practice training records to review. The administrator/practice manager told us all staff were up to date with attending mandatory courses such as annual basic life support. The practice had an undated induction policy in place for staff. This noted the staff confidentiality policy which was signed by staff. It also mentioned the practice health and safety policy, but there was no health and safety policy in place.

The GP told us they were up to date with their yearly continuing professional development requirements and had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England). No records where seen of the long term locum GPs training as no staff files were held. Staff said they attended the practice learning time events held with the local CCG, the ANP attended various peer group events.

The administrator/practice manager told us staff received appraisals. There was no documented evidence of appraisals seen for staff. Staff could not recall their last appraisal. Staff told us that should they require or request training, this was agreed by the GP. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses, for example the management of long term conditions and basic life support. However, we found for example that staff had not received chaperone training, some staff could not recall their adult safeguard training and not all staff could recall when they last attended fire safety awareness training. Records had not been kept of staff training.

There was no evidence of staff job descriptions which would outline their roles and responsibilities. The ANP told us they would forward their training details following the inspection to evidence their training and updates to demonstrate that they had appropriate training to fulfil their roles.

The administrator/practice manager had been working on the practice staff handbook which was nearing completion. The administrator/practice manager told us that should poor staff performance be identified that appropriate action would be taken to manage this.

Working with colleagues and other services

The practice had good working arrangements with other health and social care providers, to co-ordinate care and meet people's needs. Correspondence from other services such as test results and letters from hospitals were received either electronically or via the post. All correspondence was scanned and passed to the GP. We saw the practice computer system was used effectively to log and progress any necessary actions. The GP who saw these documents and results was responsible for the action required. The practice told us there were no instances identified within the last year of any results or discharge summaries that were not followed up.

The number of emergency hospital admissions for 19 ambulatory care sensitive conditions per 1,000 head of population between April 2013 and March 2014 was 17.79% which was slightly higher than the national average of 14.4%.

We spoke with the registered managers at two local learning disability care homes. They praised the practice and said they found the staff to be helpful in arranging patient appointments to minimise stress. They also said patients gained prompt access to appointments on the same day. Staff had a good rapport with patients in the care homes. The relationships and communication between the services was said to be exceptionally good.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. We saw evidence there was a system for sharing appropriate information for patients with complex needs with the ambulance and out-of-hours services. For patients who were referred to hospital in an emergency there was a policy of providing a printed copy of a summary record for the patient to take with them to Accident and Emergency.

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record to coordinate, document and manage patients' care. All staff were fully trained on the system. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference. The practice held regular minuted meetings with

the Health Visitor to discuss any children at risk including patients who did not attend for their vaccination and immunisations. We saw minutes of the last meeting held in May 2015.

Consent to care and treatment

We found that clinical staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it. For some specific scenarios where capacity to make decisions was an issue for a patient, the practice had awareness of how patients should be supported to make their own decisions and how these should be documented in the medical notes. This included do not attempt resuscitation orders.

Some patients with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision. All clinical staff demonstrated a clear understanding of the Gillick competency test. (These are used to help assess whether a child under the age of 16 has the maturity to make their own decisions and to understand the implications of those decisions).

The GP told us the practice did not have a formal written consent policy but that it was practice policy to document consent for specific interventions. For example, for all minor surgical procedures, a patient's written consent was documented and scanned into the electronic patient notes with a record of the discussion about the relevant risks, benefits and possible complications of the procedure. Staff spoken with were clear about when to obtain written consent.

The practice had not needed to use restraint, but staff were aware of the distinction between lawful and unlawful restraint.

Health promotion and prevention

It was practice policy to offer a health check to all new patients registering with the practice. The GP was informed of any health concerns detected and these were followed up in a timely way. We noted a culture among the GPs and ANP to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering opportunistic health screening and offering smoking cessation advice to smokers.

The practice also offered NHS Health Checks to all its patients aged 40 to 75 years. Of the patients eligible the practice to April 2015 had achieved a 36% uptake. The practice had many ways of identifying patients who needed additional support, and it was pro-active in offering additional help. Similar mechanisms of identifying 'at risk' groups were used for patients who were obese and those receiving end of life care. These groups were offered further support in line with their needs. The ANP recorded any referrals for exercise to a gym and in the last 12 months ten patients had been referred. The practice had yet to audit the findings from the referrals made. Referrals were also made to health trainers via the Healthy Lifestyle Hub. This serves as a single point of access to a range of health promotion and lifestyle change programmes designed to improve the health and well-being of the residents of Telford and Wrekin.

The practice offered blood taking on-site along with electrocardiogram (ECG) testing, (this records the electrical activity of the heart to detect abnormal rhythms and the cause of chest pain). The practice had a higher population group of Asian descent but we saw very little literature in languages to support these patients.

The practice's performance for the cervical screening programme was 69.97%, which was below the national average of 81.88%. There was a policy to offer telephone reminders for patients who did not attend for their cervical screening test. The ANP had responsibility for following up patients who did not attend. The ANP said the results where reflective of the need for an Asian ethnic minority link worker to support health education and promotion of health screening in the local community. The practice also encouraged its patients to attend national screening programmes for bowel cancer and breast cancer screening.

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

Inadequate

Are services effective?

(for example, treatment is effective)

• Flu vaccination rates for patients aged over 6 months to under 65 years in the clinical risk groups was 80.3% which was higher than the national average of 73.24%.

• Childhood immunisation rates for the vaccinations given to under twos ranged from 81.1% to 100% and five year olds from 88.1% to 100%. The majority were in line with the local CCG averages.

Requires improvement

Are services caring?

Our findings

Respect, dignity, compassion and empathy

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

The evidence from all these sources showed the majority of patients were satisfied with how they were treated and that this was with compassion, dignity and respect. However some figures were below the local CCG and national averages. For example:

• 69% said the GP was good at listening to them compared to the CCG average of 87% and national average of 89%.

• 68% said the GP gave them enough time compared to the CCG average of 86% and national average of 87%.

• 91% said they had confidence and trust in the last GP they saw compared to the CCG average of 94% and national average of 95%.

• 94% said they had confidence and trust in the last nurse they compared to the CCG average of 97% and national average of 97%.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 39 completed cards and all were extremely positive about the service experienced. Patients said they felt the practice offered a good or excellent service and staff were friendly, helpful and caring. They said staff treated them with dignity and respect. We also spoke with six patients. All said the care provided by the practice was good and that their dignity and privacy was always respected.

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

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. The position of the open reception desk within the waiting room made it difficult for confidential conversations to take place. Reception staff were aware of the difficulties. Systems were in place to maintain patient's confidentiality. These included taking patients to a private room to continue a private conversation and of transferring confidential telephone calls to a private room if a person rang the practice for investigation results. The national GP survey published in July 2015 found that 91% of respondents found the receptionists at the practice helpful which was higher than both the local CCG average and national average of 87%.

Staff told us that if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected, they would raise these with the GP or administrator/practice manager. The administrator/practice manager told us she would investigate these and any learning or training identified would be shared with staff. Patients could access the practice without fear of stigma or prejudice. The inspection team found that staff would benefit from equality and diversity training based on some of the stereotypical comments raised during the inspection.

Care planning and involvement in decisions about care and treatment

The national GP patient survey information we reviewed showed how patients had responded to questions about their involvement in planning and making decisions about their care and treatment. For example:

• 55% said the last GP they saw was good at explaining tests and treatments, which was lower than the CCG average of 84% and national average of 86%.

• 62% said the last GP they saw was good at involving them in decisions about their care which was lower than the CCG average of 79% and national average of 81%.

When we asked about these findings the administrator/ practice manager told us she had been unaware of this particular survey. The GP had completed on audit on their personal feedback from patient and colleagues feedback in June 2015. These reflections include reviewing communication skills.

Patients told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision

about the choice of treatment they wished to receive. Patient feedback on the comment cards we received were also positive and aligned with these views, with the exception of two patients who had remarked on a GPs lack of bedside manner, and two patients felt they were not always listened to.

Staff at two local learning disability care homes said staff a good rapport with patients as they were known to each other and patients with capacity had requested and chosen to stay with practice. The relationships and communication between the services was said to be exceptionally good and staff were found to have awareness of patient's capacity in decision making and consent.

Staff told us that on-line translation services were available for patients who did not have English as a first language.

Patient/carer support to cope emotionally with care and treatment

The patient survey information we reviewed showed patients were positive about the emotional support provided by the practice nurse; however the results for the GP were lower than the local CCG and national average. For example:

• 57% said the last GP they spoke to was good at treating them with care and concern which was lower than the local CCG average of 83% and national average of 85%.

• 93% said the last nurse they spoke to was good at treating them with care and concern which was higher than both the local CCG and the national average of 90%.

The patients we spoke with on the day of our inspection and the 39 comment cards we received were not consistent with the survey information. The vast majority of the comment card respondents highlighted that staff, including the GP, were friendly and kind, and provided support when required.

Notices in the lobby area of the patient waiting room 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. Although staff noted that the system was reliant on patients and their carer's informing the practice of this information. There was specific information on the noticeboard for patients and carers in the waiting room.

Staff told us that if families had suffered bereavement, they contacted the practice and the GP would call them, and this would be 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. We spoke with the registered managers at two local learning disability care homes. They praised the practice and found the staff to be helpful in the arrangements of appointments to minimise stress. They also said patients gained prompt access to appointments on the same day.

The practice communicated with the care coordinator in respect of specific patients with long term conditions or complex needs. The introduction of care co-ordinators was a CCG initiative, based on providing as much support through community settings, such as is possible to enable patients to live independently for longer.

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

Patients who were aged over 75 had a named GP. The practice had a palliative care register and engaged in multidisciplinary discussions to discuss patients and their families' care and support needs. The practice worked collaboratively with other agencies and regularly shared information to ensure communication of changes in care and treatment.

The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered. The GP and nursing team fitted in urgent patient appointments during their day and took time with patients to deliver health promotion and advice. The long term locum GP at the practice had written to the inspection team and said the practice was a local, family friendly practice, focused on meeting patients' needs. Patients who were carers were identified on their medical records so that the practice could identify them to be aware of their support needs. The practice had some care plans in place for patients experiencing poor mental health.

The practice did not have a patient participation group (PPG). A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care. The administrator/practice manager told us they had found difficulty in gaining interest from their registered patients. We didn't see any posters advertising for PPG membership in the waiting room. The two learning disability care homes the practice visited told us that staff provided a responsive service above their expectations.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example, longer appointment times were available for patients with learning disabilities and at times when the practice was least busy to reduce patient stress. The practice provided telephone consultations in the afternoon and morning which assisted in patient access for some patients. The practice had higher than the national average proportion of patients aged 18 years and younger (46.3%). The practice average across England was 32.2%. There were male and female GPs in the practice; therefore patients could choose to see a male or female doctor. Fifty-three per cent of the registered patients were of Asian descent. Staff were aware of the registered population groups and one staff member could speak three languages Urdu, Hindi and Punjabi as well as English. The GP carried out an audit to identify whether it would be beneficial for ethnic minority patients to have access to an Asian link-worker to provide screening and education regarding chronic disease management in the community. The outcome from this patients and healthcare professional survey was that all those surveyed felt the local community would benefit from an Asian link-worker. The GP recommendations included approaching the local CCG to consider these findings and to reaudit within a six to 12 month period dependant on the outcomes of the proposal presented to the CCG.

The practice actively supported patients who had been on long-term sick leave to return to work by referring them to other services such as physiotherapists, counselling services and by providing 'fit notes' for a phased or adapted return to work.

Staff accessed translation services for patients requiring interpreter services when they were needed. Staff were aware of when a patient may require an advocate to support them and there was information on advocacy services available for patients.

The practice premises where all situated on the ground floor. The waiting area was able to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients. Facilities for patients with mobility difficulties included designated car parking spaces and appropriately adapted toilet facilities, baby change facilities were also available. A hearing loop for patients with a hearing impairment was available.

Staff told us that they did not have any patients who were of "no fixed abode" but would see someone if they came to the practice asking to be seen and would register the patient so they could access services. There was a system for flagging vulnerability in individual patient records.

Access to the service

The surgery was open from 8.30am to 6pm Monday to Friday. During the period between 8am and 8.30am when the out-of-hours service is transferred to the practice calls are directed through to the GP. Comprehensive information was available to patients about appointments in the practice literature. The practice did not have a website. This

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

literature included how to arrange urgent appointments and home visits and how to book appointments. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients.

Longer appointments were also available for older patients, those experiencing poor mental health, patients with learning disabilities and those with long-term conditions. This also included appointments with a named GP or nurse. Home visits were made to patients if necessary.

The patient survey information we reviewed showed patients responded positively to some but not all questions about access to appointments and the majority of patients surveyed rated the practice well in these areas. For example:

• 68% were satisfied with the practice's opening hours, which was lower than the local CCG average of 76% and national average of 75%.

• 74% described their experience of making an appointment as good which was higher than the local CCG average of 71% and national average of 73%.

• 62% said they usually waited 15 minutes or less after their appointment time when compared with the local CCG average of 68% and national average of 65%.

• 80% said they could get through easily to the surgery by phone which was higher than the local CCG average of 71% and national average of 73%.

Patients we spoke with were extremely satisfied with the appointments system and said it was easy to use. The patient views in the 39 CQC comments cards we received aligned with these views. They confirmed that they could see a GP on the same day if they felt their need was urgent, although this might not be their GP of choice. They also said they could see another GP if there was a wait to see the GP of their choice. Routine appointments were available for booking in advance. Appointments were available outside of school hours for children and young people. Patients could book appointments in person or via telephone for GP appointments, Advanced Nurse Practitioner (ANP) appointments and for telephone consultations. The practice offered support to enable patients to return to work.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. There was information in the practice literature and a poster in the waiting room which informed patients about how to complain. Information about how to complain was easy to understand and evidence showed that the practice responded quickly to issues raised. We looked at complaints the practice had received for the period September to November 2014. There were few complaints recorded and notes about some complaints within the file were incomplete as they had been referred to professional bodies and the outcome was not recorded. Staff told us that not all verbal complaints were documented as there was not enough time to do this and they were immediately acted upon. Written complaints had been acknowledged and answered by the practice.

The administer/practice manager told us that the staff were spoken with on a one to one basis should a complaint be raised. The complaint would be acknowledged, investigated and reported on and where appropriate a letter of apology to the patient would be sent.

Are services well-led?

Inadequate

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

Our findings

Vision and strategy

The practice did not have a vision or strategy for the future. There was no business development plan or business development meetings. There was a lack of evidence of long term strategic review and the practice was working on a day to day basis with no planning ahead. The practice recognised areas in which they needed to improve. They told us that these were improving the use of their IT systems, areas within the QOF, policies and procedures and staff recruitment records.

Governance arrangements

There was a lack of effective governance arrangements. There were few policies and procedures in place and these were not always up dated. The staff were aware there was a disaster recovery plan. The practice did not have a business continuity plan. There were risks to the health and safety of patients and staff which had not been assessed. We saw a limited system of clinical audit.

There was a leadership structure with named members of staff in lead roles. For example, there was a lead GP for safeguarding, and the Advanced Nurse Practitioner (ANP) was the lead for infection control. However, staff told us they approached the ANP or the administrator/practice manager regarding most aspects of the day to day running of the practice. We found that the practice management function was not fully exercised or well developed.

There was an absence of a number of policies and procedures in place to govern activity within the practice. For example, there was no adult safeguarding policy, health and safety policy or recruitment policy. Some of the policies in place had not been recently reviewed or updated. For example, the chaperone policy had not been updated since 2004. There was no documented evidence to show that staff had read the policies.

Some staff said they did not feel valued or well supported. The administrator/practice manager was responsible for overseeing that the systems in place to monitor the quality of the service were being consistently used and were effective. This included using the Quality and Outcomes Framework to measure its performance (QOF is a voluntary incentive scheme which financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). The practice could not demonstrate that its QOF data was formally discussed on a regular basis. There was no awareness of the QOF dementia care plan and mental health care plan figures. There were no minutes of meetings other than notes which had not been transcribed from the administrator/practice manager notebook. There had been no action plans produced to maintain or improve patient outcomes.

There had been no recent infection and prevention control audit, there were no staff recruitment records, no systems to verify staff registration with their appropriate professional bodies, no staff training records, a lack of some staff training including chaperone training, no completed clinical audits, and no formal staff meetings.. Although checks of medicines where in place we found that the oxygen was out of date (2010) and had a broken area on the value so could not be used in the event of an emergency. There were no governance meetings held. The practice did not have a formalised workforce succession plan in place.

The administrator/practice manager had been working on a staff handbook which was to be available to all staff, which included sections on equality and harassment and bullying at work. There was no whistleblowing policy in place.

Leadership, openness and transparency

Staff told us that the GPs were approachable, focused on patients first and were less concerned about policies and processes. Staff reported that they had approached management about the sufficiency of staffing but that no action had been taken. Staff said they could put forward ideas on how to improve the practice for patients, but did not receive feedback. Some staff found the administrator/practice manager less approachable when suggesting ideas.

Staff gave varying views on the practice culture of openness. For example one felt it was not an open culture, another that they were listened to but preferred to go to a different staff member and two others felt they could openly discuss their concerns or views but all said they felt respected and valued.

Practice seeks and acts on feedback from its patients, the public and staff

Staff did not feel engaged in the planning and delivery of services. The practice said it encouraged and valued

Are services well-led?

Inadequate

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

feedback from patients. It had gathered feedback from patients through surveys including the National GP survey, an in house-suggestion box and from complaints or compliments received. We saw evidence that the GP had reviewed the practice results from the national GP survey to see if there were any areas that needed addressing. The administrator/practice manager was unaware of the National GP survey or the practice results.

The administrator/practice manager said no formal meeting were held other than with the health visitor. There were no whole staff meetings. The only time the whole staff team got together was when staff attended the practice learning time half day training events run by the CCG. Some staff could not recall when they had last had an appraisal. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training. We did not see any documented evidence of staff appraisals or personal development plans. Staff however, told us that the practice was very supportive of training. There was little innovation or service development. There was some evidence of learning and reflective practice, as discussed with staff for example, audits on whether an Asian link- worker would be of benefit to the practice and community, changes in disease modifying medicine repeat prescribing. Evidence of training could not be provided and some training had not been carried out. Staff did not always receive feedback on the significant events process or receive any learning as a result of the incidents they reported.

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 Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The oxygen cylinder displayed an expiry date of 2010 and had a broken area on the oxygen regulator value device so could not be used in the event of an emergency. An absence of some emergency medicines such as those used to treat suspected meningitis and seizures. No appropriate risk assessment to identify why they there was an absence of emergency medicines, or why they are not suitable for the practice to stock. A lack of an Infection Prevention and Control audit since 2012. **Regulation 12 (1) (2) (a) (b) (c) (e) (f) & (h)**

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 Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance A lack of recruitment arrangements and policy including all necessary employment checks for all staff. No evidence held of any staff DBS checks completed. No systems for checking staff registration with their professional bodies. No formal consent policy in place but evidence that consent both written and verbal was gained. A lack of robust systems to ensure all clinicians are kept up to date with national guidance and guidelines. A GP was not aware of the latest NICE Atrial Fibrillation, anticoagulation prescribing guidance. A lack of second cycle clinical audits of practice No appropriate trained individual responsible for the practices health and safety and they needed to devise a health and safety policy. All products subject to Control of Substances Hazardous to Health (COSHH) requirements to be stored appropriately which includes the staff toilet used by patients after 5pm. No copy of the fire risk assessment; no evidence held of staff fire awareness training and staff had not attended regular fire drills-some staff could not recall ever attending a fire drill. No accident book to comply with health and safety legislation. The practice disaster recovery plan, which was a plan of where to relocate to in the event of a disaster, did not deal with the range of emergencies that may impact on the daily operation of the practice. It held no specific contact numbers for example for services and IT support.

This section is primarily information for the provider

Enforcement actions

A lack of formal governance arrangements in place including systems for assessing and monitoring risks and the quality of the service provision.

A lack of appropriate policies and guidance to carry out their roles in a safe and effective manner which are reflective of the requirements of the practice.

A need to ensure there is leadership capacity to deliver all improvements.

Poor record management in that the practice had lost their significant events/incident reports from previous years.

No practice website to improve patient access to information regarding the service it provides.

No patient participation group to assist the practice in gaining meaningful patient feedback.

Two significant events/incidents were said to have been reported but had not been recorded or acted upon. Staff had not taken individual responsibility for recording first-hand the significant event. Staff was not aware of their own responsibilities for both reporting and recording significant events. Significant events records were not complete and the practice had not investigated, mitigated risks or provided any shared learning regarding these incidents.

25%- The percentage of patients diagnosed with dementia whose care has been reviewed in a face-to-face review in the preceding 12 months. (Seven patients at the practice). When compared to the national average of 83.82% between 01/04/2013 and 31/03/2014. The practice electronic systems on 10 July 2015 also demonstrated that 25% of patients had been reviewed in a face-to-face review in the preceding 12 months.

17.39% -The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive, agreed care plan documented in the record, in the preceding 12 months compared to national average 86.04%. (33 mental health patients at the practice).

This section is primarily information for the provider

Enforcement actions

The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 64 mmol/mol or less in the preceding 12 months, was 59.79% when compared with the national average of 77.72% between 01/04/2013 and 31/03/2014.

The percentage of women aged 25-64 whose notes record that a cervical screening test has been performed in the preceding 5 years was 69.97% when compared to the national average of 81.88%.

Regulation 17 (1) (2) (b) (d) (e) (f)

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing A review of staffing sufficiency was needed to ensure there are sufficient numbers of suitably qualified skilled and experienced staff. As staff found they were unable to complete the roles fully in their normal working time. No records available of staff appraisals. Staff gave differing time frames as they could not recall the date of their last appraisal, ranging from 2 to three years. The practice held insufficient evidence of staff qualifications and skills to be assured that they worked within their scope of practice. No evidence held by the practice of staff qualifications skills or experience, recent training and refresher training to enable to undertake the role for which they were employed. No management oversight of the training staff had completed or training planner in place with records of staff qualifications or recent training dates or a record of when staff refresher training was due to take place. Staff had not attended chaperone training. A lack of equality and diversity training for all staff. A lack of whole staff meetings, clinical, management and governance meetings which are minuted. No member of staff we spoke with felt fully supported by their employer, although all were loyal to the practice and the patients.

This section is primarily information for the provider

Enforcement actions

Regulation 18 (1) (2) (a) (c)