Limefield and Cherry Tree Surgeries

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Limefield and Cherry Tree Surgeries on 7 October 2016. Overall the practice is rated as inadequate.

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 actions identified to address concerns with infection control practice had not been taken.
- There was not a systematic approach to assessing and managing risks. For example, a fire risk assessment was not available. Where risks had been identified, appropriate mitigating action had not been completed.
- While we saw that significant events were analysed and some actions identified to reduce the possibility of the events being repeated, we found that the analysis undertaken was not always thorough so learning was not maximised.
- The governance arrangements within the practice were insufficient. Many policies were overdue a review and not all were detailed enough to adequately describe the activity to which they related.
- There was a lack of managerial oversight around staff training and training needs. Evidence that all staff had received training in safeguarding patients from abuse was not available.
- Many staff had not had an appraisal for over a year.
- There was limited evidence that audit was driving improvement in patient outcomes.
- Patients were positive about their interactions with staff during face to face consultations and said they were treated with compassion and dignity.

Summary of findings

- Some patients expressed frustration with the practice's appointment system. They told us they found telephone triage appointments impersonal.
- Staff told us they felt supported by the GP and management staff.

The areas where the provider must make improvements are:

- Implement effective processes for reporting, recording, acting on and monitoring significant events, incidents and near misses.
- Ensure regular infection prevention and control audits are completed.
- Ensure recruitment arrangements include all necessary employment checks for all staff.
- Carry out quality improvement initiatives which may include clinical audits, and re-audits, to ensure improvements to care and treatment have been achieved and sustained.
- Implement formal governance arrangements including systems for assessing and monitoring risks and the quality of the service provision. Once identified, take appropriate mitigating action to manage risks.
- Ensure appropriate policies and procedures are available to staff which reflect current guidance and the activities undertaken at the practice.
- Improve the management and monitoring of staff training so that all staff are trained to ensure they have the skills and qualifications to carry out their roles.
- The practice's own complaints process should be followed when managing patient's complaints.

The areas where the provider should make improvement are:

- Re-establish links with the patient participation group in order to gain feedback from a cohort of patients who are keen to support the practice.
- Continue efforts to identify patients who have caring responsibilities, and utilise alerts on the patient record system in order to maximise their access to appropriate care and support.

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

The service will be kept under review and if needed could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service by adopting our proposal to remove this location or cancel the provider's registration.

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

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Inadequate

The practice is rated as inadequate for providing safe services and improvements must be made.

- Although the practice carried out investigations when there were unintended or unexpected safety incidents, these were not always thorough, meaning that learning opportunities were not maximised and there was a risk of the incidents being repeated.
- Patients were at risk of harm because systems and processes were not in place in a way to keep them safe. For example, the practice did not hold an oxygen cylinder on the premises for use in medical emergencies at the time of inspection.
- There was not a systematic approach to assessing and managing risk. The practice had not carried out suitable remedial action when electrical safety inspections had identified risks, and risk assessments relating to fire and legionella were not available.
- There were gaps in staff in training in areas such as safeguarding and infection prevention and control.
- An infection prevention and control audit had not been carried out since October 2014.
- Recruitment processes were not comprehensive, leading to gaps in pre-employment checks being completed prior to staff commencing work.

Are services effective?

Requires improvement

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

- Data showed patient outcomes were lower than average in some clinical areas. For example, performance for diabetes related indicators was lower than the local and national averages by at least 5% or more.
- Clinicians referenced national guidelines to ensure care was in keeping with best practice.
- There was limited evidence that audit was driving improvement in patient outcomes; we were shown only one example of a completed two-cycle audit, where four years had elapsed between cycles.

Summary of findings

- Multidisciplinary working was taking place to ensure patients received appropriate care. For example, multidisciplinary team meetings were held on a monthly basis to ensure the needs of patients with complex needs were being met.
- There was a lack of managerial oversight around staff training needs. Only three staff had received an appraisal in the previous year and we were not shown evidence of the role specific training undertaken by the health care assistant.

Are services caring?

Good

The practice is rated as good for providing caring services.

- Data from the national GP patient survey showed patients rated the practice higher than others for several aspects of care.
- Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment during face-to-face consultations.
- Information for patients about the services available was easy to understand and accessible.
- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.
- The practice had identified 67 patients who were also carers, but had not made use of alerts on the computer system to ensure staff were aware of this and so maximise the chances of them being offered the care they needed.

Are services responsive to people's needs?

Requires improvement

The practice is rated as good for providing responsive services.

- Practice staff reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group to secure improvements to services where these were identified. For example, the practice was in the process of attempting to secure funding for new premises.
- The GPs told us how they had updated the appointment system approximately 12 months ago to incorporate more telephone appointments. They told us that patients had offered them verbal feedback to confirm its success. However, evidence of this feedback had not been documented or formally recorded by the practice. Some patients we spoke to told us they did not always find it easy to make an appointment with a named GP.
- The practice had good facilities and was well equipped to treat patients and meet their needs.

Summary of findings

- Information about how to complain was available and easy to understand, however the practice did not consistently follow its own complaints procedure when offering a response. We saw that the practice offered an appropriate apology when something had gone wrong.
- It was not clear how learning from complaints was shared with staff in order to maximise learning outcomes.

Are services well-led?

Inadequate

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

- The practice displayed a clear vision and strategy in the waiting areas and on the practice website.
- The practice had a number of policies and procedures to govern activity, but many of these we reviewed were overdue a review or did not reflect actual practice procedures.
- The practice had recently reintroduced a meeting structure in an effort to formalise information flow within the organisation.
- The practice had not proactively sought feedback from patients. Members of the patient participation group informed us that the group was not active at the time of inspection and communication channels with the practice had deteriorated over the previous 12 months.
- One of the GPs had sought staff feedback on their leadership qualities as part of a 360 degree appraisal process in August 2016.
- There was no evidence that staff received regular performance reviews and so they did not have clear objectives.
- There was no evidence of systematic risk management in place and we found numerous risks which had not been mitigated, such as those relating to the safety of the building's electrical installation and the practice's capability to manage medical emergencies.
- There was a lack of managerial oversight around coordinating training and following appropriate recruitment processes which had resulted in gaps in these areas.

Summary of findings

The six population groups and what we found

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

Older people

Inadequate

The provider was rated as inadequate for safety and for well-led and requires improvement for being effective and responsive. The issues identified as requiring improvement overall affected all patients including this population group. However:

- The practice offered proactive, personalised care to meet the needs of the older people in its population.
- The practice was responsive to the needs of older people, and offered home visits and urgent appointments for those with enhanced needs.
- Regular multidisciplinary meetings were held to discuss patients nearing the end of life in order to ensure their needs were being met.

People with long term conditions

Inadequate

The provider was rated as inadequate for safety and for well-led and requires improvement for being effective and responsive. The issues identified as requiring improvement overall affected all patients including this population group.

- The practice's performance on diabetes related indicators was lower than local and national averages.

However:

- Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority.
- Longer appointments and home visits were available when needed.
- All these patients had a named GP and a structured annual review to check their health and medicines needs were being met. For those patients with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.
- Annual review appointments were offered in the month of patient's birth in order to make them more memorable and to maximise attendance.

Summary of findings

Families, children and young people

Inadequate

The provider was rated as inadequate for safety and for well-led and requires improvement for being effective and responsive. The issues identified as requiring improvement overall affected all patients including this population group. However:

- The practice identified and followed 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.
- The practice's uptake for the cervical screening programme was 83%, which was comparable to the CCG average of 80% and the national average of 82%.
- Appointments were available outside of school hours and the premises were suitable for children and babies.
- We saw positive examples of joint working with midwives, health visitors and school nurses.

Working age people (including those recently retired and students)

Inadequate

The provider was rated as inadequate for safety and for well-led and requires improvement for being effective and responsive. The issues identified as requiring improvement overall affected all patients including this population group. However:

- The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care.
- The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group.
- Telephone consultations were available, allowing patients to access health advice without attending the practice in person.

People whose circumstances may make them vulnerable

Inadequate

The provider was rated as inadequate for safety and for well-led and requires improvement for being effective and responsive. The issues identified as requiring improvement overall affected all patients including this population group. However:

Summary of findings

- The practice held a register of patients living in vulnerable circumstances including those with a learning disability.
- The practice offered longer appointments for patients with a learning disability.
- The practice regularly worked with other health care professionals in the case management of vulnerable patients.
- The practice informed vulnerable patients about how to access various support groups and voluntary organisations.
- Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

People experiencing poor mental health (including people with dementia)

Inadequate

The provider was rated as inadequate for safety and for well-led and requires improvement for being effective and responsive. The issues identified as requiring improvement overall affected all patients including this population group. However:

- The percentage of patients diagnosed with dementia whose care had been reviewed in a face to face review in the preceding 12 months was 94% compared to the CCG average of 87% and national average of 84%.
- The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those with dementia.
- The practice carried out advance care planning for patients with dementia.
- The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations.
- The practice had a system in place to follow up patients who had attended accident and emergency where they may have been experiencing poor mental health.
- Staff had a good understanding of how to support patients with mental health needs and dementia.

Summary of findings

What people who use the service say

The national GP patient survey results were published in July 2016. The results showed the practice performance was variable when compared with national averages. A total of 249 survey forms were distributed and 111 were returned. This represented a response rate of 44.6% and 2.5% of the practice's patient list.

- 67% of patients found it easy to get through to this practice by phone compared to the national average of 73%.
- 64% of patients were able to get an appointment to see or speak to someone the last time they tried compared to the national average of 76%.
- 89% of patients described the overall experience of this GP practice as good compared to the national average of 85%.
- 85% of patients said they would recommend this GP practice to someone who has just moved to the local area compared to the national average of 80%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection.

We received nine comment cards which were all positive about the standard of care received. Many identified clinical staff by name to praise the care and treatment offered, and described an individualised and holistic approach to meeting patient's needs. However, as well as making positive comments about the practice, three of the cards also raised some concerns and expressed dissatisfaction around the speed at which an appointment could be obtained and the appointment system in general, with one patient describing it as stressful. Another patient told us how they were not happy that telephone triage consultations carried out by the GPs preceded any face to face contact with a GP.

We spoke with two patients on the telephone shortly following the inspection. Both patients said they were satisfied with the care they received and thought staff were approachable, committed and caring. However, some concerns were also raised around the telephone triage appointment system, difficulties getting a face to face appointment, and inconsistent communication from the practice when receiving feedback from test results.

Areas for improvement

Action the service MUST take to improve

The areas where the provider must make improvements are:

- Implement effective processes for reporting, recording, acting on and monitoring significant events, incidents and near misses.
- Ensure regular infection prevention and control audits are completed.
- Ensure recruitment arrangements include all necessary employment checks for all staff.
- Carry out quality improvement initiatives which may include clinical audits, and re-audits, to ensure improvements to care and treatment have been achieved and sustained.
- Implement formal governance arrangements including systems for assessing and monitoring risks and the quality of the service provision. Once identified, take appropriate mitigating action to manage risks.
- Ensure appropriate policies and procedures are available to staff which reflect current guidance and the activities undertaken at the practice.
- Improve the management and monitoring of staff training so that all staff are trained to ensure they have the skills and qualifications to carry out their roles.
- The practice's own complaints process should be followed when managing patient's complaints.

Summary of findings

Action the service SHOULD take to improve

The areas where the provider should make improvement are:

- Re-establish links with the patient participation group in order to gain feedback from a cohort of patients who are keen to support the practice.
- Continue efforts to identify patients who have caring responsibilities, and utilise alerts on the patient record system in order to maximise their access to appropriate care and support.

Limefield and Cherry Tree Surgeries

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector**.** The team also included a GP specialist adviser.

Background to Limefield and Cherry Tree Surgeries

Limefield and Cherry Tree Surgeries is a GP practice registered with CQC under a partnership of Drs Burn and Brown. It is a single location registered at the main site (Limefield Surgery, 295 Preston New Road, Blackburn) with a branch surgery (Cherry Tree Surgery, 513 Preston Old Road, Blackburn). The practice occupies two converted and refurbished residential properties on the outskirts of Blackburn. This inspection visited the main site, Limefield Surgery only.

The practice delivers primary medical services to a list size of 4345 patients under a general medical services (GMS) contract with NHS England, and is part of the NHS Blackburn with Darwen Clinical Commissioning Group.

The average life expectancy of the practice population is above the local average and slightly below the national average (82 years for females, compared to the local average of 80 and national average of 83 years, 78 years for males, compared to the local average of 76 and national average of 79 years).

The practice caters for a higher proportion of patients over the age of 65 years (18.1%) and 75 years (9%) compared to local averages (14.1% and 6.2% respectively). However, the practice does cater for a lower percentage of patients who experience a long standing health condition (46.3%, compared to the local average of 55.6% and national average of 54%). More of the population in the practice's catchment area are unemployed (10.6%) compared to the local average of 6.7% and national average of 5.4%.

Information published by Public Health England rates the level of deprivation within the practice population group as four on a scale of one to ten. Level one represents the highest levels of deprivation and level ten the lowest.

The practice is staffed by two GP partners (one male and one female). In addition the practice employs an advanced nurse practitioner, two practice nurses and a health care assistant. Clinical staff are supported by a practice manager (who had been in post since June) and a team of seven administrative and reception staff.

The practice is a teaching and training practice, taking medical students, foundation year doctors as well as registrars.

The main surgery is open between 8am and 6.30pm Monday and Friday, and 8am and 3pm Tuesday, Wednesday and Thursday. The branch surgery opens between 8am and 12 midday each Monday and from 3pm until 6.30pm each Tuesday, Wednesday and Thursday. Surgeries are offered throughout the time the practice is open. Extended hours appointments are available on Tuesday and Thursday mornings between 7.30 and 8am (although these surgeries were not advertised on the practice website).

Detailed findings

Outside normal surgery hours, patients are advised to contact the out of hour's service by dialling 111, offered locally by the provider East Lancashire Medical Services.

Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 7 October 2016. During our visit we:

- Spoke with a range of staff including the GPs, practice manager, one of the practice nurses, reception and administrations staff and spoke with patients who used the service.
- Observed how staff interacted with patients.
- Reviewed an anonymised sample of the personal care or treatment records of patients.
- Reviewed comment cards where patients and members of the public shared their views and experiences of the service.

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

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

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

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

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

Inadequate

Are services safe?

Our findings

Safe track record and learning

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

- Staff told us they would inform the practice manager of any incidents and there was a recording form available on the practice's computer system.
- The practice manager told us that when things went wrong with care and treatment, patients were informed of the incident, received support, truthful information and an apology as appropriate.

We reviewed safety records, incident reports, patient safety alerts and minutes of meetings where these were discussed. We found that these had not been handled consistently. For example, we reviewed one Significant Event Analysis (SEA) which related to the poor management of patient's samples in June 2016; two samples had been put into the wrong tray in reception and so were not sent to the lab for testing. While this had been documented, the record was incomplete; the section of the form where any actions implemented following the analyses should have been recorded only contained the abbreviation "TBC." The inspection team asked to view the practice's sample handling policy in order to ascertain whether it had been reviewed following the incident. However, the practice manager confirmed that the practice did not hold such a policy. This suggested that the analysis and resulting implementation of remedial action was not thorough. The GPs and practice manager told us that a new tray system had been implemented following analysis of the incident. We saw minutes confirming that this SEA was discussed at both an administration meeting in June 2016 and a clinical team meeting in August 2016.

We did however see that the practice's epilepsy protocol was updated following receipt of a safety alert into the practice to reflect its content in June 2016.

Overview of safety systems and processes

The practice had some systems, processes and practices in place to keep patients safe and safeguarded from abuse, although there were gaps in these:

- Arrangements were in place to safeguard children and vulnerable adults from abuse. These arrangements reflected relevant legislation and local requirements. Policies were accessible to all staff, although when asked, staff did have some difficulty locating them. There were multiple versions of policies available to staff, some of which did not clearly outline who to contact for further guidance if staff had concerns about a patient's welfare. However, we did see that safeguarding referral flowcharts were displayed in each room containing this information. There was a lead member of staff for safeguarding. The GPs attended safeguarding meetings when possible and provided reports where necessary for other agencies. Staff demonstrated they understood their responsibilities however, not all had received training on safeguarding children and vulnerable adults relevant to their role. We saw evidence demonstrating that both of the GPs were trained to child protection or child safeguarding level three, and the practice nurses and health care assistant were trained to level two. However, no training certificates were available demonstrating that the advanced nurse practitioner or any of the non-clinical staff had received appropriate safeguarding training. One of the non-clinical staff we spoke with told us that she had completed safeguarding training in 2015, but we were not shown a certificate of attendance to corroborate this.
- A notice in the consultation rooms advised patients that chaperones were available if required. The practice had nominated two non-clinical staff who would act as chaperones should patients or clinicians request this. However, evidence that training had been completed for the role of chaperone was only available for one of these staff members. One of the GPs told us that the other staff member had completed the training in a previous job. However, the practice did not have any documentary evidence available to confirm this. Neither of the designated staff members had received a Disclosure and Barring Service (DBS) check or a risk assessment (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).
- The practice maintained appropriate standards of cleanliness and hygiene. We observed the premises to be clean and tidy. One of the practice nurses was the infection control clinical lead. There was an infection control protocol in place, however this did not cover

topics such as sample handling and dealing with needle stick injuries. We asked whether the practice held such policies separately but neither the practice manager nor practice nurse were aware of them and after looking were unable to locate them. The infection control policy stated that staff should receive training around infection control on an annual basis, but no evidence was available to demonstrate any staff had received up to date training. One member of staff told us that they had completed infection prevention and control training in a previous job prior to commencing employment with the practice. The policy also stated that bi-monthly infection control inspections would be completed. The last infection prevention and control audit that had been completed by the practice was undertaken in October 2014.

- The arrangements for managing medicines, including emergency medicines and vaccines, in the practice kept patients safe (including obtaining, prescribing, recording, handling, storing, security and disposal). Processes were in place for handling repeat prescriptions which included the review of high risk medicines. For other medication reviews, we did note that the practice was not following its own repeat prescribing policy in the way medicine reviews were recorded in the patient notes. The practice carried out regular medicines audits, with the support of the local CCG pharmacy teams, to ensure prescribing was in line with best practice guidelines for safe prescribing. Blank prescription forms and pads were securely stored and while there were systems in place to monitor their use and provide an audit trail of their location, not all staff were aware of this system. Patient Group Directions (PGDs) had been adopted by the practice to allow nurses to administer medicines in line with legislation (PGDs are written instructions for the administration of medicines to groups of patients).
- We reviewed three personnel files in detail and found appropriate recruitment checks had not always been undertaken prior to employment. For example, proof of identification was not recorded in two of the three files. References were available for two of the three employees, but they did not adequately cover the staff members' most recent employment history. No references were available in the third file, for a member of staff who commenced work at the practice in April 2016.
- During the inspection visit the practice was unable to demonstrate the appropriate checks through the Disclosure and Barring Service had been completed for any staff other than the GPs and advanced nurse practitioner. Evidence that other clinical staff had received DBS checks was not available during the visit. However, in the days following the inspection the practice was able to provide appropriate evidence that the practice nurses and health care assistant had received appropriate DBS checks in their time employed by the practice. However, other non-clinical staff had neither a DBS check, nor a risk assessment to document the justification for such checks not being completed on record.

Monitoring risks to patients

Risks to patients were not consistently assessed and so the practice was unable to demonstrate that they were well managed.

- There was a health and safety poster in the corridor which identified local health and safety representatives.
- The practice did not have a fire risk assessment available at the time of inspection and could not provide documentary evidence to demonstrate regular fire drills were carried out. The practice manager confirmed that no fire drills had been completed in the short time since she had commenced work at the practice. While all electrical equipment was checked to ensure the equipment was safe to use, we noted these checks were last completed in September 2014. The practice was able to demonstrate that a further portable appliance test was booked for later in October 2016. We saw that clinical equipment was checked to ensure it was working properly.
- The last electrical installation safety assessment had been carried out in September 2015. This had identified that the electrical installation in the premises was unsatisfactory, and had identified one urgent remedial action and a further 11 recommended improvements as a result. The certificate held by the practice also indicated that a further test would be required in one year's time. The practice was unable to demonstrate that any action had been carried out following this assessment. We told the provider that we needed to see evidence that this had been progressed, and five days after the visit the provider was able to confirm that a further electrical installation safety assessment had

been arranged for two weeks' time. The practice was unable to show the inspection team the gas safety certificate to confirm the integrity of the gas installation of the premises was appropriate.

- We saw a document relating to a health and safety inspection of the premises dated July 2016. It was not specified who had completed the inspection. This document did identify some issues such as electrical cables being over-stretched. The document did not specify what action, if any, had been taken in relation to the issues identified. The practice also lacked other risk assessments to monitor safety of the premises. For example, no legionella risk assessment had been completed (Legionella is a term for a particular bacterium which can contaminate water systems in buildings).
- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system in place for all the different staffing groups to ensure enough staff were on duty.

Arrangements to deal with emergencies and major incidents

The practice did not have adequate arrangements in place to respond to emergencies and major incidents.

- There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency.
- We were told all staff received annual basic life support training. We asked to view staff training certificates and were provided with a training folder. This contained training certificates for four of the practice's 14 staff to confirm basic life support training had been completed. Following the inspection the practice provided training certificates for a further eight of the 14 staff. There were no certificates to confirm that one of the administration staff or the health care assistant had received appropriate training in basic life support. There were emergency medicines available in the treatment room.
- The practice had a defibrillator available on the premises. However, there was no oxygen cylinder available on site, meaning that the practice could not demonstrate that it was appropriately equipped to deal with any medical emergencies such as acute exacerbation of asthma and other causes of hypoxaemia (lack of oxygen). The practice had previously had oxygen on site, but had taken the decision to stop doing so a number of years ago following an incident that highlighted it had not been maintained appropriately. Following the inspection we advised the practice of our concern that this presented a risk and the practice responded by sourcing an oxygen cylinder for use in medical emergencies.
- A first aid kit and accident book were available.
- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and stored securely.
- The practice had a business continuity plan in place for major incidents such as power failure or building damage. However, the plan did not include emergency contact numbers for staff or contractors.

Requires improvement

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

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

- The practice had systems in place to keep all clinical staff up to date. Staff had access to guidelines from NICE and used this information to deliver care and treatment that met patients' needs.
- The practice monitored that these guidelines were followed through audits and case discussions.

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent (2015/16) published results were 96.4% of the total number of points available, with a 9.8% exception reporting rate for clinical domains (Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects).

Data from 2015/16 showed:

- Performance for diabetes related indicators was lower than the local and national averages, although in all cases the practice exception reporting rate was also lower than local and national averages. For example:
  - The percentage of patients with diabetes on the register in whom the last IFCC-HbA1c was 64mmol/mol or less in the preceding 12 months was 68% compared to the clinical commissioning group (CCG) average of 79% and national average of 78%.
  - The percentage of patients with diabetes on the register in whom the last blood pressure reading (measured in the last year) was 140/80 mmHg or less was 72%, compared to the CCG average of 80% and national average of 78%.
  - The percentage of patients with diabetes on the register whose last measured total cholesterol (measured in the preceding 12 months) was five mmol/l or less was 75% compared to the CCG average of 83% and national average of 80%.
  - The percentage of patients with diabetes on the register who had had influenza immunisation in the preceding 1 August to 31 March was 82% compared to the CCG average of 96% and national average of 95%.
  - The percentage of patients on the diabetes register with a record of a foot examination and risk classification within the last 12 months was 87% compared to the CCG average of 94% and national average of 89%.
- Performance for mental health related indicators were in line with or slightly higher than the local and national averages, with exception reporting higher than local and national averages for the three indicators listed below. For example:
  - The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who had a comprehensive, agreed care plan documented in the record in the preceding 12 months was 93% compared to the CCG average of 94% and national average of 89%.
  - The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses whose alcohol consumption had been recorded in the preceding 12 months was 91% compared to the CCG average of 93% and national average of 90%.
  - The percentage of patients diagnosed with dementia whose care had been reviewed in a face to face review in the preceding 12 months was 94% compared to the CCG average of 87% and national average of 84%.
- The percentage of patients with hypertension in whom the last blood pressure reading measured in the preceding 12 months was 150/90mmHg or less was 88% compared to the CCG average of 85% and national average of 83% (9.6% exception reporting rate, 5% higher than the local average and 6% higher than the national average).

Requires improvement

Are services effective?

(for example, treatment is effective)

- The percentage of patients with asthma on the register who had an asthma review in the preceding 12 months that included an appropriate assessment of asthma control was 78%, compared to the CCG average of 79% and national average of 76% (exception reporting rate of 14.6%, 4% above the local average and 7% above the national average).

There was some evidence of quality improvement including some clinical audit.

- The GPs discussed two audits with us that had been recently completed; one of these was a completed audit cycle where the improvements made were implemented and monitored. However, we noted four years had lapsed between the audit cycles.
- The practice participated in local audits, national benchmarking, accreditation and peer review.
- Findings were used by the practice to improve services. For example, following an audit completed by the practice in 2010 and 2012 where the practice's use of oxycodone was reviewed (medicine to treat moderate to severe pain), the practice revisited the audit in September 2016 and confirmed that the number of patients using the medication had reduced from seven in 2010 to three in 2016.

Information about patients' outcomes was used to make improvements. For example following an alert received from the national patient safety agency which highlighted that anticoagulants were one of the medicines most frequently identified as causing preventable harm and admission to hospital, the practice reformed its anticoagulation monitoring protocol and implemented the use of a template to alert GPs to the potential risks associated with these medicines which in turn made it a safer process.

Effective staffing

Staff had the skills, knowledge and experience to deliver effective care and treatment, although we found managerial oversight of training undertaken by staff was lacking.

- We were told about the induction process provided by the practice by the recently employed practice nurse. Over a three month period, she was given opportunities to shadow more experienced colleagues before a phased approach to her seeing patients of her own; for example she was allocated longer appointments initially in order to allow her time to complete tasks thoroughly.
- The practice could demonstrate how they ensured role-specific training and updating for the two practice nurses, for example, for their work reviewing patients with long-term conditions. However, the practice were not able to provide evidence to document the role specific training undertaken by the health care assistant.
- Staff administering vaccines and taking samples for the cervical screening programme had received specific training which had included an assessment of competence. Staff who administered vaccines could demonstrate how they stayed up to date with changes to the immunisation programmes, for example by access to on line resources and discussion at practice meetings.
- The practice was unable to demonstrate that a systematic approach was taken in identifying the learning needs of staff. For example, while we saw documentary evidence that probationary review meetings had taken place between management staff and two recently employed non-clinical employees, and that one of the practice nurses had received an appraisal in February, no other evidence could be provided that other staff had received appraisals. We spoke to staff who confirmed it had been over two years since their last appraisal meeting.
- Staff had access to and made use of e-learning training modules and in-house training. However, the lack of management oversight resulted in gaps in key areas of training such as safeguarding and infection prevention and control training for non-clinical staff.

Coordinating patient care and information sharing

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

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

Requires improvement

Are services effective?

(for example, treatment is effective)

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

Consent to care and treatment

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

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

Supporting patients to live healthier lives

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

- Patients receiving end of life care, carers, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation. Patients were signposted to the relevant service.
- Smoking cessation advice was available locally at a nearby health centre.

The practice's uptake for the cervical screening programme was 83%, which was comparable to the CCG average of 80% and the national average of 82%. The practice demonstrated how they encouraged uptake of the screening programme by ensuring a female sample taker was available. There were failsafe systems in place to ensure results were received for all samples sent for the cervical screening programme and the practice followed up women who were referred as a result of abnormal results. The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening.

Childhood immunisation rates for the vaccinations given were comparable to CCG/national averages. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 90.6% to 97.4% and five year olds from 86.2% to 95.4%.

Patients had access to appropriate health assessments and checks. These included health checks for new patients, NHS health checks for patients aged 40–74 as well as health checks for those patients over the age of 75 years. Appropriate follow-ups for the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.

Good

Are services caring?

Our findings

Kindness, dignity, respect and compassion

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

- Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- We noted that consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- Reception staff knew when patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.

All of the nine patient Care Quality Commission comment cards we received were positive about the service experienced. Patients said they felt the practice offered an good service and staff were helpful, caring and treated them with dignity and respect.

We spoke with two members of the patient participation group (PPG) who were also patients at the practice. They also told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. Comment cards highlighted that staff responded compassionately when they needed help and provided support when required.

Results from the national GP patient survey showed patients felt they were treated with compassion, dignity and respect. The practice was mostly above average for its satisfaction scores on consultations with GPs and nurses. For example:

- 98% of patients said the GP was good at listening to them compared to the clinical commissioning group (CCG) average of 91% and the national average of 89%.
- 95% of patients said the GP gave them enough time compared to the CCG average of 89% and the national average of 87%.
- 99% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 96% and the national average of 95%.
- 91% of patients said the last GP they spoke to was good at treating them with care and concern compared to the national average of 85%.
- 97% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the national average of 91%.
- 83% of patients said they found the receptionists at the practice helpful compared to the CCG average of 88% and the national average of 87%.

Care planning and involvement in decisions about care and treatment

Patients told us they felt involved in decision making about the care and treatment they received most of the time. They also told us they felt listened to and supported by staff and had sufficient time during face to face consultations to make an informed decision about the choice of treatment available to them. Patient feedback from the comment cards we received was also positive and aligned with these views. We also saw that care plans were personalised. However, patient feedback relating to telephone consultations was less positive, with patients describing it as impersonal.

The GPs told us that they would make onward referrals using the 'choose and book' system themselves, with the patients present as part of their consultation.

Results from the national GP patient survey showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. Results were higher than local and national averages. For example:

- 92% of patients said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 87% and the national average of 86%.
- 84% of patients said the last GP they saw was good at involving them in decisions about their care compared to the national average of 82%.
- 96% of patients said the last nurse they saw was good at involving them in decisions about their care compared to the national average of 85%.

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

Good

Are services caring?

- Staff told us that translation services were available for patients who did not have English as a first language.
- Information leaflets were available in easy read format.

Patient and carer support to cope emotionally with care and treatment

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

The practice had identified 67 patients as carers (1.5% of the practice list). However, we looked at three of these records and found that that practice was not using alerts on the computer system to make GPs aware that a patient was also a carer. Alerts such as this can be used by a practice to maximise the chances of patients receiving the care and support they need. Written information was available to direct carers to the various avenues of support available to them.

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

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. For example, the practice was working with two neighbouring surgeries in an effort to secure new and improved premises; a bid had been submitted to NHS England in an effort to secure funding support to this end.

- The practice offered extended hours appointments on a Tuesday and Thursday morning from 7.30am for working patients who could not attend during normal opening hours.
- There were longer appointments available for patients with a learning disability.
- Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice.
- Same day appointments were available for children and those patients with medical problems that require same day consultation.
- Patients were able to receive travel vaccinations available on the NHS and were referred to other clinics for vaccines available privately.
- There were disabled facilities, a hearing loop and translation services available.
- Consultation rooms were spread over two floors, but staff told us clinicians would see patients on the ground floor if they were aware the patient experienced difficulties with mobility.
- Long term condition review appointments were arranged by patient's month of birth in an effort to make them more memorable for patients and to maximise attendance.

The main surgery was open between 8am and 6.30pm Monday and Friday, and 8am and 3pm Tuesday, Wednesday and Thursday. The branch surgery opened between 8am and 12 midday each Monday and from 3pm until 6.30pm each Tuesday, Wednesday and Thursday. Surgeries were offered throughout the time the practice was open. Extended hours appointments were available on Tuesday and Thursday mornings between 7.30 and 8am (although these surgeries were not advertised on the practice website). In addition to pre-bookable appointments that could be booked up to one month in advance, urgent appointments were also available for people that needed them. On the day of inspection, the next available pre-bookable appointment with a GP was in two days' time.

Results from the national GP patient survey showed that patient's satisfaction with how they could access care and treatment was lower than national averages.

- 72% of patients were satisfied with the practice's opening hours compared to the CCG average of 78% and national average of 76%.
- 67% of patients said they could get through easily to the practice by phone compared to the CCG average of 75% and national average of 73%.

The GPs told us how they had updated the appointment system approximately 12 months ago to incorporate more telephone appointments. They told us that patients had offered them verbal feedback to confirm its success. However, evidence of this feedback had not been documented or formally recorded by the practice. Patients told us over the telephone after the inspection that they felt appointments were not always available when they needed them. Patients told us they were aware that the new telephone triage system had been put in place, but were frustrated that the practice had not appeared to seek patient feedback on whether this had resulted in a positive impact on ease of access.

The practice had a system in place to assess:

- whether a home visit was clinically necessary; and
- the urgency of the need for medical attention.

The practice was able to utilise the local acute visiting service should a patient urgently require assistance at home. In cases where the urgency of need was so great that it would be inappropriate for the patient to wait for a GP home visit, alternative emergency care arrangements were made. Clinical and non-clinical staff were aware of their responsibilities when managing requests for home visits.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. However, we found that the practice's complaints policy was not always fully implemented.

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

- Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England.
- The practice manager was the designated responsible person who handled all complaints in the practice.
- We saw that information was available to help patients understand the complaints system; a complaints information leaflet was available from reception for those patients who asked for it. This leaflet explained the practice's complaints procedure, although we did not it still referred to the previous practice manager.

The practice manager told us that 11 complaints had been received in the last 12 months. We looked at one complaint in detail during the inspection which was not detailed on the practice's complaints summary provided in advance of the visit. While we saw that the written response to this complaint included an apology and provided the complainant with details of the Parliamentary Health Service Ombudsman should the patient wish to pursue their complaint further, we noted that the practice's complaints policy had not been followed. The written response had been produced nine working days after the date of the complaint, however, no acknowledgement had been sent out within three days as per the practice policy. The practice manager informed us that telephone conversations with the patient had taken place following receipt of the complaint, but these had not been documented. We did not see evidence of how learning from complaints was shared amongst practice staff, and the staff we spoke to were unable to provide examples where changes had been implemented as a result of a complaint. For example, following a recent complaint regarding the practice's appointment system, the practice had documented the need to re-evaluate the urgent appointment line for vulnerable patients. It was unclear from the documentation whether this had been done.

Are services well-led?

Inadequate

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

Our findings

Vision and strategy

The practice had a vision to deliver high quality care and promote good outcomes for patients. The organisation's mission statement was displayed in the waiting areas and on the website and staff knew and understood the values.

Governance arrangements

The practice lacked an overarching governance framework in order to support the delivery of the strategy and good quality care. It was evident that the practice did not have structures and procedures sufficiently embedded, which meant there were gaps in governance arrangements.

- There was a clear staffing structure and that staff were aware of their own roles and responsibilities.
- Not all of the policy documents in use were practice specific. For example, the lone working policy available to staff was a document relating to a local NHS Foundation Trust. Many of the policies we reviewed were overdue a review; for example, the safeguarding children policy was dated as last reviewed in March 2013, the whistleblowing policy dated 2010 and the recruitment policy January 2014. We found duplicate versions of some policy documents, such as the fire safety policy, and it was not clear which was the up to date copy.
- Policies such as that relating to infection prevention and control were not comprehensive enough to sufficiently govern the scope of activity in which the practice was engaged. For example, it made no reference to sample handling processes or the procedure to deal with needle stick injury.
- Some clinical and internal audit was used; however audit cycles were too sporadic to be fully effective in monitoring quality and to make improvements.
- Arrangements for identifying, recording and managing risks, issues and implementing mitigating actions were not adequate to ensure patient and staff safety. For example there was no fire risk assessment available, nor any evidence that the risk of legionella had been considered. When risks had been identified, for example by an external contractor in relation to the safety of the electrical installation, no mitigating action had been taken by the practice.
- The practice lacked a systematic approach to monitoring and managing staff training, which resulted in gaps.
- Key documentation was not available. For example, while DBS checks had been completed for clinical staff, no record of these checks had been made by the practice and so it was unable to evidence they had been carried out during the inspection visit. In order to evidence they had been done, the practice had to seek the original documentation from the staff members in the days following the visit.

Leadership and culture

There was insufficient leadership evidenced at the time of inspection, although the newly appointed practice manager had only been in post for a short period of time. Staff told us the partners were approachable, extremely supportive and always took the time to listen to all members of staff.

The provider was aware of and had systems in place to ensure compliance with the requirements of the duty of candour (the duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment). The partners encouraged a culture of openness and honesty. The practice ensured that when things went wrong with care and treatment it gave affected people support, truthful information and a verbal and written apology. However, we found evidence that written records of verbal interactions were not always kept as well as written correspondence.

There was a clear leadership structure in place and staff felt supported by management.

- The new practice manager had begun to reinstate regular team meetings.
- Staff told us there was an open culture within the practice and they had the opportunity to raise any issues informally and more recently at team meetings. They said they felt confident and supported in doing so. We were told by the partners that social events had been organised including staff from neighbouring practices who it is planned will share the new premises.

Are services well-led?

Inadequate

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

- Staff said they felt respected, valued and supported by both the partners and practice manager.

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

There was little evidence that the practice encouraged and valued feedback from patients. It was not proactive in seeking patients' feedback and did not engage patients in the delivery of the service.

- We spoke to two members of the practice's patient participation group (PPG) who told us that the group was not currently active; the last meeting had been approximately a year ago. We were told that members of the group were keen for further meetings to take place, but that communication channels with the practice had deteriorated since the last meeting. Patients expressed concern that the new telephone triage appointment system had been implemented without requests for patient feedback, and similarly that feedback had not been sought once it had been trialled in order for them to offer their opinions on its success. The practice manager confirmed that to her knowledge, the practice had not conducted any patient surveys to gather patient feedback.
- Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. However, formal opportunities for staff offering feedback were limited; for example, most staff had not had appraisals in the last year. The practice did provide evidence demonstrating that one of the GPs had sought staff feedback on their leadership qualities as part of a 360 degree appraisal process in August 2016.

Continuous improvement

The GPs told us how they valued the fresh approach, skills and enthusiasm offered by the medical students and trainee doctors placed with the practice. One of the GPs was the CCG lead for IT, and the other was clinical communication skills lead in the undergraduate department of the local hospital.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **How the regulation was not being met:** The registered person did not do all that was reasonably practicable to assess, monitor, manage and mitigate risks to the health and safety of service users. We found that investigations into significant events were not always thorough. An infection prevention and control audit had not been completed since October 2014. This was in breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed **How the regulation was not being met:** The registered person did not do all that was reasonably practicable to ensure recruitment arrangements included all necessary employment checks for all staff, including those required in schedule 3. This was in breach of regulation 19(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **How the regulation was not being met:** There was no evidence of a systematic approach to staff appraisals being documented, and staff training had not been managed resulting in key gaps. There was limited evidence of clinical audit demonstrating quality improvement. There were key gaps in policies and no evidence of a systematic approach to document control. Limited managerial oversight of risk assessment and management. When risks had been identified, mitigating action had not been undertaken. The practice complaints policy was not always implemented. This was in breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.