# Dr Wayne Sefton Davis

## Quality Report

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Date of inspection visit: 22 October 2014
Date of publication: 05/02/2015

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

## Ratings

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

# Summary of findings

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## Overall summary

**Letter from the Chief Inspector of General Practice**

Leicester Road medical practice was inspected on the 22 October 2014. This was a comprehensive inspection. This means we reviewed the provider in relation to the five key questions leading to a rating on each on a four point rating scale. We assessed all six of the population groups and the inspection took place at the same time as we inspected a number of practices in the area overseen by Salford Clinical Commissioning Group (CCG). The named GP had temporarily been unable to practice since February 2014. A part time GP was providing the service supported by locum GP cover.

Overall we rated Leicester Road Medical Practice as being inadequate.

Specifically, we found the practice inadequate for providing safe and effective services and being well led. It was also inadequate for providing services for the six population groups that we assess. Improvements were also required for providing responsive and caring services.

Our key findings 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.
- Staff were not consistently clear about reporting incidents, near misses and concerns and there was no evidence of learning and communication with staff.
- There was insufficient assurance to demonstrate people received effective care and treatment. For example mandatory training was not provided to staff.
- Patients were positive about their interactions with staff and said they were treated with compassion and dignity.
- Urgent appointments were usually available on the day they were requested. However patients said that they sometimes had to wait a long time for non-urgent appointments and that it was very difficult to get through the practice when phoning to make an appointment.
- The practice had no clear leadership structure, insufficient leadership capacity and limited formal governance arrangements.

# Summary of findings

The areas where the provider must make improvements are:

- Take action to prevent the risk of infection.
- Take action to more effectively manage medications.
- Take action to ensure that people who use the service are protected by operating effective recruitment and selection procedures.
- Take action to ensure that persons employed are suitably supported and trained to perform their role.
- Complete and submit a Statement of Purpose.
- Take action to assess and monitor the quality of its service.

The areas where the provider should make improvement are:

- Improve team working and ensure staff are aware of lead roles, responsibilities and practice vision.
- Record minor complaints.
- Access and record results from blood tests carried out on patients.
- Review medical equipment and ensure all damaged and un-calibrated equipment is removed.
- Ensure whistleblowing policy contains all relevant information and is available to staff.
- Ensure vulnerable patients are identified and relevant information is available to staff.

**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 safe and improvements are required. Staff understood their responsibilities to raise concerns, report incidents and near misses and there was an open blame free culture at the practice. However, when things went wrong, reviews and investigations were not sufficiently thorough and lessons learnt were not communicated widely enough to support improvement. Risks to patients who used services were not fully assessed. Systems and processes to address these risks were not implemented well enough to ensure patients were kept safe. Medicine management was not effective and staff lacked training to carry out some key safety measures. For example staff had not been trained in fire safety, fire drills were not completed and there was little equipment for dealing with emergency medical situations.

**Are services effective?**

**Inadequate**

The practice is rated as inadequate for effective and improvements are required. Data showed that care and treatment is not delivered in line with recognised professional standards and guidelines. Patient outcomes were hard to identify as little or no reference was made to audits nor was there evidence the practice was comparing its performance to others – either locally or nationally. There is minimal engagement with other providers of health and social care. There is limited recognition of the benefit of an appraisal process for staff and little support for any additional training that may be required. Basic care and treatment requirements are not met. Patients we spoke with were very happy with the care they were provided.

**Are services caring?**

**Requires improvement**

The practice is rated as requires improvement for caring as there are areas where improvements should be made. Data showed patients rated the practice lower than others for some aspects of care. The majority of patients said they were treated with compassion, dignity and respect. However not all felt supported and listened to. Information was available to help patients understand the care available to them but it was not accessible to all. Patients we spoke with were very happy with the care they were provided.

**Are services responsive to people's needs?**

**Requires improvement**

The practice is rated as requires improvement for responsive. Although the practice had informally reviewed the needs of their local population, it had not put in place a plan to secure service improvements for all groups of patients. Patient feedback reported

# Summary of findings

that access to appointments and continuity of care was not always available quickly although urgent appointments were usually available the same day. The practice was equipped to treat patients and meet their needs. Accessible information was provided to help patients understand the complaints system. However, there was no evidence of shared learning from complaints with staff and minor complaints often went unrecorded.

**Are services well-led?**

**Inadequate**

The practice is rated as requires improvement for well-led. The practice did not have a clear vision and strategy in place. Staff we spoke with were not clear about their responsibilities in attempting to achieve the aims of the practice. There was no clear leadership structure and staff did not always feel supported by management. The practice had a number of policies and procedures to govern activity; however these were produced over 5 years ago and had not been reviewed since. The practice did not hold regular governance meetings and issues were discussed at ad-hoc meetings or emailed to staff. The practice had not proactively sought feedback from staff. A patient participation group had been established although communication had proved difficult due to patient's lack of access to information technology. Staff told us they had not received regular performance reviews or appraisals and did not have clear objectives. The ability of the lead GP to exercise clear leadership had been reduced by him being unable to practice for several months. The fact it was not certain when the lead GP would return to practice created an air of uncertainty for both patients and staff.

# Summary of findings

## What people who use the service say

We spoke with ten patients on the day of our visit. We spoke with men, women, working age patients and mothers with children. All patients were very complimentary about the care provided by the clinical staff and the positive and friendly atmosphere fostered by all staff at the practice. They found the doctors, to be professional and knowledgeable about their treatment and care needs. Patients reported that the whole practice staff team treated them with dignity and respect.

The National GP patient survey results for the practice, published in July 2014, 429 surveys were sent out and 123 were returned, giving a 29% completion rate. The survey results found that 83% of respondents with a preferred GP usually got to see or speak to that GP, 89% of respondents were satisfied with the surgery's opening hours and 80% of respondents found it easy to get through to this surgery by phone.

## Areas for improvement

**Action the service MUST take to improve**

Infection control measures were poor.

Medicines were not consistently being well managed.

Robust staff recruitment procedures were not being followed.

Staff were not fully supported or trained to perform their roles.

There was no Statement of Purpose available.

Effective quality monitoring and auditing systems were not in place.

**Action the service SHOULD take to improve**

Team working needed to be improved to ensure staff are aware of lead roles, responsibilities and the practice vision.

Minor complaints were not recorded.

Results from blood tests carried out on patients were not being recorded.

Damaged and un-calibrated equipment was present in the practice.

Infection control audits did not take place.

The whistleblowing policy did not contain all the information required by staff.

Systems did not allow vulnerable patients to be easily identified.

# Dr Wayne Sefton Davis

**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 and an expert by experience (this is a person with knowledge and experience of healthcare).

## Background to Dr Wayne Sefton Davis

The practice is located within a row of commercial shop premises on the main A576 in Salford at 53 Leicester Road, Lower Broughton. There is a pharmacy located next door to the practice, which is available for patients to use for prescriptions and other medical support, it does not form part of the GP practice. The practice provides a service for 3,400 patients in the Lower Broughton area. We were told by the practice manager that 90% of the patients are Orthodox Jews and this created a very atypical demographic for the practice. This meant that comparisons against other population groups were potentially misleading. Due to the absence of the lead GP for a number of months, cover has been provided by another salaried GP who previously worked part time at the practice. Additional services are provided by a locum GP who has surgeries to cover further appointments. The practice has a health care assistant (HCA) and several part time receptionists and administration staff. All clinical staff at the practice are males, reception and administration staff are female. Out of hours services are provided by NHS 111.

Due to religious reasons the practice is closed on Friday afternoons and cover is provided by a nearby health centre should patients require appointments during this time.

## Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme.

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. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

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

## How we carried out this inspection

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?

# Detailed findings

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

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

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 22 October 2014. During our visit we spoke with all of staff present and spoke with patients who used the service.

We saw how staff interacted with patients and managed patient information from patients ringing and calling at the service. We saw how patients accessed the service and the accessibility of the facilities for patients with a disability. We reviewed a variety of documents used by the practice to run the service.

# Are services safe?

## Our findings

### Safe Track Record

The practice used a range of information to identify risks and improve quality in relation to patient safety. For example, reported incidents, as well as comments and complaints received from patients. Staff we spoke to were aware of their responsibilities to raise concerns, and how to report incidents.

We reviewed safety records, incident reports and minutes of meetings where incidents were discussed. This showed the practice had managed these consistently over time and so could evidence striving to achieve a safe track record over the long term.

### Learning and improvement from safety incidents

The practice had a method in place for reporting, recording and investigating significant events, however this method was not systematic and was difficult to review. The practice had a positive approach to recognising and learning from significant incidents however these were not audited regularly for the purpose of learning and improving patient safety. We saw from minutes of staff meetings that when a significant event occurred it was discussed with all staff at the meeting, an action plan was agreed and learning outcomes identified. We discussed the need to audit and review significant events with the practice manager and they agreed that a better system of recording and monitoring significant events would be of benefit.

We examined in detail two of these significant events which had both occurred recently. The first related to the storage of vaccines where as a result of a failure to properly manage their storage, vaccines needed to be destroyed and replaced. The second related to the incorrect issuing of a prescription to a patient with a similar name to the person it was intended for. Both incidents had been recorded and discussed at staff meetings, processes had been put in place to prevent recurrence. However no checks had been made to see if the changes made had been effective and neither had been referred to the local Clinical Commissioning Group (CCG).

There was no system in place for recording and disseminating National patient safety alerts. Staff we spoke with were unable to give examples of recent alerts relevant to the care they were responsible for.

### Reliable safety systems and processes including safeguarding

We saw evidence the practice had systems in place to ensure fire alarms and equipment were regularly tested and maintained. Emergency exit routes were clearly signposted. None of the staff had completed training on fire safety and no fire Marshall was appointed in case of an emergency. The practice had recently commissioned an independent provider to carry out a fire risk assessment and it had been assessed as “broadly compliant”.

All staff were trained in basic life support and we saw certificates which confirmed this.

The practice had systems to manage and review risks to vulnerable children, young people and adults. Practice training records made available to us showed that all staff had received relevant role specific training on safeguarding. We asked members of medical, nursing and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact the relevant agencies in and out of hours. Contact details were easily accessible and found in a folder located in the reception area.

The practice had a clear whistleblowing policy; however there were no contact details for external agencies and the policy suggested that all concerns should be reported internally. We discussed this with the practice manager who indicated they would add external contact numbers to the policy and display a summary of the policy within the practice.

The practice had not documented who was the dedicated GP appointed as a lead in safeguarding vulnerable adults and children. The GP who was currently not practicing had been trained to Level 3 in safeguarding and still maintained regular contact with the surgery and consequently was available to provide advice and guidance if it was required. However when we asked the covering GP who the safeguarding lead was for the practice, he was unaware.

There was no system to highlight vulnerable patients on the practice’s electronic records. This meant that if a child who was on the child protection register attended for an

# Are services safe?

appointment, the GP or locum GP would be unaware of their status and as a consequence would not have heightened vigilance to identify any further safeguarding concerns.

A chaperone policy was in place and was visible on the waiting room noticeboard. Chaperone training had been undertaken by the practice manager and cascaded by informal training to the reception staff who carried out chaperone roles. Reception staff told us they were confident in carrying out this role.

Patient's individual records were written in a way to help ensure safety. Records were kept on an electronic system (Vision) which collated all communications about the patient including communications from hospitals. Updates from paper files to electronic records were completed by a dedicated member of staff on Sundays. We saw no evidence audits had been carried out to assess the completeness of these records and that action had been taken to address any shortcomings identified. We asked the practice manager about the lack of auditing of records and they accepted that there was a need for improvement in this area.

### Medicines Management

We checked vaccines stored in the practice refrigerator and found they were stored securely and were only accessible to authorised staff. There was no "cold chain" policy in place (this is to ensure that vaccines are always maintained at the correct temperature) and this had led to a significant incident where vaccines had been left unrefrigerated for several days. The practice had identified the problem before any patients were put at risk and had completed and investigation resulting in new practices to avoid a repetition. The temperature of the fridge was regularly checked; however there was no annual audit of this process.

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

Child immunisations were completed at a weekly clinic. This clinic was serviced by a nurse from a nearby "buddy" practice. The practice manager told us that on some occasions the vaccines arrived with the nurse in a cool box and on other occasions vaccines were stored in the practice fridge. There appeared to be no clear system for the management of vaccines for child immunisation.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

There was a protocol for repeat prescribing which was in line with national guidance and was followed in practice. The protocol complied with the legal framework and covered all required areas. For example, how staff who generate prescriptions were trained and how changes to patients' repeat medicines were managed. This helped to ensure that patient's repeat prescriptions were still appropriate and necessary.

### Cleanliness & Infection Control

We observed the premises to be clean but in need of some updating in areas. The practice manager told us that some fixtures and fittings although due for replacement had not been due to an imminent move to new purpose built premises. We saw there were cleaning schedules in place and cleaning records were kept. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

None of the staff had received formal training about infection control specific to their role since their induction. We asked the practice manager about infection control audits carried out by the practice, they told us that none had been done, but that no complaints had been received about the subject.

An infection control policy was available for staff to refer to. This was located in the practice manager's office on the first floor. The staff we spoke to were not aware of the policy

Hand hygiene techniques signage was displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were readily available. People using the toilets had to walk from their location several metres to a wash basin located in the main corridor where there was a through flow of people. Personal protective equipment (PPE), such as disposable gloves was

available throughout the practice and sufficient stocks were held in reserve. There were sharps boxes in consultation and treatment rooms for disposal of used needles. These were stored out of reach of children.

The practice manager told us about an infection control audit completed by the local authority in March 2014 in which the practice achieved a mark of over 90%. We were not shown documents which supported this statement.

All clinical waste was collected on a weekly basis by a registered company, we were able to inspect collection receipts which evidenced these collections took place.

### Equipment

Staff we spoke with told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example weighing scales and the equipment measure blood pressure. However we found two pieces of equipment in the treatment room (a set of scales and a sphygmomanometer) that had not been tested since 2009; we were told that these were no longer used.

### Staffing & Recruitment

We looked at records to check for evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks via the Disclosure and Barring Service (DBS). The practice had a recruitment reference checking policy that set out the standards it should follow when recruiting clinical and non-clinical staff. We could find no evidence that any such checks had been undertaken. We asked about the last member of staff who had been employed by the practice and were told that a receptionist had been employed in December 2013. The practice manager told us that they had been referred from a local recruitment agency. We saw records of a job interview that had taken place, where relevant questions had been asked, but there was no evidence of any employment checks having been carried out. There was no proof of identity, no employment reference checks, no declaration of the person being medically and physically fit to carry out the roles. These documents are all required in schedule 3 of the Health and Social Care Act 2008. These requirements assist in ensuring that all staff are suitable and sufficiently trained to treat people who use a regulated service.

We were shown DBS application forms that had been completed for members of staff; these had been submitted and returned by the DBS for additional information several months previously. The practice manager told us they intended to re –submit the forms when the necessary amendments had been made.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure there was enough staff on duty. There was also an arrangement in place for members of staff, including nursing and administrative staff to cover each other's annual leave. Newly appointed staff had this expectation articulated in their job interview notes. Agency staff were available if staffing needs could not be met by the practice's own staff.

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to ensure patients were kept safe.

### Monitoring Safety & Responding to Risk

The practice did not have effective systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These could have included annual and monthly checks of the building, the environment, medicines management, dealing with emergencies and equipment. None of these policies appeared to be in place.

### Arrangements to deal with emergencies and major incidents

We asked about staff training for potential emergencies, we were told that no staff had been trained in fire safety and there was no fire Marshall identified. Fire safety training is a mandatory legal requirement under British Standards (BS 9999:2008 Code of Practice for Fire Safety in the design, management and use of buildings).

All staff had received basic life support training and when spoken to demonstrated a sound knowledge of what to do

if there was a medical emergency within the practice. We were told that staff had requested a panic button at reception several months ago in case of them needing assistance; we noted that one had not yet been installed.

The only emergency medical equipment that was available within the surgery was adrenaline which was located in one of the treatment rooms. We saw that the adrenaline was in date and syringes were available for its injection should the need to treat anaphylaxis. However there was no documented system in place to check it was suitable for use and within the expiry date recommended by the manufacturer. We discussed the need to deal with other potential emergencies (such as cardiac arrest and hypoglycaemia) with the practice manager. They were not aware of what other emergency drugs may be required and stated that they would research the matter. We asked whether emergency oxygen and masks were available for use, we were told that the practice did not keep oxygen and would rely on the ambulance service in the event of an emergency. There was no defibrillator at the practice.

We asked about contingency planning, the practice manager told us that this had been discussed with the practice manager from their "buddy" practice. The practice manager from the "buddy" practice had agreed several months ago to produce a contingency plan for both practices but this had not yet been forthcoming. A business continuity plan attempts to mitigate against identified risks. These risks could include: power failure, adverse weather, unplanned sickness and access to the building. The document should contain relevant contact details for staff to refer to. For example, contact details of a heating company to contact in the event of failure of the heating system.

# Are services effective?

(for example, treatment is effective)

## Our findings

### Effective needs assessment

The GP and health care assistant (HCA) we spoke with could clearly outline the rationale for their treatment approaches. They were familiar with current best practice guidance accessing guidelines from the National Institute for Health and Care Excellence and from local commissioners. The HCA told us about testing for diabetes and how a podiatrist had recently been employed to conduct tests on patient's feet to assist in identifying the condition.

The HCA told us that they were trained in spirometry and the practice had a spirometer, but he could not recall in the four years they had worked there anybody using it. (A spirometer is an apparatus for measuring the volume of air inspired and expired by the lungs. A spirometer measures ventilation, the movement of air into and out of the lungs. The spirogram will identify two different types of abnormal ventilation patterns, obstructive and restrictive.)

We asked the practice manager about how they dealt with people who had recently been discharged from hospital and what was put in place to ensure their care needs were met. We were told that discharge notes were added to patient records in order that the GP could review them. There appeared to be no system to ensure a review took place of their needs following discharge from the hospital. There was no policy or system in place at the practice to conduct medical reviews.

We spoke to the GP about historic inappropriate prescribing of Paracetamol and mouthwash for cases of sore throats. The GP recognised that this used to be an issue but told us this no longer took place.

We asked about the high levels of prescribing of cephalosporin and quinolones shown in data from 2012/2013. We were told that the GP who was currently not practicing was very keen on prescribing these types of antibiotics. The GP we spoke to said he was very cautious about prescribing these and was aware of the current CCG guidelines surrounding these medicines.

We talked with the GP about his knowledge and practice for treating rheumatoid conditions. He was clearly aware of NICE guidance and the need to regularly conduct blood tests on patients prescribed drugs (Methotrexate) to treat this condition. The HCA had an effective system in place to recall patients for blood tests.

The GP told us that patients who were prescribed blood thinning medicines (Warfarin) were referred to the anti-coagulation clinic for blood tests. We noted that the results of these tests were not returned to the GP and relied solely on the patient to inform the GP of the results. We spoke to the practice manager about this and he assured us he would request the return of results from the hospital in future.

We reviewed the records of a number of patients; seven of these patients had long term conditions which included diabetes, hypertension and asthma. We saw that patient reviews had not been conducted within suitable timeframes. We saw one patient who had been prescribed an unusual combination of medicines had not had their blood analysed for over three years. We saw that one of the two asthma patients was prescribed five different medicines and had not been seen for a clinical review.

We spoke to the practice manager about medical reviews. We were told there was no policy or system in place at the practice to conduct medical reviews.

We saw no evidence of discrimination when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were referred on need basis.

### Management, monitoring and improving outcomes for people

We talked to the GP and the practice manager about clinical audits. Other than the example of A and E attendance completed in 2013, there was no evidence of other clinical audits taking place. The GP had undertaken a number of data collection exercises, one relating to uptake of contraception and another relating to cervical screening. These did not however constitute clinical audits and no action and review of the data had taken place.

From data collected by the inspection team we saw that the practice had outlier indicators for a number of issues which included: Ratio of reported versus expected prevalence for chronic obstructive pulmonary disease (COPD) and The ratio of expected to reported prevalence of coronary heart disease (CHD). We investigated these anomalies and saw that the demographics of the patient

# Are services effective?

## (for example, treatment is effective)

population may have had some effect on this. There was an extremely high percentage of younger people registered at the practice (0 to 4 years 15% when the area average is 6%, 5 to 14 years 29% when the area average is 11% and over 65 years being 4% when the area average is 16%). This may explain some of the variance from the mean for the CCG area. A large number of patients at the practice are Orthodox Jewish people. Lower rates of smoking and alcohol misuse amongst this patient group could also be a factor the difference from the expected levels.

We asked the practice manager if peer reviews took place to check the treatment and decision making of the clinicians, we were told they did not. Peer reviews are an effective method of quality assuring a colleague's work and provide an opportunity for colleagues to share knowledge and learning.

### Effective staffing

We spoke with the GP who had been providing most of the surgeries at the practice since February 2014 (This due to the lead GP being unable to practice since that time). The GP had prior to February been conducting three sessions per week, since that time he had been conducting eight sessions per week. We saw that he was well qualified and received annual appraisals from an external assessor. We were told that the GP's revalidation was due in the near future. (Every GP is appraised annually and every five years undergoes a process called revalidation. When revalidation has been confirmed by the General Medical Council the GP's licence to practice is renewed which allows them to continue to practice and remain on the National Performers List held by NHS England.).

Practice staffing included medical, nursing, managerial and administrative staff. We talked to the practice manager about staff training and concluded that staff had attended some training such as annual basic life support. However, there were a number of areas of mandatory training that had not been conducted including: fire safety, health and safety, control of substances hazardous to health (COSHH) and display screen equipment (DSE).

Other than the GP no staff undertook annual appraisals which should identify learning needs from which action plans could be documented. Staff interviews confirmed that the practice was failing to provide training opportunities.

There was no practice nurse; the practice manager told us that a full time female nurse had been employed up to approximately six years ago; however they had left the practice. Following their departure a part time female nurse had been employed but due to financial pressures and low take up of appointments from female patients, it had been decided to dispense with the services of the nurse. This resulted in the practice having all male clinical staff.

The HCA at the practice undertook a number of roles including performing electrocardiograms (ECG), flu and vitamin injections and new patient checks. The HCA told us that he had received initial NHS training four years ago, but had received no updates on clinical training since that time.

### Working with colleagues and other services

We saw that the practice had last attended a meeting with the area commissioners in May 2013. The meeting was referred to as a cluster group meeting; other practices had also attended and shared information and good practice. The practice manager told us that information from the meeting had been shared with all staff at the practice in the form of a letter. We were told attendance at this type of meeting had reduced since the primary care trusts (PCT) had been replaced by the CCG.

The practice manager told us about an audit undertaken in June 2013 where the practice examined patient attendance at A and E and whether it was for good reason or not. The results showed that the patient sample group had all had a good reason to attend. We were told how the local Jewish community had a privately funded paramedic service, staffed by trained personnel from within their own community who were familiar with the cultural differences of the population they served. This service called "Hatzoloh" reduced the need to call on the mainstream ambulance service and A and E departments.

The practice worked with other service providers to meet people's needs and manage complex cases. Blood results, X ray results, letters from the local hospital including discharge summaries, out of hours providers and the 111 service were received both electronically and by post. Reception staff and a dedicated member of staff were responsible for updating records to ensure that the latest and most accurate information was available for patient care.

# Are services effective?

## (for example, treatment is effective)

The practice held multidisciplinary team meetings every three months to discuss patients with complex needs e.g. those with end of life care issues. These meetings were attended by district nurses, social workers, palliative care nurses and decisions about care planning were documented in a shared care record.

The practice manager told us about the close working relationship with the pharmacy located next door, this enabled patients to collect any medication they required in a timely manner, any questions raised could be quickly resolved. The practice is closed every Friday afternoon. An arrangement was in place with a nearby medical centre so that appointments were available to any patients who might require one.

### Information Sharing

The practice used paper and electronic systems to communicate with other providers. For example, there was a shared system with the local out of hour's provider to enable patient data to be shared in a secure and timely manner. Results of blood tests were not routinely requested by the practice and they relied on patients bringing their results back on their next appointment. We discussed this with the practice manager and they agreed that in future requests for results would be made so that patient records were more accurately updated.

The practice had systems in place to provide staff with the information they needed. An electronic patient record was used by staff to coordinate, document and manage patients' care. Some staff were fully trained on the system, and commented positively about the system's safety and ease of use. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference. Staff told us that the practice manager was not proficient in the system and that if they were, then better management of records and information would be possible.

We saw that the practice manager had received training in 2010 on information security, information governance and data protection. They told us that they had cascaded this training to all staff, however other than the practice manager no staff had received formal training on these subjects. The practice had a comprehensive confidentiality policy that had been signed by all staff to say they had read and understood it.

### Consent to care and treatment

We found that staff were not consistently aware of the Mental Capacity Act 2005 and the Children's and Families Act 2014 and their duties in fulfilling it. All the clinical staff we spoke to understood the key principles of the legislation and were able to describe how they implemented it in their practice. Clinical staff had not received formal training in the legislation surrounding consent and we were told that "common sense" was used when decisions about people's best interests were required. We talked to the practice manager about how decisions about end of life care were made and whether "do not attempt to resuscitate" (DNAR) decisions were documented. We were told that culturally this matter never arose as orthodox Jewish people must make every attempt to preserve life whatever the circumstances.

Patients with learning disabilities and those with dementia were supported to make decisions by having a family member or carer with them. There was no system in place to document the care needs of people who lacked the capacity to make all their own informed decisions.

### Health Promotion & Prevention

The practice understood the need for various types of immunisation. During our inspection we saw that many people attended in order to have a flu vaccination. There were posters on display in the waiting area relating to the availability and need for flu immunisations.

It was practice policy to offer all new patients registering with the practice a health check with the health care assistant. The GP was informed of all health concerns detected and these were followed-up in a timely manner. We noted that the GP used their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering opportunistic screening to patients. We were told that for cultural reasons the need to offer smoking cessation or alcohol abuse advice was not necessary as culturally neither were an issue in the patient group. We were told patients who suffered mental health issues would not respond to referrals to external agencies as it was not culturally acceptable to discuss these issues outside the boundaries of the community. We were told that the practice clinical staff had skilled themselves to advise patients about matters relating to mental health issues. The practice manager was not aware of any formal training on the treatment of mental health conditions by

# Are services effective?

## (for example, treatment is effective)

staff. We saw from national quality and outcomes framework (QOF) data, that between 2012 and 2104 no patients at the practice had been assessed as having depression.

The practice did not have ways of identifying patients who needed additional support, For example, no register was held of patients with learning disabilities, obesity or other risk groups. We talked to the practice manager about how patient calls were assessed and if a triage system was in place. We were told that the receptionist were very experienced and knew the patients well enough to assess whether an appointment, a home visit or a telephone response was required. We were told there had been no complaints about this system.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Well baby clinics and child immunisation clinics were available to mothers and babies every Wednesday morning. All people over the age of 75 were invited to see the health care assistant for an annual well person check.

# Are services caring?

## Our findings

### Respect, Dignity, Compassion & Empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey, 83% of respondents with a preferred GP usually got to see or speak to that GP with the CCG (regional) average being 61%. However, 60% of respondents said the last nurse they saw or spoke to was good at listening to them, with the CCG (regional) average being 80%. 66% of respondents had confidence and trust in the last nurse they saw or spoke to with the CCG (regional) average being 86%

We spoke with 10 patients on the day of our inspection. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. Some said that access to female GP would be preferable as only male GPs and clinical staff were employed at the practice.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. We noted that consultation / treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard. Some patients reported that privacy in the reception area was not as good as it might be.

We observed staff were careful to follow the practice's confidentiality policy when discussing patients' treatments in order that confidential information was kept private. The practice switchboard was co-located with the reception desk and consequently patients standing at the reception desk could potentially overhear conversations taking place on the telephone. We saw that computer screens were sited so that they could not be seen by patients whilst waiting to be spoken to at the reception desk. Staff told us they were careful what they said within the hearing of other patients. All staff had individual passwords to access computer systems; this helped in maintaining the security of patient information.

Staff told us if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected they would raise these with the practice manager. We saw that the practice had a violence and aggression policy, this was located in a file with other policies in the practice manager's office. The policy was comprehensive but staff were not aware of it. The policy had not been signed by any staff members and there was no evidence of it having been circulated. We asked the practice manager about this, he told us that this like many of the other policies held at the practice we there to fulfil a requirement, but they were not referred to and had not been reviewed or updated in several years.

### Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example, data from the national patient survey showed 81% said the last GP they saw or spoke to was good at involving them in decisions about their care and 87% said the last GP they saw or spoke to was good at treating them with care and concern. However 54% said the last nurse they saw or spoke to was good at involving them in decisions about their care and 64% said the last nurse they saw or spoke to was good at treating them with care and concern. The practice does not currently employ a nurse, a health care assistant is employed.

Patients we spoke to on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive.

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

### Patient/carer support to cope emotionally with care and treatment

Patients we spoke to told us that staff responded compassionately when they needed help and provided support when required.

We spoke to the practice manager about support groups available to patients, we were told that members of the orthodox Jewish community are very unlikely to seek support from external groups and that most support would be found within the family group or their own GP. This was confirmed by the patients who we spoke to.

# Are services responsive to people's needs?

(for example, to feedback?)

## Our findings

### Responding to and meeting people's needs

We found the practice had an individual approach to being responsive to people's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs. The practice used its knowledge of the patients they were responsible for as a measure of how best to respond to their needs. The practice manager described at length the close and supportive nature of the community and how religious beliefs, moral standards and family values differed to those of other groups within the area. For example the practice did not have a website to provide information and services to patients as very few orthodox Jewish people have access to the internet.

Some patients we spoke to were frustrated by the difficulty in obtaining an appointment. We were told that many people found it easier to call at the practice in person when it opened rather than ring for an appointment.

There had been very little turnover of staff during the last seven years which enabled good continuity of care and accessibility to appointments with a GP of choice. Longer appointments were available for people who needed them and those with long term conditions.

The practice had a patient participation group; we spoke to the chair of the group about how patients were involved in the way the practice was run and how their care was delivered. We were told that communication was mainly by word of mouth as so few patients had internet access or access to emails. Any comments or suggestions would be fed back to the practice manager. The results of any responses to suggestions were difficult to feedback to patients as there was no newsletter or website to publish information.

We talked to the practice manager about other ways that the practice responded to the needs of their patients. We were told of their involvement in an innovation funding workshop held in June 2014. This was an initiative that could benefit patients where the feasibility of an in house pharmacist had been assessed. We were also told that older people were offered home visits and longer appointments when they needed them. Appointments were available outside school and working hours and up until 7.30PM one day per week.

We were told of some GP to GP training for all practice staff which had taken place in October 2013, where staff had been given an input on improved patient transfer.

### Tackle inequality and promote equality

The practice had recognised there were other groups who might potentially use their services. We were told and saw during the inspection that almost all patients were orthodox Jewish people.

The practice had access to telephone translation services and most staff spoke English and Hebrew.

The practice did not provide equality and diversity training. Staff we spoke with confirmed that they had not completed any such training either in the in the last twelve months or previously.

The premises and services had been adapted to meet the needs of disabled people, in that wider doors and adapted toilets had been made available.

### Access to the service

Appointments were available from 8:30am to 6:30 pm on weekdays. Extended hours appointments were available until 7:30PM on Mondays to cater for people who found it difficult to make appointments during normal business hours. On Fridays the practice closed at 3:00PM in the summer and 2:00PM in the winter due to religious reasons.

There were no practice leaflets available to give information to patients and prospective patients. There was no website due to the fact that most patients do not use the internet. However the practice manager showed us a practice information sheet that had recently been drafted and was soon to be published and made available to patients. This contained a wide variety of information about opening times, out of hours and emergency services, staff, prescriptions, complaints and chaperone services.

Patients were generally satisfied with the appointments system. They confirmed that they could see a doctor on the same day if they needed to but some commented that obtaining an appointment via the telephone was often difficult.

# Are services responsive to people's needs?

## (for example, to feedback?)

The practice was situated on the ground floor of the building with offices and administrative functions on the first floor. The practice had wide corridors and a ramp at the front door for the use of patients with mobility issues. This made movement around the practice easier and helped to maintain patients' independence.

We saw that the waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities.

Staff and patients told us they were looking forward to the practice moving to a new purpose built site nearby, where there would be facilities shared with other practices in the area that were also moving to the new location.

### Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Their complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. The practice manager was responsible for handling all complaints in the practice. We noted that reception staff were confident in dealing with complaints of a minor nature however these were not routinely recorded.

Patients we spoke with were aware of the process to follow should they wish to make a complaint. None of the patients spoken with had ever needed to make a complaint about the practice. We noted that the new practice information leaflet included information on how to make a complaint or suggestion.

We looked at three complaints received in the last twelve months and found that they were not recorded in any particular format. However appropriate information was contained in the complaint file and complainants were responded to in a timely manner.

The practice did not review complaints on an annual basis to detect themes or trends. We talked to the practice manager about this and he accepted that a review or audit of complaints could prove useful in identifying trends. He also told us that a system for recording minor complaints dealt with by reception staff would be introduced.

# Are services well-led?

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

## Our findings

### Vision and Strategy

The practice did not have a statement of purpose or any clear documented vision. We talked to the practice manager about the statement of purpose and he told us that one would be completed as soon as possible. There was no practice vision documented or displayed anywhere within the practice. We spoke with five members of staff and none could express what the vision and values of the practice were. However, the staff we spoke to were all clear that they wanted to provide a high quality service to their patients. Patients we spoke to had a very high regard for the GP that was currently not practicing as well as the clinical staff currently working at the practice.

### Governance Arrangements

The practice had a number of policies and procedures in place to govern activity and these were stored in a folder in the practice manager's office. There was no evidence (other than the confidentiality policy) that staff had been made aware of the policies. The practice manager told us that most of these policies had been introduced in order to comply with requirements and they had not been embedded into the workings of the practice. None of the policies had been reviewed for several years (examples included the infection control policy dated 2006, reviewed 2010 and not reviewed since).We asked the practice manager about this and he told us that he had received advice that they did not require review unless national guidance had changed. We discussed this and he agreed that unless they had been reviewed it would be difficult to check if national guidance had altered.

The practice had not completed any clinical audits, although some data gathering had been completed. We discussed the need for clinical audits with the practice manager who accepted that they were a good method for continuous improvement and improving outcomes for patients.

The practice had little in place for identifying, recording and managing risks. The practice manager told us that this was about common sense and having good staff. We discussed risk assessment with him and he accepted that documented risk assessments were a good method of demonstrating a robust system of reducing the likelihood of any risk to patients and staff.

### Leadership, openness and transparency

Leadership structure at the practice had been disrupted since February 2014 when the lead GP had been unable to practice as a GP. It was clear that patients and staff at the practice had high regard for him and that he still involved himself in some of the management of the practice. Staff we spoke to told us that such was the position that this person held, they found it difficult to make suggestions or challenge decisions for fear of the response.

We were told that that to change the culture within the practice so that female receptionists could feel able to challenge the male GPs would be almost impossible. The practice manager was also seen by staff as an authority figure who did not respond well to suggestions and challenge.

Staff were clear about their responsibilities and told us that they knew what their role was on a day to day basis. However there was a lack of team spirit. For example we were told that the practice manager would talk to reception staff on arrival in the morning, and then work from his first floor office for most of the rest of the day, with little communication.

We talked to the practice manager about team meetings, the last having been held in March 2014. The minutes were clear and recorded which staff had been in attendance. The practice manager told us that staff were encouraged to contribute and make suggestions. This was not what other staff told us as they found it difficult to make suggestions or disagree with decisions made by management. They also told us that it was not in the practice culture to promote team building.

### Practice seeks and acts on feedback from users, public and staff

The practice had attempted to gather feedback from patients through a suggestion box placed on the reception counter, there were no suggestions in the box and the practice manager told us that few were placed there. We were shown the complaints/comments folder which contained a number of hand written cards complimenting the practice on the way it was run. There was no system in place for reviewing and responding to comments made by patients. The practice had not completed any customer satisfaction surveys and relied on "word of mouth" to gather the views of its patients.

# Are services well-led?

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

The practice had a patient participation group (PPG) which consisted solely of the chairperson. We spoke to the chair of the PPG on the day of the inspection, they told us how highly patients regarded the GPs and that people were anxious to have the lead GP return to practice. They told us how they had been able to discuss the lack of female clinical staff with the practice manger and that a reasoned explanation had been given as to why there was none. Because most patients had no internet access and the practice did not have a website this made communication between the practice, the PPG and the patients more difficult.

The practice did not conduct staff surveys and relied on day to day contact with staff to gather their views. Other than the GP no staff had received an appraisal of a formal supervision meeting. We discussed this with the practice manager who accepted that an appraisal system would be a good method of identifying training and welfare needs and well providing staff with leadership, development and performance initiatives. Staff told us they had little or no training opportunities or potential to advance within the organisation. It was accepted by staff that opportunities within such a small practice were limited.

We had noted that two comments had been made on the NHS Choices website, both of which had been positive. We asked the practice manager about these and if they had considered responding to them, they were unaware of the comments but said they would ensure that that they looked at them and would respond if appropriate.

### Management lead through learning & improvement

The practice had completed reviews of significant events and other incidents and shared with staff via meetings to ensure the practice improved outcomes for patients. For example a failure in the storage of drugs and a wrongly issued prescription.

The GP we spoke to told us that the practice supported them to maintain their clinical professional development through training and mentoring. Other staff were not so well supported with training. The HCA told us that they had received no clinical training in the last four years and reception staff told us that very little training had been offered.

This section is primarily information for the provider

# Compliance actions

## Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

| Regulated activity | Regulation |
|---|---|
| Diagnostic and screening procedures<br>Family planning services<br>Maternity and midwifery services<br>Surgical procedures<br>Treatment of disease, disorder or injury | Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control<br>People who use services were not protected against the risks associated with the risk of infection arising from carrying on of the regulated activity. The provider must take action to ensure that people who use the service are protected by the effective operation of systems designed to assess the risk of and to prevent, detect and control the spread of healthcare associated infection. Contrary to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 |

| Regulated activity | Regulation |
|---|---|
| Diagnostic and screening procedures<br>Family planning services<br>Maternity and midwifery services<br>Surgical procedures<br>Treatment of disease, disorder or injury | Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines<br>People who use services and others were not protected against the risks associated with unsafe or unsuitable management of medicines as appropriate systems were not in place to record, handle, use, keeping safe, and dispose of medicines. Contrary to Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 |

| Regulated activity | Regulation |
|---|---|
| Diagnostic and screening procedures<br>Family planning services<br>Maternity and midwifery services<br>Surgical procedures<br>Treatment of disease, disorder or injury | Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers<br>People who use services were not protected against the risks associated with ineffective recruitment procedures and not carrying out relevant checks when employing staff. The provider must take action to ensure that people who use the service are protected by operating effective recruitment and selection procedures that |

# Compliance actions

includes relevant checks being carried out (and evidenced) when staff are employed. Contrary to Regulation 21(a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010

| Regulated activity | Regulation |
|---|---|
| Diagnostic and screening procedures<br>Family planning services<br>Maternity and midwifery services<br>Surgical procedures<br>Treatment of disease, disorder or injury | Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff<br>People who use services were not protected against the risks associated with ineffective support for workers as they were not receiving appropriate training, professional development, supervision and appraisal; demonstrating evidence of clinical governance and audit Contrary to Regulation 23 1 (a), 2 and 3 (a) and (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 |

| Regulated activity | Regulation |
|---|---|
| Diagnostic and screening procedures<br>Family planning services<br>Maternity and midwifery services<br>Surgical procedures<br>Treatment of disease, disorder or injury | Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers<br>People who use services were not protected against the risks associated with the failure to assess and monitor the quality of service provision as there were no robust risk assessments or quality relating to the health, welfare and safety of service users and others who may be at risk from the carrying on of the regulated activity. There was insufficient analysis of incidents, clinical audits, research projects service users, their agents and staff reviews Contrary to Regulation 10 1 a and b, 2 c (i) and (ii) and d (i) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 |