Charterhouse Surgery

Quality Report

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Date of inspection visit: 24 November 2016
Date of publication: 30/03/2017

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?	Inadequate
Are services well-led?	Inadequate

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We previously carried out an announced comprehensive inspection of the practice on 5 April 2016. The practice was rated Requires Improvement overall with Inadequate in safe and requires improvement in effective, responsive and well-led and good in caring.

We undertook this follow-up comprehensive inspection on 24 November 2016 to check that the practice had followed their plan and to confirm that they now met the legal requirements. 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 there was no robust system in place for the monitoring of patients on high risk medicines.
- The practice did not have a business continuity plan in place for major incidents; they had not undertaken a health and safety risk assessment of the premises, fire legionella and asbestos risk assessments to ensure safety of the staff and patients.
- The practice had not undertaken an infection control audit and did not have a safe system in place for monitoring of emergency medicines and vaccines stored in the refrigerators.
- There was no evidence of appraisals for most non-clinical staff.
- There was limited evidence that the practice was comparing its performance to others; either locally or nationally.
- Staff were clear about reporting incidents, near misses and concerns and there was some evidence of learning and communication with staff.
- Patients were positive about their interactions with staff and said they were treated with compassion and dignity.
- Information about services were available; however the practice did not have a complaints leaflet and practice leaflet was not up to date.

Summary of findings

- During the day of inspection patients reported difficulties in accessing routine and emergency appointments and also reported difficulty in accessing the surgery by phone.
- The practice had a leadership structure; however had limited formal governance arrangements.

There were areas of practice where the provider must make improvements:

- Ensure there is a clear system in place for the implementation and monitoring of medicines and safety alerts and a safe system in place for the monitoring of patients on high risk medicines.
- Ensure face to face basic life support training is provided for all staff.
- Ensure records are maintained when checking the working status of a defibrillator.
- Ensure all patient group directions are authorised and signed by relevant staff.
- Ensure that a fire, legionella, asbestos and health and safety risk assessment of the premises is undertaken and the recommendations following the risk assessments are actioned. Ensure that an infection control audit is regularly undertaken and that any recommendations identified are actioned.
- Ensure the system in place for the monitoring of emergency medicines and vaccines stored in the refrigerators is safe and there is a system for monitoring of refrigerator temperatures.
- Ensure that a business continuity plan is in place to identify how the practice will deal with a range of major incidents such as power failure or buildings damage.
- Ensure that regular appraisals are undertaken for all staff.
- Consider how patients would call for help from the patient toilet.

There were areas of practice where the provider should make improvements:

- Review the quality improvement process so it demonstrates that changes are made following the completion of audits and monitored through re-audits.
- Review the care and treatment provided to ensure that the outcomes for patients with long term conditions are improved.
- Review how patients with caring responsibilities are identified to ensure information, advice and support can be made available to them.
- Review practice information to ensure it is up to date and gives patients information about the services provided and how to make a complaint and that complaints are widely discussed with all staff.
- Review result of the national GP patient survey results and address low scoring areas to improve patient satisfaction especially in access.

We are placing this service in special measures. Where a service is rated as inadequate for one of the five key questions or one of the six population groups or overall and after re-inspection has failed to make sufficient improvement, and is still rated as inadequate for any key question or population group, we place it into special measures.

Services placed in special measures will be inspected again within six months. If, after re-inspection, the service has failed to make sufficient improvement, and is still rated as 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 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.

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.

- Patients were at risk of harm because systems and processes were not in place to keep them safe. For example the practice did not have a suitable system in place for the monitoring of patients on high risk medicines.
- The practice did not have a business continuity plan in place for major incidents; they had not undertaken a health and safety risk assessment of the premises or a fire, legionella and asbestos risk assessment to ensure safety of patients and staff. The practice were undertaking fire drills.
- The practice had not undertaken an infection control audit and did not have a safe system in place for monitoring of emergency medicines and vaccines stored in the refrigerators.
- Although the practice carried out investigations when there were unintended or unexpected safety incidents, the learning from significant events could be improved.

Are services effective?

Inadequate

The practice is rated as inadequate for providing effective services.

- Data from the Quality and Outcomes Framework showed patient outcomes were below average for the locality and compared to the national average.
- There was no evidence of appraisals and personal development plans for one clinical and seven non-clinical members of staff.
- Staff assessed needs and delivered care in line with current evidence based guidance.
- Clinical audits demonstrated quality improvement.
- Staff had the skills, knowledge and experience to deliver effective care and treatment.
- Staff worked with multidisciplinary teams to understand and meet the range and complexity of patients' needs.

Are services caring?

Requires improvement

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

- Data from the national GP Patient Survey showed patients rated the practice below average for many aspects of care.

Summary of findings

- Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment; however one of the nine patients we spoke to reported that they felt interrogated by reception staff when making appointments.
- Information for patients about the services available was easy to understand and accessible; however the practice did not have an up to date practice leaflet to give patients information about the services provided.

Are services responsive to people's needs?

Inadequate

The practice is rated as inadequate for providing responsive services.

- Although the practice had reviewed the needs of its local population, it had not put in place a plan to secure improvements for all of the areas identified.
- Feedback from patients indicated that access to a named GP and continuity of care was not always available quickly, although urgent appointments were usually available the same day.
- Learning from complaints was shared with staff and other stakeholders; however the practice had no complaints leaflet.

Are services well-led?

Inadequate

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

- The practice did not have a clear vision and strategy. Staff were not always clear about their responsibilities in relation to the vision or strategy.
- There was a leadership structure but it was not adequately implemented; however staff felt supported by management and reported that it had improved over the last year.
- The practice had daily staff huddles during which issues were discussed.
- The practice had not proactively sought feedback and engagement through a patient survey; even though they had an active patient participation group.
- Staff told us they had not received regular performance reviews and did not have clear objectives.
- The practice had limited arrangements in place to identify and manage risk.

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.

- Nationally reported data showed that outcomes for patients for conditions commonly found in older people were poor especially for patients with diabetes and hypertension.
- The practice offered home visits and urgent 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.

- The national Quality and Outcomes Framework (QOF) data showed that 69% of patients had well-controlled diabetes, indicated by specific blood test results, compared to the Clinical Commissioning Group (CCG) average of 76% and the national average of 78%. The number of patients who had received an annual review for diabetes was 67%.
- Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. The practice ran nurse led clinics for patients with asthma, chronic obstructive pulmonary disease, diabetes and chronic heart disease.
- The national QOF data showed that 66% of patients with asthma in the register had an annual review, compared to the CCG average of 73% and the national average of 76%.
- Longer appointments and home visits were available for people with complex long term conditions when needed.
- Structured annual reviews were not always undertaken to check that patients' health and care needs were being met.

Families, children and young people

Inadequate

The practice is rated as inadequate for the care of families, children and young people.

- 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.

Summary of findings

- The practice's uptake for the cervical screening programme was 84%, which was in line with the Clinical Commissioning Group (CCG) average of 82% and the national average of 81%.

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).

- The practice did not offer extended hours appointments with GPs or nurses to suit the needs of this age group.

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.

- The practice held a register of patients living in vulnerable circumstances including homeless people, carers, travellers and those with a learning disability; however these were not up to date.
- The practice offered longer appointments and extended annual reviews for patients with a learning disability; only one out of six patients with learning disability had received a health check in the last year.
- The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people.

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).

- 74% of 56 patients with severe mental health conditions had a comprehensive agreed care plan in the last 12 months which was below the CCG average 83% and national average of 89%.
- The number of patients with dementia who had received annual reviews was 82% which was in line with the Clinical Commissioning Group (CCG) average of 82% and national average of 84%.
- The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia.

Summary of findings

What people who use the service say

The National GP patient survey results were published on 7 July 2016. The results showed that the practice was performing below local and national averages. Two hundred and twenty eight survey forms were distributed and 116 were returned. This represented approximately 1% of the practice's patient list.

- 22% found it easy to get through to this surgery by phone (Clinical Commissioning Group (CCG) average of 70%, national average of 73%).
- 71% were able to get an appointment to see or speak to someone the last time they tried (CCG average 84%, national average 85%).
- 61% described the overall experience of their GP surgery as fairly good or very good (CCG average 82%, national average 85%).
- 45% said they would definitely or probably recommend their GP surgery to someone who has just moved to the local area (CCG average 75%, national average 78%).

As part of our inspection we also asked for CQC comment cards to be completed by patients. We received 17 comment cards which mostly positive about the standard of care received. Patients felt that they were treated with dignity and respect and were satisfied with their care and treatment.

We spoke with 16 patients during the inspection. Most patients said they were happy with the care they received and thought staff were approachable, committed and caring.

Charterhouse Surgery

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 specialist advisor and an Expert by Experience.

Background to Charterhouse Surgery

The Charterhouse Surgery provides primary medical services in Bromley to approximately 8000 patients and is one of 48 practices in Bromley Clinical Commissioning Group (CCG). The practice population is in the least deprived decile in England.

The practice population has a lower than CCG and national average representation of income deprived children and older people. The practice population of working age people and older people are higher than local and national averages and the population of children and younger people is lower than local and national averages. Of patients registered with the practice for whom the ethnicity data was recorded, 68% are white British, 2% are Asian and 1% Black/African.

The practice operates in converted premises. All patient facilities are wheelchair accessible. The practice has access to four doctors' consultation rooms, one nurse consultation room and one healthcare assistant consultation room on the ground floor.

The clinical team at the surgery is made up of three GP partners (two part-time female and one part-time male GP), one part-time long-term female locum GP, one part-time female locum practice nurse and one part-time female healthcare assistant. The non-clinical practice team consists of practice manager and eight administrative/ reception staff members. The practice provided a total of 27 GP sessions per week.

The practice had significant changes in partnership and management structure during the period between March 2014 and July 2015 where six GP partners, a practice manager, two practice nurses, a nurse practitioner and six reception staff left the practice.

The practice operates under a General Medical Services (GMS) contract, and is signed up to a number of local and national enhanced services (enhanced services require an enhanced level of service provision above what is normally required under the core GP contract).

The practice reception and telephone lines are open from 8:00am till 6:30pm Monday to Friday. Appointments are available from 8:30am to 11:30am and 4pm to 6:00pm Monday to Friday.

The practice has opted out of providing out-of-hours (OOH) services to their own patients between 6:30pm and 8:00am and directs patients to the out-of-hours provider for Bromley CCG. The practice is a member of local GP Alliance and provides at least three appointments each day seven days a week through Primary Care Hubs; weekend appointments could be booked in advance.

The practice is registered as a partnership with the Care Quality Commission to provide the regulated activities of diagnostic and screening procedures, family planning, maternity and midwifery services, treatment of disease, disorder or injury and surgical procedures.

Detailed findings

Why we carried out this inspection

We undertook a follow-up comprehensive inspection of The Charterhouse Surgery on 24 November 2016. This is because the service had been identified as not meeting some of the legal requirements and regulations associated with the Health and Social Care Act 2008. From April 2015, the regulatory requirements the provider needs to meet are called Fundamental Standards and are set out in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Specifically a breach of regulation 12(1) and 12(2) (Safe care and treatment), Regulation 17(1) and 17(2) (Good Governance) and Regulation 18(2) (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 was identified.

This inspection was carried out to check that improvements to meet legal requirements planned by the practice after our comprehensive inspection on 5 April 2016 had been made.

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 inspection on 24 November 2016.

During our visit we:

- Spoke with a range of staff including two reception and administrative staff, the practice manager, three GPs and the practice nurse and we spoke with 16 patients who used the service including seven members of the practice's Patient Participation Group (PPG).
- Observed how patients were being cared for and talked with carers and family members.
- Reviewed a 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

During the comprehensive inspection carried out on 5 April 2016 we found that the practice did not have adequate arrangements in place for reporting and recording significant events and monitoring of medicines and safety alerts. The practice had not carried out fire, asbestos and legionella risk assessments and an infection control audit. Patient records were not securely stored. They had no business continuity plan in place; staff who acted as chaperones had not received a Disclosure Barring Service check (DBS Check). They had not carried out the necessary recruitment checks before employing permanent and locum staff and some staff had not completed mandatory training.

Safe track record and learning

At our inspection on 24 November 2016 we found 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 carried out an analysis of the significant events and maintained a log on the computer system. Following the initial inspection in 5 April 2016 the practice had made improvements in the system of reporting and recording significant events; they had brought in an external facilitator to improve their quality and understanding of the significant event process.
- The practice did not have a clear system for the receipt, dissemination and monitoring the implementation of medicines and safety alerts. The practice had no record to demonstrate individual GPs had taken the required actions. During the inspection we checked one safety alert for a medicine used for heart failure and found there were no patients at risk at that time.

We reviewed incident reports and minutes of meetings where these were discussed. Lessons were shared to make sure action was taken to improve safety in the practice. For example, the practice identified that one member of practice staff had two electronic profiles on their computer system and tasks were sent to one profile the staff member was not aware of. As a result of this the practice identified that 110 unactioned tasks and these were reviewed the day after and referrals were resent appropriately. The practice apologised all the affected patients. Following the incident the practice put a system in place to ensure all referrals were made as requested and then followed up.

When there were unintended or unexpected safety incidents, patients received reasonable support, truthful information, a verbal and written apology and were told about any actions to improve processes to prevent the same thing happening again.

Overview of safety systems and processes

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

- The provider had made improvements by ensuring all staff were appropriately trained in child protection. Arrangements were in place to safeguard children and vulnerable adults from abuse that reflected relevant legislation and local requirements and policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. There was a lead member of staff for safeguarding. Staff demonstrated they understood their responsibilities and all had received training relevant to their role. GPs were trained to Child Protection level 3, nurses were trained to Child Protection level 2 and non-clinical staff were trained to Child Protection level 1.
- We found the provider had made improvements to ensure chaperones were appropriately trained and received DBS check. Notices in the clinical rooms advised patients that chaperones were available if required. All staff who acted as chaperones were trained for the role and had received a Disclosure and Barring Service check (DBS check). (DBS
- The practice maintained appropriate standards of cleanliness and hygiene. We observed the premises to be clean and tidy. The practice nurse had recently taken on the responsibilities of the infection control clinical lead. There was an infection control protocol in place, but no infection control audits had been undertaken despite this being identified as a required action following the visit from an infection control nurse in October 2016. We found that the practice had not changed one of the disposable curtains in a consultation room since December 2014.

Inadequate

Are services safe?

- The practice did not have adequate arrangements for managing vaccines to keep the patients safe. During the inspection we found two boxes of meningococcal group ACWY vaccines which had expired in February 2016; we also found that vaccine boxes were stored against the back of the refrigerator which made the boxes damp and had a potential to freeze the vaccines which would render them unsafe to use. We found gaps in monitoring of refrigerator temperatures in which vaccines were stored; the temperatures were only recorded every second day. The practice was not clear who was accountable for stock control and refrigerator temperature monitoring.
- The practice did not have a robust system in place for the review of patients on high risk medicines. We found that out of 977 patients on medicines to control high blood pressure 115 patients had not had a blood pressure review for over 15 months. For patients taking medicines for heart rhythm disorders, two patients were overdue checks; Out of 31 patients taking medicines for heart failure, five patients were overdue renal function tests and 12 patients were overdue thyroid function tests (one patient's test was overdue by three years); Out of 975 patients taking medicines to control blood cholesterol, 305 patients were overdue cholesterol tests and eight had not had a liver function test (data indicated that some patients had their tests elsewhere); Out of eight patients on medicines for high blood pressure two patients were overdue thyroid function tests; For patients taking medicines for autoimmune disorders 14 patients were overdue blood tests and for patients taking a medicine to treat cancer, 22 patients were overdue blood tests; Out of eight patients taking a medicine for mental health disorders, two patients were overdue creatinine tests and three patients were overdue thyroid function tests.
- Prescription pads were securely stored and there were systems in place to monitor their use. Patient Group Directions had been adopted by the practice to allow nurses to administer medicines in line with legislation. (PGDs are written instructions for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment.); however we found that one of the PGDs was not authorised and signed by appropriate staff.
- Following the initial inspection in 5 April 2016 the practice had made improvements to the security of storage of medical records.
- We reviewed three personnel files and found appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service. The practice used long-term locum GPs and performed all the necessary checks.

Monitoring risks to patients

Risks to patients were not always assessed and well-managed.

- There were limited procedures in place for monitoring and managing risks to patient and staff safety. The practice had no up to date fire risk assessments; however they carried out regular fire drills. They also had identified fire marshals. All electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly.
- The practice had a control of substances hazardous to health risk assessment; however they had not undertaken asbestos and Legionella risk assessments (Legionella is a term for a particular bacterium which can contaminate water systems in buildings); we saw evidence that the practice had booked for an asbestos and legionella risk assessment to be completed on 25 November 2016.
- The practice had not undertaken a health and safety risk assessment of the premises.
- 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 that enough staff were on duty.

Arrangements to deal with emergencies and major incidents

The practice had 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.
- All staff had received annual basic life support training; however non-clinical staff only received online basic life support training which does not include hands on staff training. There were emergency medicines available in

the treatment room. The practice did not have adequate arrangements for managing emergency medicines to keep patients safe; we found that the emergency anaphylaxis pack had out of date anaphylactic medicines which expired in October 2016 and the pack had consumables which were two years out of date.

- The practice had a defibrillator available on the premises and oxygen with adult and children's masks; however the practice did not have a clear system to check the working status of the defibrillator. A first aid kit and accident book was available.
- The practice had no business continuity plan in place for major incidents such as power failure or building damage; the practice informed us that the plan was currently being drafted and showed us a copy of the draft plan.

Inadequate

Are services effective?

(for example, treatment is effective)

Our findings

During the comprehensive inspection carried out on 5 April 2016 we found that the practice did not have adequate arrangements in place to ensure all staff have regular appraisals and mandatory training. We saw no evidence of improvements and monitoring following clinical audits.

Effective needs assessment

At our inspection on 24 November 2016 from the information we saw on the inspection we found 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.

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent published results were 82.3% of the total number of points available (a decline when compared to the previous year which was 87.4%), which was below the Clinical Commissioning Group (CCG) average and national average of 95.4%, with an exception reporting rate of 5.9%. (Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects.) The practice was aware of the low results and explained this was due to rapid changes in clinical staff and increased use of locums over the last year and the lack of administrative support. The provider was able to articulate an awareness of the issues and had targeted improvements as a result; however they did not have a clear strategy to improve the results. Data from 2015/16 showed:

- Performance for diabetes related indicators was below the Clinical Commissioning Group (CCG) and national average. For example, 69% (2.0% exception reporting) of patients had well-controlled diabetes, indicated by specific blood test results, compared to the CCG average of 76% and the national average of 78%. The number of patients who had received an annual review for diabetes was 67%. The percentage of patients with diabetes on the register for whom the last blood pressure reading was 140/80 mmHg or less was 56% (6.3% exception reporting) which was below the CCG average of 75% and national average of 78%.
- Performance for mental health related indicators was below the CCG and national averages; 74% (3.6% exception reporting) of patients had a comprehensive agreed care plan in the last 12 months compared with the CCG average of 83% and national average of 89%.
- The percentage of patients with asthma in the register who had received annual reviews was 66% (0.2% exception reporting) compared to the CCG average of 73% and the national average of 76%.
- The number of patients with Chronic Obstructive Pulmonary Disease (COPD) who had received annual reviews was 49% (2.8% exception reporting) compared with the CCG average of 89% and national average of 90%.
- The percentage of patients over 75 with a fragility fracture who were on the appropriate bone sparing agent was 100% (0% exception reporting), which was above the CCG average of 89% and national average of 84%.
- The percentage of patients with atrial fibrillation treated with anticoagulation or antiplatelet therapy was 87% (4.5% exception reporting), which was in line with the CCG average of 86% and national average of 87%.
- The number of patients with dementia who had received annual reviews was 82% (1.5% exception reporting) which was in line with the CCG average of 82% and national average of 84%.

Clinical audits demonstrated some quality improvement.

- There had been two clinical audits carried out in the last two years, one of these was a completed audit where the improvements made were implemented and monitored.
- For example, an audit of prescribing was undertaken to ascertain if patients with heart failure were prescribed optimised doses of a medicine which improved heart condition. In the first cycle the practice identified 51 patients with heart failure of which 43 were taking this medicine; 12 were not on optimised doses of this medicine and those patients were offered an appointment with their usual GP to have their medicine treatment optimised; three new patients were started this medicine. In the second cycle, after changes had

Inadequate

Are services effective?

(for example, treatment is effective)

been implemented the practice identified 47 patients with heart failure; all were taking this medicine; only two patients were not on optimised doses of medicine which was an improvement compared to the first cycle.
- The practice worked with the Clinical Commissioning Group (CCG) medicines management team and undertook mandatory and optional prescribing audits such as those for antibiotic prescribing.

Effective staffing

Staff had the skills, knowledge and experience to deliver effective care and treatment.

- The practice had an induction programme for all newly appointed staff. It covered topics such as safeguarding, fire safety, health and safety, confidentiality and basic life support.
- The practice could demonstrate how they ensured role-specific training and updating for relevant staff for example, for those reviewing patients with long-term conditions. Staff administering vaccines and taking samples for the cervical screening programme had received specific training which had included an assessment of competence. Staff who administered vaccines could demonstrate how they stayed up to date with changes to the immunisation programmes, for example by access to online resources and discussion at practice meetings.
- The learning needs of staff were identified through a system of appraisals; however one clinical and seven non-clinical members of staff have not had yearly appraisals. The appraisals were not carried out despite this was identified as a required action during the inspection carried out on 5 April 2016. Staff had access to appropriate training to meet their learning needs and to cover the scope of their work.
- Staff received mandatory update training that included: safeguarding, fire procedures, basic life support and information governance awareness; however non-clinical staff only received online basic life support training. Staff had access to and made use of e-learning training modules and in-house training. Following the initial inspection in 5 April 2016 the practice had made improvements to ensure all staff are appropriately trained.

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. Information such as NHS patient information leaflets were also available.
- The practice shared relevant information with other services in a timely way, for example when referring patients to other services.

Staff worked together and with other health and social care services to understand and meet the range and complexity of patients' needs and to assess and plan on-going care and treatment. This included when patients moved between services, including when they were referred, or after they were discharged from hospital. The practice had daily clinical discussions; however these were not minuted. We saw evidence that multi-disciplinary team meetings took place on a bi-monthly basis and that care plans were routinely reviewed and updated.

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.

- These included patients in the last 12 months of their lives, carers, those at risk of developing a long-term condition, patients with a learning disability and those requiring advice on their diet, smoking and alcohol cessation and those with dementia. Patients were then signposted to the relevant service.

Inadequate

Are services effective?

(for example, treatment is effective)

The practice's uptake for the cervical screening programme was 84%, which was in line with the CCG average of 82% and the national average of 81%. There was a policy to offer telephone reminders for patients who did not attend for their cervical screening test. The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening. For example:

- The percentage of females aged 50-70, screened for breast cancer in last 36 months was 75% compared with 73% in the CCG and 72% nationally.
- The percentage of patients aged 60-69, screened for bowel cancer in last 30 months was 64% compared with 58% in the CCG and 58% nationally.

Childhood immunisation rates for the vaccines given were comparable to CCG averages. For example, childhood immunisation rates for the vaccines given to under two year olds ranged from 88% to 97% compared to the CCG rates of 89% to 96%, and five year olds from 77% to 100% compared to CCG rates of 83% to 96%. Flu immunisation target rates for diabetes patients were 100% which was above the CCG and national averages.

Patients had access to appropriate health assessments and checks. These included health checks for new patients and NHS health checks for patients aged 40–74.

Requires improvement

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.

Most of the 17 patient Care Quality Commission comment cards we received were positive about the service experienced; One patient said that they had to wait long time to be seen and another patient said that there was no continuity of care and had to wait many weeks to get an appointment with their preferred GP. Patients said they felt the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect.

We spoke with 16 patients including seven members of the Patient Participation Group. They also told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

Results from the National GP patient survey published on 7 July 2016 showed the practice were in line with or below the local and national averages. For example:

- 81% said the GP was good at listening to them (Clinical Commissioning Group (CCG) average of 88%; national average of 89%).
- 75% said the GP gave them enough time (CCG average 85%, national average 87%).
- 88% said they had confidence and trust in the last GP they saw (CCG average 95%, national average 95%)
- 72% said the last GP they spoke to was good at treating them with care and concern (CCG average 83%, national average 85%).
- 86% said the last nurse they spoke to was good at treating them with care and concern (CCG average 91%, national average 91%).
- 81% said they found the receptionists at the practice helpful (CCG average 86%, national average 87%).

The practice were aware of the above results; however they had not undertaken any specific actions to improve patient experience.

Care planning and involvement in decisions about care and treatment

Patients told us they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them. Patient feedback on the comment cards we received was also positive and aligned with these views.

Results from the national GP patient survey published on 7 July 2016 showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment with GPs. The practice was in line with or below average for consultations with GPs and nurses. For example:

- 77% said the last GP they saw was good at explaining tests and treatments compared to the Clinical Commissioning Group (CCG) average of 85% and national average of 86%.
- 71% said the last GP they saw was good at involving them in decisions about their care (CCG average 80%, national average 82%).
- 80% said the last nurse they saw was good at involving them in decisions about their care (CCG average 89%, national average 90%).

Staff told us that translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patients this service was available.

Patient and carer support to cope emotionally with care and treatment

Notices in 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. The practice had identified 0.2% (15 patients) of the practice list as carers; this was lower than the number of carers identified during the initial inspection on 5 April 2016.

Requires improvement

Are services caring?

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

Inadequate

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

Although the practice had reviewed the needs of its local population, it had not put in place a plan to secure improvements for all of the areas identified. The practice manager informed us that they had not done any specific analysis of the needs of the local population.

- There were longer appointments available for patients with a learning disability and those with complex long-term conditions.
- Home visits were available for older patients and patients who would benefit from these.
- Same day appointments were available for children and those with serious medical conditions.
- The building was accessible and translation services available; however the practice had no hearing loop. Homeless people were able to register at the practice.
- Patients were able to receive travel vaccines available on the NHS as well as those only available privately.
- Patients could electronically check in on the touchscreens available in the reception area.
- The practice offered a text messaging service which reminded patients about their appointments and reviews.

Access to the service

The practice was open between 8:00am and 6:30pm Monday to Friday. Appointments were available from 8:30am to11:30am and 4:00pm to 6:00pm daily. In addition to pre-bookable appointments that could be booked up to four weeks in advance, urgent appointments were also available for people that needed them. The practice was part of local GP Alliance and provided three appointments seven days a week through primary care hubs; weekend appointments could be booked in advance.

Results from the national GP patient survey published on 7 July 2016 showed that patient's satisfaction with how they could access care and treatment were below the local and national averages.

- 45% of patients were satisfied with the practice's opening hours (Clinical Commissioning Group (CCG) average 72%; national average of 76%).
- 22% patients said they could get through easily to the surgery by phone (CCG average 70%, national average 73%).
- 29% patients said they always or almost always see or speak to the GP they prefer (CCG average 58%, national average 59%).

People told us on the day of the inspection that they had difficulties in accessing both routine and emergency appointments when they needed them. Many patients reported that they would prefer to be seen by the long-term GP. The practice was aware of this problem and they were in the process of appointing two salaried GPs to provide more emergency and routine clinical sessions. Some of the patients we spoke to reported difficulties in accessing the surgery by phone; the practice had not done anything specific to improve this.

Listening and learning from concerns and complaints

The practice had an effective system in place for handling complaints and concerns.

- Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England.
- There was a designated responsible person who handled all complaints in the practice; however the practice did not have a complaints leaflet for patients.

We looked at 30 complaints received in the last 12 months and these were satisfactorily dealt with in a timely way; out of the 30 complaints six were regarding the lack of appointments. We saw evidence that the complaints had been acknowledged and responded to and letters were kept to provide a record of correspondence for each complaint. It was not always clear that lessons were learnt from concerns and complaints and action was taken to as a result to improve the quality of care; not all complaints were widely discussed with all practice staff. For example, a patient had complained about the attitude of reception staff. The practice investigated this incident, apologised to the patient and spoke to the reception staff; however this was not widely discussed as a team.

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

he practice had a vision and strategy; however it was not adequately implemented.

Governance arrangements

The practice had a governance framework; however this was not appropriately implemented.

- The practice had limited arrangements in place to identify and manage risk. Patients were at risk of harm because systems and processes were not in place to keep them safe. For example the practice had no robust system in place for the monitoring of patients on high risk medicines.
- Following the comprehensive inspection on 5 April 2016 the practice had sent us an action plan to address the issues identified during the inspection and informed us that they will be compliant by 30 September 2016; however we found that the practice had not addressed all the identified issues.
- There was an understanding of the performance of the practice which was generally below the local average. The partners were aware of the challenges and problems and informed us that they would require additional support to address them.
- The provider was aware of the problems with access to appointments; they had conducted interviews and was in the process of appointing two salaried GPs to provide more emergency and routine clinical sessions. However the practice had not done anything specific to improve telephone access.
- There was a staffing structure and staff were aware of their own roles and responsibilities.
- Practice specific policies were available to all staff.
- The practice had daily staff huddles during which they discussed general issues; discussions from these meetings were recorded. Staff we spoke to reported that this was useful as they discussed current issues as a practice team.
- The practice had quarterly reception staff meetings where they discussed reception specific issues which was attended by GP partners on an ad-hoc basis.

Leadership and culture

The provider did not always prioritise safe, high quality and compassionate care. The partners were visible in the practice and staff told us they were approachable. There was a leadership structure; however had limited formal governance arrangements.

- The practice had significant changes in partnership and management structure in the last year during which three partners retired or left the practice in a short time and new partners joined the practice. Staff we spoke to said that management and support in general had improved over the last year.
- Staff told us there was an open culture within the practice.
- The provider was aware of and complied with the requirements of the Duty of Candour.

When there were unexpected or unintended safety incidents:

- The practice gave affected people reasonable support, truthful information and a verbal and written apology.

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

- The practice encouraged and valued feedback from patients, the public and staff. However it had not proactively sought patients' feedback and engaged patients in the delivery of the service.
- The practice had gathered some feedback from patients through the Patient Participation Group (PPG). The practice had an active PPG with 21 members which met regularly and submitted proposals for improvements to the practice management team. For example, the practice introduced a system to inform patients when the GPs were running late following feedback from the PPG.
- Following the inspection on 5 April 2016 the practice met with the PPG and discussed the findings of the report and action plan.

Continuous improvement

We saw no evidence of continuous improvement.

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 Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **How the regulation was not being met:** The provider had not ensured that face to face basic life support training was provided for all staff. The provider had not ensured that records were maintained for defibrillator checks. The provider had not ensured that all patient group directions were authorised and signed by relevant staff. The provider had not considered how patients would call for help from the patient toilet. This was in breach of regulation 12(1) and 12(12) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **How the regulation was not being met:** The provider had not ensured that a robust system in place for the implementation and monitoring of medicines and safety alerts. The provider had not ensured to seek and act on feedback from service users. This was in breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.