

Oldham Medical Services

Quality Report

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Date of inspection visit: 16/02/2018
Date of publication: 01/05/2018

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

Ratings

Overall rating for this service

Inadequate



Are services safe?

Inadequate



Are services effective?

Requires improvement



Are services caring?

Requires improvement



Are services responsive to people's needs?

Requires improvement



Are services well-led?

Inadequate



Key findings

Contents

Key findings of this inspection

Letter from the Chief Inspector of General Practice	Page 2
The six population groups and what we found	4
Areas for improvement	5

Detailed findings from this inspection

Our inspection team	6
Background to Oldham Medical Services	6
Detailed findings	7
Action we have told the provider to take	19

Letter from the Chief Inspector of General Practice

This practice is rated as Inadequate overall. (Previous inspection March 2015 – Good)

The key questions are rated as:

Are services safe? – Inadequate

Are services effective? – Requires improvement

Are services caring? – Requires improvement

Are services responsive? – Requires improvement

Are services well-led? – Inadequate

As part of our inspection process, we also look at the quality of care for specific population groups. The population groups are rated as:

Older People – Inadequate

People with long-term conditions – Inadequate

Families, children and young people – Inadequate

Working age people (including those recently retired and students – Inadequate

People whose circumstances may make them vulnerable – Inadequate

People experiencing poor mental health (including people with dementia) – Inadequate

We inspected Oldham Medical Services on 5 March 2015. The practice was rated as good in all domains and overall good. There were some areas where we suggested improvements should be made, but not all these had been carried out. During 2017 an assistant practice manager had joined the practice. They left in October 2017 and the practice manager left in November 2017. The practice had had no manager in place until the current practice manager started work six weeks prior to the inspection.

We carried out an announced comprehensive inspection at Oldham Medical Services on 16 February 2018. This was part of our inspection programme. We found that the overall rating had reduced to inadequate.

At this inspection we found:

- The practice did not have systems in place to manage risk so that safety incidents were less likely to happen. For example the fire risk assessment was not adequate and fire checks were not up to date.
- The infection control audit was not adequate and it had not been identified that some items were not stored hygienically.
- Minor surgery took place approximately every month but the last recorded audit for minor surgery was in June 2013.

Summary of findings

- Medicines were not securely stored.
- The cold chain was not effectively monitored.
- When incidents did happen, there was no evidence of learning from them.
- The practice had identified that 300 children had outstanding immunisations but the partners had not been informed of this by nursing or administrative staff..
- There was no evidence new safety guidelines or medicine alerts were disseminated to appropriate staff.
- There was no focus on continuous learning and improvement at any levels of the organisation.
- Staff were not well supported and there was little evidence of appraisal.
- Only 0.2% of patients had been identified as carers and no additional support was offered to carers.
- Not all complaints were investigated and responses to complaints did not contain all the required information.
- The governance in the practice did not support good practice.
- The practice was not correctly registered by the Care Quality Commission (CQC); the registered manager had left and CQC had received no application to register a new one.

The areas where the provider **must** make improvements are:

- The provider must ensure care and treatment is provided in a safe way to patients.
- The provider must ensure that any complaint received is investigated and any proportionate action is taken in response to any failure identified by the complaint or investigation. The provider must ensure there is an effective system for identifying, receiving, recording, handling and responding to complaints by patients and other persons in relation to the carrying on of the regulated activity.

- The provider must establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.
- The provider must ensure persons employed in the provision of the regulated activity receive the appropriate support, training, professional development, supervision and appraisal necessary to enable them to carry out the duties.
- The provider must ensure recruitment procedures are established and operated effectively to ensure only fit and proper persons are employed. The provider must ensure specified information is available regarding each person employed.

In addition the provider should:

- The provider should take steps to correctly identify patients who are carers so appropriate support can be offered.

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

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

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

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

Summary of findings

The six population groups and what we found

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

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

Key findings

Areas for improvement

Action the service **MUST** take to improve

- The provider must ensure care and treatment is provided in a safe way to patients.
- The provider must ensure that any complaint received is investigated and any proportionate action is taken in response to any failure identified by the complaint or investigation. The provider must ensure there is an effective system for identifying, receiving, recording, handling and responding to complaints by patients and other persons in relation to the carrying on of the regulated activity.
- The provider must establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.

- The provider must ensure persons employed in the provision of the regulated activity receive the appropriate support, training, professional development, supervision and appraisal necessary to enable them to carry out the duties.
- The provider must ensure recruitment procedures are established and operated effectively to ensure only fit and proper persons are employed. The provider must ensure specified information is available regarding each person employed.

Action the service **SHOULD** take to improve

- The provider should take steps to correctly identify patients who are carers so appropriate support can be offered.

Oldham Medical Services

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC lead inspector. The team also included a GP specialist adviser.

Background to Oldham Medical Services

Oldham Medical Services is located in a two storey building on a main road in the Hathershaw area of Oldham. The practice moved to this adapted building in 2010.

There are two partners at the practice, both female, and there is a female salaried GP. There are also two practice nurses and a healthcare assistant. They are supported by a practice manager, who had been in post for six weeks at the time of our inspection, and administrative staff.

The practice is open:

Monday 7am – 6.30pm

Tuesday 7.30am – 6.30pm

Wednesday 7.30am – 6.30pm

Thursday 8am until 6.30pm

Friday 7.30am – 6.30pm.

Clinics started at the time the practice opened and were at various times throughout the day.

The practice delivers commissioned services under a General Medical Services (GMS) contract. At the time of our inspection 4784 patients were registered with the practice.

The practice is in an area of high deprivation with a deprivation level of one on a scale of one to 10, where one is the most deprived.

Oldham Medical Services had opted out of providing out-of-hours services to their patients. This service was provided by Go to Doc Limited via NHS 111.

Are services safe?

Our findings

At the inspection 5 March 2015 the practice was rated as good for providing safe services.

At the inspection in March 2015 we told the provider they should train all staff in infection prevention and control, carry out a legionella risk assessment and regular testing if needed, and formalise and record health and safety walkarounds. At this inspection we found hand washing training had not been carried out since June 2015, a legionella risk assessment had been carried out in August 2016 but the 12 month check had been missed, and health and safety checks were not documented.

At this inspection on 16 February 2018 we rated the practice, and all of the population groups, as inadequate for providing safe services.

The practice was rated as inadequate for providing safe services because:

- The practice did not have clear systems to manage risk so that safety incidents were less likely to happen. Safety was not a sufficient priority and there was limited monitoring. For example there were no recent fire safety checks, fridge checks were not sufficient for cold chain monitoring, and the infection control audit was not fully completed. Not all the required pre-recruitment checks were carried out. Significant events were not all collated within the practice so they could be effectively monitored. There was no system for acting on safety or medicine alerts. 300 child vaccinations had been missed and the partners had not been made aware of this.

Safety systems and processes

The practice did not have systems to keep patients safe and safeguarded from abuse.

- Although fire safety was covered within a policy that had been reviewed in June 2014. The processes within this document were not implemented or practice specific. The practice did not have an adequate up to date fire risk assessment and had not carried out regular fire drills or fire evacuations. The new practice manager had identified there had been no fire marshal so they were sourcing training for a staff member.

- The six month service dates for the fire alarm and emergency lighting were overdue. We saw no evidence of recent fire alarm or emergency lighting checks being carried out.
- An automatic external defibrillator was kept in the reception office and oxygen was kept in the healthcare assistant's room. The practice manager told us the defibrillator was checked monthly, but there was no clear system in place to evidence this. The oxygen was checked appropriately every week.
- The practice worked with other agencies to support patients and protect them from neglect and abuse. Staff took steps to protect patients from abuse, neglect, harassment, and discrimination. There was evidence that staff had completed safeguarding training at the appropriate level. This assurance was not held for all locum GPs, although we saw no evidence that procedures were not followed.
- The recruitment process was not safe.
- Checks on locum GPs were carried out when they first worked at the practice but these were not repeated. We looked at the information held for two current locum GPs who had worked at the practice since May 2015. Their professional registration had not been checked since then and no check had been carried out on their medical indemnity insurance, which had expired 3 October 2015. We saw no evidence of current medical indemnity insurance for one partner or the salaried GP. This was raised with the practice manager and partner at the time of the inspection. The practice manager was unable to provide this following the inspection as one was on annual leave and one had just returned from maternity leave.
- There was no effective system to manage infection prevention and control. The practice manager told us an infection control audit had been carried out the week prior to our inspection. This was supplied but it was not dated and it had not been fully completed so it was not possible to determine a score or if there were any issues. The last evidence for hand washing training for staff, that was said to be carried out annually, was from May and June 2015. There was no evidence staff employed since that date had received training.
- In one of the nurse's rooms we saw seven cervical smear cell sampler brushes kept out of sterile packaging stood

Are services safe?

in a pot next to the examination couch. If used this was a risk to patients. The room was not in use on the day of the inspection. The practice manager removed these while we were there.

- A legionella risk assessment had been carried out on 3 August 2016. This stated that another inspection was due in August 2017. This had not been carried out.

Risks to patients

Systems to assess, monitor and manage risks to patient safety were not adequate.

- The practice told us it had been difficult to recruit staff and they would need to re-advertise for new reception staff as a few staff had left over a short period of time. However, they said current staff were flexible and would work extra hours if needed. The two practice nurses and the healthcare assistant did not work on Fridays.
- Staff understood their responsibilities to manage emergencies on the premises and to recognise those in need of urgent medical attention.
- There was no clinical guidance for clinicians to enable an assessment of patients with presumed sepsis, in line with guidance from the National Institute of Health and Care Excellence (NICE). Reception staff had received training in how to recognise red flag symptoms.

Information to deliver safe care and treatment

Staff had the information they needed to deliver safe care and treatment to patients.

- Individual care records were written and managed in a way that kept patients safe. The care records we saw showed that information needed to deliver safe care and treatment was available to relevant staff in an accessible way.
- The practice had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.
- Referral letters included all of the necessary information.

Safe and appropriate use of medicines

The practice did not have reliable systems for appropriate and safe handling of medicines. The systems for managing medicines, including vaccines, medical gases, and emergency medicines and equipment were not sufficient.

- The temperatures of the two medicine fridges, one in each of the nurses' rooms, were recorded in a logbook. However we saw several days when the fridge temperatures had not been recorded. Some of these days were when the nurses and healthcare assistant were not on duty. In addition, we saw occasions when the fridge temperature had been re-set without an explanation being given. On two occasions the maximum temperature had been recorded as 8.5°C (the maximum safe temperature is 8°C) but on one occasion it was 6.6°C. On one occasion the maximum temperature was recorded as being 8.4°C but no action had been taken.
- One fridge contained flu vaccinations that had expired 29 January 2018. This had not been identified by the practice.
- Emergency medicines were kept in the healthcare assistant's room and this was kept unlocked for easy access. All medicines were within their expiry date. However, they were easily accessible to patients. The nurses' rooms were also unlocked at the time of the inspection, and the medicine fridge in each room was unlocked. The practice manager told us they thought the rooms were unlocked in case we required access.
- The practice told us they prescribed, administered or supplied medicines to patients and gave advice on medicines in line with legal requirements and current national guidance. However, there was no process to disseminate or record new National Institute of Health and Care Excellence (NICE) or Medicines and Healthcare products Regulatory Agency (MHRA) guidance or alerts and no evidence seen of any discussions around guidance or alerts.
- Patients' health was monitored to ensure medicines were being used safely and followed up on appropriately. The practice involved patients in regular reviews of their medicines.

Track record on safety

The practice did not have a good safety record. Risk assessments in relation to safety issues were not adequate.

Are services safe?

These included the fire risk assessment. The infection control audit did not provide an assessment of possible issues, and had not identified some of the issues we identified during the inspection. Medicine checks were not effective as we found out of date vaccines and medicines that were not stored securely. The practice did not monitor or review activity to understand the risks and give a clear, accurate and current picture that could lead to safety improvements.

Lessons learned and improvements made

We did not see evidence that the practice learned and made improvements when things went wrong.

- The system for recording and acting on significant events and incidents was not adequate. Staff did not have an understanding of what should be reported.
- The systems for reviewing and investigating when things went wrong were not adequate. There was a significant event folder. For the year to date 2017-18 there was only one recorded significant event in the folder, from a cyber-attack on 12 May 2017. This had been reviewed 24 May 2017 and the action recorded was 'discussed in meeting'. There was no learning documented.
- In addition to significant events formally recorded by the practice, the GP partners also recorded significant events which they kept as evidence for their appraisals. These were kept by the individual partners and not collated. We saw examples of two significant events recorded by the GP partner available during the inspection. These were both well-documented and included learning points. They were said to have been discussed in a clinical team meeting in July 2017, but these minutes were not held in the meeting minute's folder. They told us the other GP partner also held evidence of significant events but they were on annual leave so they were unavailable.
- The practice manager told us that it had been discovered that 300 children had outstanding childhood vaccinations. The practice nurses had worked over the previous year and reduced this number to 15. No significant event was recorded when the discovery was made and the child health team or Public Health England had not been informed. The GP partner told us they had been unaware this had occurred until the morning of our inspection.
- The practice manager told us significant events were discussed in meetings. However we saw evidence of only one administration team meeting and this was since the practice manager started in their role six weeks prior to the inspection. We saw evidence of there being four clinical team meetings in the previous 12 months. The cyber-attack had been discussed.
- There was no system for receiving and acting on safety alerts. The practice manager told us they emailed alerts to the GPs but they had only been in post for six weeks. No log was kept of this. There was no record of alerts being discussed.

Are services effective?

(for example, treatment is effective)

Our findings

At the inspection 5 March 2015 the practice was rated as good for providing responsive services.

At the inspection in March 2015 the practice was told all staff should have an appraisal with their line manager. We saw some recent examples of appraisals but records were not adequate.

At this inspection on 16 February 2018 we rated the practice, and all of the population groups, as requires improvement for providing effective services.

The practice was rated as requires improvement for providing effective services because:

- The practice did not have a comprehensive effective programme of quality improvement activity where they routinely reviewed the effectiveness and appropriateness of the care provided. The partners were unaware 300 children had missed childhood immunisations. The learning needs of staff were not well-monitored and staff did not receive on-going support through appraisals.

Effective needs assessment, care and treatment

The practice did not have systems to keep clinicians up to date with current evidence-based practice. However, we saw that clinicians assessed needs and delivered care and treatment in line with current legislation, standards and guidance supported by clear clinical pathways and protocols.

- Patients' needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.
- The rate of prescribing for hypnotic medicines was above the clinical commissioning group (CCG) and national average.
- The rate of anti-biotic prescribing was in line with the CCG and national average.
- We saw no evidence of discrimination when making care and treatment decisions.

Older people:

- Older patients who are frail or may be vulnerable received an assessment of their physical, mental and social needs.

- Patients aged over 75 were invited for a health check. If necessary they were referred to other services such as voluntary services and supported by an appropriate care plan.
- The practice followed up on older patients discharged from hospital. It ensured that their care plans and prescriptions were updated to reflect any extra or changed needs.

People with long-term conditions:

- Patients with long-term conditions had a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- Performance for diabetes related indicators was 87%. This was in line with the CCG average of 88% and the national average of 91%.
- Performance for asthma related indicators was 100%. This was in line with the CCG average of 99% and the national average of 97%.
- Performance for chronic obstructive pulmonary disease related indicators was 89%. This was below the CCG average of 97% and the national average of 96%.

Families, children and young people:

- Childhood immunisations were carried out in line with the national childhood vaccination programme. Uptake rates for the vaccines given were 83%, which was below the target percentage of 90% or above. The practice nurse had identified that 300 children had outstanding immunisations, and they had managed to reduce this to 15 over the previous year. A significant event had not been raised.

Working age people (including those recently retired and students):

- The practice's uptake for cervical screening for 2016-17 was 65%, which was below the 80% coverage target for the national screening programme. The CCG average and national average was 72%. However the practice provided evidence that the figure for 2017-18 was 77% on the day of the inspection.

Are services effective?

(for example, treatment is effective)

- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40-74. There was appropriate follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.

People whose circumstances make them vulnerable:

- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability. Patients with a learning disability had an annual review.

People experiencing poor mental health (including people with dementia):

- 70% of patients diagnosed with dementia had their care reviewed in a face to face meeting in the previous 12 months. This was below the CCG average of 84% and the national average of 84%.
- 90% of patients diagnosed with schizophrenia, bi-polar affective disorder and other psychoses had a comprehensive, agreed care plan documented in the previous 12 months. This was in line with the CCG average of 89% and the national average of 90%.
- The practice specifically considered the physical health needs of patients with poor mental health and those living with dementia. For example the percentage of patients experiencing poor mental health who had received discussion and advice about alcohol consumption was 96%; compared to the CCG average of 92% and the national average of 91%.

Monitoring care and treatment

The practice did not have a comprehensive effective programme of quality improvement activity where they routinely reviewed the effectiveness and appropriateness of the care provided. The GP partner did not know until the day of the inspection that 300 children had been identified as having outstanding vaccinations, and they had not identified that nurses had not received supervision or appraisal.

The most recent published Quality Outcome Framework (QOF) results were 95% of the total number of points available compared with the clinical commissioning group (CCG) average of 96% and national average of 94%. The

overall exception reporting rate was 11% compared with the CCG average of 8% and the national average of 10%. (QOF is a system intended to improve the quality of general practice and reward good practice. Exception reporting is the removal of patients from QOF calculations where, for example, the patients decline or do not respond to invitations to attend a review of their condition or when a medicine is not appropriate.)

The practice manager provided us with two clinical audit cycles that had been completed since April 2016. Although the GP partner available during the inspection talked us through one audit the other partner had completed the second one. They told us the audits had not been shared or discussed between the partners so there was no evidence improvements had been implemented practice-wide.

Effective staffing

We did not always see evidence that staff had the skills, knowledge and experience to carry out their roles.

- The practice did not understand the learning needs of staff. The practice manager told us the nurses were good at monitoring their own training and they managed their own continuing professional development. The practice manager provided us with training information for staff. Although most training for staff was up to date the last recorded cervical smear update training for one practice nurse was in 2011, and there was no record of them having infection control training.
- The practice did not provide staff with on-going support. We saw that induction checklists were in place but these had not been completed or signed off for newly employed staff. We saw some evidence of staff appraisal. However records were brief and not fully completed. Most records were not dated and did not say who had carried out the appraisal. The practice nurses did not have appropriate appraisals carried out. One of the nurses had been employed since 2015 and their first appraisal was in February 2018. The other nurse had been employed for several years. Their most recent personal development plan was dated 2011.
- There was no clear approach to supporting and manage staff when their performance was poor or variable. We saw evidence of a meeting to discuss performance issues for one staff member during 2016. The record did not state which manager the meeting was with. There

Are services effective?

(for example, treatment is effective)

was no record of this being discussed again and no indication of performance improving. The previous practice manager who had been in post for several years had left in November 2017. There was no record of any appraisals or performance management issues in their personnel file.

Coordinating care and treatment

Staff worked together and with other health and social care professionals to deliver effective care and treatment.

- We saw records that showed that appropriate staff, including those in different teams, services and organisations, were involved in assessing, planning and delivering care and treatment.
- Patients received coordinated and person-centred care. This included when they moved between services, when they were referred, or after they were discharged from hospital. The practice worked with patients to develop personal care plans that were shared with relevant agencies.
- The practice ensured that end of life care was delivered in a coordinated way which took into account the needs of different patients. Monthly multi-disciplinary meetings were held. We also saw that best interest meetings were held when appropriate

Helping patients to live healthier lives

Staff were consistent and proactive in helping patients to live healthier lives.

- The practice identified patients who may be in need of extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.
- The percentage of new cancer cases that were referred using the urgent two week wait referral pathway was 58%, which was in line with the CCG average of 58% and the national average of 52%.
- Staff encouraged and supported patients to be involved in monitoring and managing their health.
- The practice told us they supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns and tackling obesity. Leaflets were available in the nurses' rooms. Patients were referred to local clinics for smoking cessation and weight management.

Consent to care and treatment

The practice obtained consent to care and treatment in line with legislation and guidance.

- Clinicians understood the requirements of legislation and guidance when considering consent and decision making.
- Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision. Clinicians had completed training in the Mental Capacity Act 2006.

Are services caring?

Our findings

At the inspection 5 March 2015 the practice was rated as good for providing caring services.

At this inspection on 16 February 2018 we rated the practice, and all of the population groups, as requires improvement for providing caring services.

The practice was rated as requires improvement for providing caring services because:

- A low number of patients who were carers had been identified and no additional support for carers was offered. There was no protocol for supporting bereaved patients. Some patient survey figures were below average. A concern raised about data protection had not been addressed.

Kindness, respect and compassion

Although we saw staff treat patients with kindness, respect and compassion, the practice manager, who had been in post for six weeks, told us they had identified that some training around customer care could be useful. There were also some negative comments on the NHS Choices website regarding how patients were treated by staff. Comments on the NHS Choices website had not been responded to since May 2017.

- Staff understood patients' personal, cultural, social and religious needs.
- Reception staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs. However there was no sign in the waiting room indicating this.
- There were no signs in the reception area to notify patients chaperones were available. There was a sign in one of the nurse's rooms. In the other there was no sign but the chaperone policy was on the wall. This was not easily seen by patients as it was in small print and among other information.
- We received 24 patient Care Quality Commission comment cards, completed on the day on the inspection. These all contained positive comments. However two also contained less positive comments about staff attitude.

Results from the July 2017 annual national GP patient survey showed most patients felt they were treated with compassion, dignity and respect. 387 surveys were sent out and 117 were returned. This was a completion rate of 30% representing about 2% of the practice population. The practice had variable scores for its satisfaction on consultations with GPs and nurses. For example:

- 78% of patients who responded said the GP was good at listening to them compared with the clinical commissioning group (CCG) average of 88% and the national average of 89%.
- 72% of patients who responded said the GP gave them enough time; CCG - 86%; national average - 86%.
- 95% of patients who responded said they had confidence and trust in the last GP they saw; CCG - 95%; national average - 95%.
- 78% of patients who responded said the last GP they spoke to was good at treating them with care and concern; CCG - 86%; national average - 86%.
- 93% of patients who responded said the nurse was good at listening to them; CCG - 92%; national average - 91%.
- 95% of patients who responded said the nurse gave them enough time; CCG - 93%; national average - 92%.
- 100% of patients who responded said they had confidence and trust in the last nurse they saw; CCG - 97%; national average - 97%.
- 97% of patients who responded said the last nurse they spoke to was good at treating them with care and concern; CCG - 92%; national average - 91%.
- 72% of patients who responded said they found the receptionists at the practice helpful; CCG - 88%; national average - 87%.

Involvement in decisions about care and treatment

There were some positive results in the national GP patient survey. Interpretation services were available for patients who did not have English as a first language, although there were no notices available to give this information in reception.

Are services caring?

There was no formal protocol for supporting bereaved patients. The GP partner told us they sent a sympathy card to these patients but the practice manager told us this had been discussed recently and cards were not sent.

The practice had identified that nine of their patients were carers. This was 0.2% of the practice list. There was no additional support offered to carers.

Results from the national GP patient survey showed most patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. Results were mostly in line with local and national averages:

- 83% of patients who responded said the last GP they saw was good at explaining tests and treatments compared with the CCG average of 87% and the national average of 86%.
- 75% of patients who responded said the last GP they saw was good at involving them in decisions about their care; CCG - 81%; national average - 82%.

- 92% of patients who responded said the last nurse they saw was good at explaining tests and treatments; CCG - 91%; national average - 90%.
- 93% of patients who responded said the last nurse they saw was good at involving them in decisions about their care; CCG - 87%; national average - 85%.

Privacy and dignity

The practice respected and promoted patients' privacy and dignity.

- Staff recognised the importance of patients' dignity and respect. Some staff had completed on-line training in equality and diversity.
- The practice complied with the Data Protection Act 1998. We saw that most staff had received on-line information governance training. However, we saw a complaint dated November 2017 regarding a data protection issue. The practice manager at the time responded in writing giving assurance that no staff would disclose a patient's personal details. However, we saw no evidence that this had been investigated or discussed with staff.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

At the inspection 5 March 2015 the practice was rated as good for providing responsive services.

At this inspection on 16 February 2018 we rated the practice, and all of the population groups, as requires improvement for providing caring services.

The practice was rated as requires improvement for providing responsive services because:

- The practice complaints were not managed, responded to or actioned in an appropriate manner.

Responding to and meeting people's needs

The practice did not always organise and deliver services to meet patients' needs.

Appointments could be booked up to two months in advance. On-line appointment booking was available. GP appointments were available from 7.30am twice a week, and nurse appointments were available from 7am and 7.30am, one day a week each.

- We saw no evidence that services were monitored to identify the unmet needs of any patient.
- The GP told us if a patient needed an urgent blood test on a Friday, they would be directed to the local hospital or the urgent care centre.
- The facilities and premises were appropriate for the services delivered.
- Care and treatment for patients with multiple long-term conditions and patients approaching the end of life was coordinated with other services.

Older people:

- All patients had a named GP who supported them in whatever setting they lived, whether it was at home or in a care home or supported living scheme.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs. The nurse carried out regular residential and nursing home visits.

People with long-term conditions:

- Patients with a long-term condition received an annual review to check their health and medicines needs were being appropriately met.
- The practice invited the local district nursing team to their clinical meetings to discuss and manage the needs of patients with complex medical issues.

Families, children and young people:

- The GP told us there were systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances.
- All parents or guardians calling with concerns about a child under the age of five were offered a same day appointment when necessary.

Working age people (including those recently retired and students):

- The needs of this population group had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. For example, there were extended opening hours.
- Telephone GP consultations were available which supported patients who were unable to attend the practice during normal working hours.

People whose circumstances make them vulnerable:

- Patients with a learning disability were offered an annual review.
- Staff received safeguarding training at the appropriate level.
- The practice held a register of patients living in vulnerable circumstances including homeless people, and those with a learning disability.

People experiencing poor mental health (including people with dementia):

- The practice had a dementia register and carried out dementia screening when appropriate.
- Patients with mental health needs were referred or signposted to local services for support.

Timely access to the service

Are services responsive to people's needs?

(for example, to feedback?)

Patients were able to access care and treatment from the practice within an acceptable timescale for their needs.

- Patients had timely access to initial assessment, test results, diagnosis and treatment.
- Waiting times, delays and cancellations were minimal and managed appropriately.
- Patients with the most urgent needs had their care and treatment prioritised.
- The appointment system was easy access and for patients to use.

Results from the July 2017 annual national GP patient survey showed that patients' satisfaction with how they could access care and treatment was comparable to local and national averages. This was supported by observations on the day of inspection and completed comment cards. 387 surveys were sent out and 117 were returned. This was a completion rate of 30% representing about 2% of the practice population.

- 77% of patients who responded were satisfied with the practice's opening hours compared with the clinical commissioning group (CCG) average of 79% and the national average of 76%.
- 71% of patients who responded said they could get through easily to the practice by phone; CCG - 73%; national average - 71%.
- 83% of patients who responded said that the last time they wanted to speak to a GP or nurse they were able to get an appointment; CCG - 81%; national average - 84%.
- 76% of patients who responded said their last appointment was convenient; CCG - 79%; national average - 81%.
- 70% of patients who responded described their experience of making an appointment as good; CCG - 72%; national average - 73%.
- 53% of patients who responded said they don't normally have to wait too long to be seen; CCG - 59%; national average - 58%.

Listening and learning from concerns and complaints

The practice did not respond appropriately to complaints with a view to improving the quality of care.

- There was no information in the waiting area about how to make a complaint, but it was available on the website. Staff told us if a patient asked about how to make a complaint they would firstly try to resolve it before passing information to the practice manager. They would give patients a complaint form if requested.
- We saw an example of a written complaint from September 2017 being dealt with by telephone. The majority of the written responses we reviewed did not inform patients of how they could escalate their complaint if they were not happy with how it had been handled. One written complaint dated 13 December 2017, had received an acknowledgement letter dated the 20 December 2017. This was to inform the patient their complaint would be investigated in the new year. We saw no evidence that any further action had been taken.
- We saw that complaints about a GP were dealt with by the GP named. We saw an example of a complaint about a locum GP. This was passed to the locum GP via the locum agency. They provided a written response, which did not contain details of the Parliamentary and Health Services Ombudsman (PHSO), which was sent to the patient by the practice manager. We saw no evidence this had been discussed with the practice partners.
- A written complaint was made in November 2017 about a patient's personal information being disclosed outside the practice. A written response was given stating staff would not do this. We saw no evidence that this had been investigated or staff had been spoken to about the complaint.
- The complaints policy had been reviewed in February 2018 and it contained appropriate guidance about how a complaint should be actioned. The new practice manager had put this policy in place.

Are services well-led?

Inadequate 

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

Our findings

At the inspection 5 March 2015 the practice was rated as good for providing well-led services.

At the inspection in March 2015 we told the practice they should improve their record keeping, including minutes being taken at staff meetings. This had not occurred.

At this inspection on 16 February 2018 we rated the practice, and all of the population groups, as inadequate for providing well-led services.

The practice was rated as inadequate for providing well led services because:

- Effective governance and management was not found or supported. The partners did not have an overall understanding of the practice and there was a lack of clarity about the systems in place. General performance had not been monitored. Staff had not been well-supported. Some policies in place were not followed and systems to identify risk were not adequate. Regular meetings had not taken place and there had been no communication with the patient participation group for several months.

Leadership capacity and capability

Leaders did not have the capacity and skills to deliver high-quality, sustainable care.

- Although the GP partners met regularly to discuss clinical issues they had not identified the issues found during this inspection.
- There was no evidence of the previous practice manager, who left in November 2017, receiving any supervision. It had not been identified by the partners that processes were not being followed.
- Partners and the practice manager were visible and approachable. Although the new practice manager had held a staff meeting where minutes were taken there was no evidence of any other administrative team meeting being held, and no full team meetings between the clinical and administrative team had been held.

- The practice manager told us one staff member had expressed a wish to go on management courses and this had been agreed previously agreed. They were in the process of completing a skills audit so they could assess what development was required.
- The practice was not correctly registered with the Care Quality Commission. There had been a change in partnership and the registered manager was no longer at the practice.

Vision and strategy

The practice did not have a clear vision and credible strategy to deliver high quality care and promote good outcomes for patients. The practice had a mission statement on their website but the staff we spoke with were not aware of this. The new practice manager had identified that changes were needed within the practice, especially in relation to more efficient use of digital resources.

Culture

The practice did not have a culture of high-quality sustainable care.

- Openness, honesty and transparency were not always demonstrated when responding to incidents and complaints. We saw an example of a complaint that had been responded to by the previous practice manager but not investigated. The provider was aware of the duty of candour and how to ensure compliance with it.
- Staff we spoke with told us they were able to raise concerns via the practice manager.
- Processes for providing all staff with the development they needed were not effective. We saw little evidence of appraisals or career development conversations.
- Nursing staff did not receive clinical support from the partners and they had recently carried out brief appraisals on each other.
- Nurses monitored their own training.
- Some staff had received equality and diversity training.

Governance arrangements

Although staff were clear about their individual responsibilities, good governance and management was not supported.

Are services well-led?

Inadequate 

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

- A new practice manager had started work six weeks prior to the inspection. They had identified systems and processes that needed to be improved. These had not been identified by the partners or the previous practice manager.
- In the previous 12 months we saw evidence of only one administrative team meeting and four clinical meetings.
- Staff had been trained in safeguarding and were clear on their roles and accountabilities. However infection control processes, including audit and training, were not in place.
- There were policies in place, some of which had been recently updated. However, we found they were not always followed, for example the recruitment and complaints policies.

Managing risks, issues and performance

There were no effective processes for managing risks, issues and performance.

- There was no effective, process to identify, understand, monitor and address current and future risks including risks to patient safety.
- We saw no processes to manage current and future performance. Performance of employed clinical staff could not be demonstrated through audit of their consultations, prescribing and referral decisions.
- Practice leaders did not have oversight of MHRA alerts, incidents, and complaints.
- Clinical audits were completed and we saw a positive impact on quality of care and outcomes for patients. However, clinical audits were not shared between clinicians.
- The practice had plans in place and had trained staff for major incidents.

Appropriate and accurate information

- We saw no evidence of monitoring of general performance and the delivery of quality care. The weaknesses identified during the inspection had not been identified by the partners.
- We saw evidence of four clinical meetings in the previous 12 months. Quality and sustainability were not discussed. We found one set of meeting minutes for the administration team, from January 2018, so it was difficult for staff to access information.
- The practice did not use information technology systems to monitor and improve the quality of care. The new practice manager had identified that previously paper based systems were in place although the practice had access to various on-line systems which would be helpful.
- The practice had received a complaint in relation to data protection involving a patient. This had not been investigated.

Engagement with patients, the public, staff and external partners

The practice did not involve others, including patients and the public to support high-quality sustainable services. The practice manager told us they arranged a patient participation group (PPG) meeting for the summer of 2017 but no-one attended. Nothing had been arranged since.

Continuous improvement and innovation

We did not see systems and processes in place for learning, continuous improvement and innovation.

- There was no focus on continuous learning and improvement at any level within the practice.
- The practice did not make use of internal and external reviews of incidents and complaints. We saw no evidence of learning being shared.
- Leaders and managers did not encourage staff to take time out to review individual and team objectives, processes and performance.

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints The registered person had failed to establish and operate effectively an accessible system for identifying, receiving, recording, handling and responding to complaints by service users and other persons in relation to the carrying on of the regulated activity. In particular: • The provider did not have information about how to make a complaint was not available in the waiting room. • Not all complaints were investigated and some had an unacceptable delay in investigation following them being received. • Clinical complaints were responded to by the clinician who the complaint was about, and this included if it was about a locum GP. • Not all complaints were appropriately responded to. For example some written complaints received a response by telephone, and most responses did not include information about how the complaint could be escalated. This was in breach of regulation 16 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed The registered person did not have systems and processes in place to ensure staff were of good character or had the required qualifications, skills or experience required for their role. In particular:

This section is primarily information for the provider

Requirement notices

- Not all relevant pre-employment checks were carried out; not all information required under Schedule 3 was requested for staff.
- Ongoing checks, such as updated locum checks, indemnity insurance and professional registration checks were not routinely carried out.

This was in breach of regulation 19 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The registered person did not have systems and processes in place that operated effectively to prevent abuse of service users. In particular: • There was no adequate fire risk assessment and fire safety checks were not up to date. • There was no adequate infection control audit. • Legionella checks were not up to date. • Equipment checks were not adequate. • There was no minor surgery audit. • The cold chain process was not adequate. There was no proper and safe management of medicines. In particular: • 300 child vaccinations had been missed and the GP partner had not been made aware of this. • Some flu vaccinations were not within their expiry date. Medicines were kept in an unlocked room available to patients. • Some medical equipment was not stored hygienically. • Vaccinations were kept in unlocked fridges in unlocked rooms. This was in breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services	Regulation 17 HSCA (RA) Regulations 2014 Good governance

Enforcement actions

Surgical procedures

Treatment of disease, disorder or injury

The registered person had ineffective systems or processes in place in that they failed to enable the registered person to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk. In particular:

- The registered person did not have a system to collate, investigate and learn from significant events.
- The registered person did have a system to assess risks to the health and safety of patients.
- Clinical audits were not shared for learning purposes.
- Governance systems to monitor and assess risks were not adequate. These included infection control audits, fire risk assessments, medicine checks, fridge temperature checks and equipment checks.
- There was little evidence of staff meetings taking place.
- The partners had not applied to be correctly registered by the Care Quality Commission (CQC).
- NICE alerts and MHRA alerts were not being actioned or circulated to staff.
- The practice did not follow their recruitment policy or process.

The registered person did not have systems in place to seek and act on feedback from relevant persons and other persons on the services provided in the carrying on of the regulated activity, for the purposes of continually evaluating and improving such services. In particular:

- Patients were not routinely consulted about aspects of the practice. There had been no recent attempt to contact members of the patient participation group (PPG).
- Not all complaints were investigated.

This was in breach of regulation 17 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Enforcement actions

Regulated activity

Diagnostic and screening procedures

Maternity and midwifery services

Surgical procedures

Treatment of disease, disorder or injury

Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing

The registered person had failed to ensure that persons employed in the provision of a regulated activity received such appropriate support, training, professional development, supervision and appraisal as was necessary to enable them to carry out the duties they were employed to perform. In particular:

- The provider did not ensure all staff had appropriate supervision and appraisals.
- Appraisal records were not adequate and the nurses signed each other's appraisals.
- Evidence of staff induction was not kept. Performance management issues were not adequately handled.
- Not all clinical training was up to date.

This was in breach of regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.