# Conway PMS

## Quality Report

Main site address:
44 Conway Road
Plumstead, London
SE18 1AH
Tel: 020 8854 2042
Branch site address:
142-146 Bellegrove Road
Welling
DA16 3QR
Tel: 020 8304 7662
Website: http://www.conwaypms.nhs.uk

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

## Ratings

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

# Summary of findings

## Contents



## Overall summary

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

We carried out an announced comprehensive inspection at Conway PMS' main and branch sites on 2 February 2016. During that visit our key findings were as follows:

- Significant event recording needed improvement.
- Systems in place to address risks were not implemented well enough to keep patients safe.
- Clinical outcomes and patient satisfaction were low across several areas.
- Consent had not always been appropriately recorded.
- There were several instances where patient confidentiality was not maintained.
- Patient information was not always available, and not all policies were fit for purpose.
- Access to appointments was difficult and we had concerns regarding staffing levels.
- Governance and leadership arrangements did not support the delivery of good care.

The overall rating for the practice was inadequate and the practice was placed in special measures for a period of six months. The full comprehensive report on the February 2016 inspection can be found by selecting the 'all reports' link for Conway PMS on our website at www.cqc.org.uk. Practices placed in special measures are inspected again within six months of the publication of their inspection report. The provider submitted an action plan to us to tell us what they would do to make improvements. We undertook this inspection to check that they had followed their plan, and to confirm that they had met the legal requirements.

This inspection, conducted as an announced comprehensive inspection of both sites on 13 December 2016, was undertaken following the period of special measures. Overall the practice is now rated as inadequate. Our key findings across all the areas we inspected in December 2016 were as follows:

# Summary of findings

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses; however, the system for recording and discussing significant events was not formalised. This was highlighted at our last inspection.
- Data showed that several patient outcomes remained below local and national averages in relation to the Quality and Outcomes Framework. Although some audits had been carried out these were initiated by the Clinical Commissioning Group. We saw no evidence of an internal audit plan.
- Published data from the national GP patient survey showed that although patients had confidence in the GPs, the service was rated below average for several aspects of care and access. Performance had declined in some areas since the previous year and the provider was unable to demonstrate if any changes they implemented had had a positive impact.
- Large amounts of patient-identifiable information had not been stored securely, an area of concern highlighted at our last inspection.
- Improvements were made to the quality of care as a result of complaints.
- The process for seeking consent had been improved since our last inspection.
- The provider had updated several policies; however, some policies did not reflect the way the practice was operating.
- The leadership structure was not well-defined and there were deficiencies in the governance of the service.
- Staff felt supported and valued by the practice's leaders. Staff had been trained to provide them with the skills, knowledge and experience to deliver care and treatment.
- The practice sought feedback from staff and patients, which it acted on.

There are areas where the provider needs to make improvements. Importantly, they must:

- Ensure records are maintained securely at all times in respect of service users.
- Ensure effective and sustainable clinical governance systems and processes are implemented to assess, monitor and improve the quality and safety of the services provided, and implement an effective strategy to ensure the delivery of good quality care.
- Implement actions to respond appropriately to patient feedback.
- Ensure there are appropriate policies to enable staff to carry out their roles, and ensure these policies are being followed.
- Assess, monitor, manage and mitigate the risks to the health and safety of service users and others that may be at risk.

In addition the provider should:

- Review and improve how patients with caring responsibilities are identified and recorded on the clinical system to ensure that information, advice and support is made available to them.
- Review the need to provide modesty screens or curtains for patients in consulting and treatment rooms.

This service was placed in special measures in September 2016. Insufficient improvements have been made such that there remains a rating of inadequate for several key questions (safe, effective, caring, responsive and well-led). Therefore we are taking 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 six months, and if there is not enough improvement we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

Professor Steve Field CBE FRCP FFPH FRCGP

Chief Inspector of General Practice

# Summary of findings

## The five questions we ask and what we found

We always ask the following five questions of services.

**Are services safe?**

Inadequate

The practice is rated as inadequate for providing safe services, as there are areas where improvements should be made.

- Staff understood their responsibilities to raise concerns, and to report incidents and near misses. However, the system for recording and discussing significant events was not formalised or consistent.
- The systems and processes in place to manage risks were not implemented well enough. For example, the provider did not stock an emergency medicine even though it had assessed that the practice needed to have it in stock.
- Although safety alerts had been cascaded, there was no clear process in place for ensuring that they were actioned.
- Staff understood their responsibilities in relation to reporting safeguarding concerns.

**Are services effective?**

Inadequate

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

- Data showed that patient health outcomes for several indicators were below local and national averages, significantly so for those related to carrying out reviews of patients newly diagnosed with cancer and depression, and for performing cervical smear tests. Exception reporting was higher than average for some health indicators. There was no clear plan of action in place to systematically review and secure improvements in these areas, and there had been no improvement since our last inspection.
- There was evidence that some audits had resulted in improved patient outcomes, but there was no evidence of any strategic internal audit plan in place.
- The provider had not conducted regular appraisals for two members of staff, and an annual appraisal for a third staff member was out of date by eight months. These were completed after the inspection.
- Multidisciplinary working was taking place.

**Are services caring?**

Inadequate

The practice is rated as inadequate for providing caring services, as there are areas where improvements should be made.

# Summary of findings

- Data from the national GP patient survey published in July 2016 showed that the provider was rated below or significantly below local and national averages for general satisfaction scores, consultations with GPs and nurses and encounters with receptionists. Most scores had either declined or had not improved since our last inspection.
- The provider had not securely stored large amounts of patient-identifiable information.
- The provider had identified less than 1% of its patient list as carers.
- Information for patients about the services offered was available.

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

**Inadequate**

The practice is rated as inadequate for providing responsive services, as there are areas where improvements should be made.

- Data from the national GP patient survey published in July 2016 showed that ratings for the provider were below or significantly below average for several aspects of accessibility in comparison to local and national averages. Most scores had either declined or had not improved since our last inspection.
- Patients reported issues with access to booked appointments and a named GP and that continuity of care was not always available, although urgent appointments were usually available the same day. Patients also fed back that access to the practice via telephone and getting appointments when needed was still difficult.
- Although the practice had reviewed the needs of its local population, it had not put in place a plan to secure improvements for all of the areas identified.
- Patients could get information about how to complain in a format they could understand, and complaints had been managed appropriately.

**Are services well-led?**

**Inadequate**

The practice is rated as inadequate for being well-led, as there are areas where improvements should be made.

- The provider did not provide us with any business plans to demonstrate that their informal strategy was delivered, monitored and reviewed. Appropriate actions had not been taken to address or improve areas where performance and patient outcomes were below average.

# Summary of findings

- There was a documented leadership structure and all staff felt supported by the practice manager and GPs, but we found the partners were largely absent from the practice and the leadership arrangements did not support the delivery of high quality care.
- Arrangements in place for managing risks were not adequately monitored and did not always operate effectively.
- The provider had a vision and values but not all staff were aware of these and their responsibilities in relation to them.
- The practice had a number of policies and procedures to govern activity, but some of these needed to be reviewed and amended to reflect current 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 

The provider was rated as inadequate for the care of older people. It was rated as inadequate for being safe, effective, caring, responsive and well-led, and the issues identified as inadequate overall affected this population group.

- The practice offered personalised care to meet the needs of the older people in its population.
- The practice was responsive to the needs of older people, and offered home visits and urgent appointments for those with enhanced needs.
- The practice told us that older people aged over 75 had been allocated a named GP.

### People with long term conditions

Inadequate 

The provider was rated as inadequate for the care of people with long-term conditions. It was rated as inadequate for being safe, effective, caring, responsive and well-led, and the issues identified as inadequate overall affected this population group.

- Performance for indicators related to conducting reviews for patients newly diagnosed with cancer was 0%. This was significantly below the local CCG average of 92% and the national average of 95%.
- Nationally reported data showed that outcomes for patients with diabetes were mostly in line with local national averages; however, exception reporting for some diabetes-related indicators was higher than average. For example, 16% of patients with diabetes had been excepted from receiving foot examinations (CCG average 5%, national average 8%).
- All patients with a long-term condition had a named GP and the majority had received a structured annual review to check their health and medicines needs were being met. However, patient outcomes were not in line with local and national averages.
- In the previous 12 months, 55% of patients with asthma had an asthma review. This was below the local average of 74% and the national average of 75%.
- In the previous 12 months, 95% of patients with chronic obstructive pulmonary disease had a review of their condition. This was in line with the local average of 84% and the national average of 90%. However, exception reporting for this indicator was higher than average at 19% (CCG average 5%, national average 12%).

# Summary of findings

- Nursing staff had lead roles in chronic disease management, and longer appointments and home visits were available when needed.
- For those patients with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

**Families, children and young people**

Inadequate

The provider was rated as inadequate for the care of families, children and young people. It was rated as inadequate for being safe, effective, caring, responsive and well-led, and the issues identified as inadequate overall affected this population group.

- In the previous 12 months, 74% of women aged between 25 to 64 years had a cervical screening test. This was below the local and national average of 82% and had declined from 85% in the previous year.
- Immunisation rates were below the national average for some standard childhood immunisations.
- There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of attendances to Accident & Emergency.
- A patient told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this.
- Appointments were available outside of school hours and the premises were suitable for children and babies.
- We saw examples of joint working with health visitors.

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

Inadequate

The provider was rated as inadequate for the care of working age people (including those recently retires and students). It was rated as inadequate for being safe, effective, caring, responsive and well-led, and the issues identified as inadequate overall affected this population group.

- The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to meet their needs.
- The practice had its own website at the time of our inspection; however, we found that some areas of the website were not functioning when accessed from devices other than the provider's, and some information regarding opening hours and the availability of appointments was not clear.

# Summary of findings

- Patients were able to access online facilities such as appointment booking and repeat prescription ordering through the practice's website.
- Extended hours opening was available on alternate Monday mornings between the main site and branch site, on Tuesday evening at the main site, Thursday evening at the branch site, and Friday evening at both sites.

**People whose circumstances may make them vulnerable**

Inadequate

The provider was rated as inadequate for the care of people whose circumstances may make them vulnerable. It was rated as inadequate for being safe, effective, caring, responsive and well-led, and the issues identified as inadequate overall affected this population group.

- The practice had created a policy (stating that homeless people could register to receive treatment) and a register for homeless patients and those with a learning disability. Although there were no homeless patients registered at the time of our inspection the practice manager assured us homeless patients would be registered.
- Of 19 eligible patients with a learning disability, only 32% had received an annual review of their health and care in the previous 12 months.
- The practice informed vulnerable patients about how to access various support groups and voluntary organisations.
- The practice regularly worked with other health care professionals in the case management of vulnerable patients.
- Staff we spoke with knew how to recognise signs of abuse in vulnerable adults and children. They were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

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

Inadequate

The provider was rated as inadequate for the care of people experiencing poor mental health (including people with dementia). It was rated as inadequate for being safe, effective, caring, responsive and well-led, and the issues identified as inadequate overall affected this population group.

# Summary of findings

- The provider told us they had a system in place to follow up patients who had attended accident and emergency where they may have been experiencing poor mental health. However, their overall unplanned emergency admissions rate was higher than the local and national average.
- Performance for indicators related to conducting reviews for patients newly diagnosed with depression was significantly below average at 0% (CCG average 79%, national average 83%).
- In the previous 12 months, 83% of patients diagnosed with dementia had their care reviewed in a face to face meeting, which was in line with the local average of 86% and the national average of 84%. This was an improvement from 76% in the previous year.
- In the previous 12 months, 87% of patients with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive agreed care plan in their record. This was in line with the local average of 83% and the national average of 89%.
- The provider regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those with dementia.
- The provider carried out advance care planning for patients with dementia, and had told patients experiencing poor mental health about how to access various support groups and voluntary organisations.

# Summary of findings

## What people who use the service say

The national GP patient survey results published in July 2016 showed the provider was performing below local Clinical Commissioning Group (CCG) and national averages in several areas. All of the scores below had declined from the previous year. Of 360 survey forms distributed, 105 were returned. This represented just over 2% of the provider's patient list.

- 58% of patients found it easy to get through to this practice by phone (CCG average 74%, national average 73%).
- 46% of patients were able to get an appointment to see or speak to someone the last time they tried (CCG average 69%, national average 76%).
- 53% of patients described the overall experience of this GP practice as good (CCG average 82%, national average 85%).
- 49% of patients said they would recommend this GP practice to someone who has just moved to the local area (CCG average 75%, national average 80%).

As part of our inspection we also asked for Care Quality Commission comment cards to be completed by patients prior to our inspection. We received two comment cards which were both positive about the standard of care received.

We spoke with five patients during the inspection; they told us they were satisfied with the care they received, and thought staff were approachable, committed and caring.

Of 380 patients surveys distributed in the practice's November NHS Friends and Family Test, 76 patients (just under 2% of the practice population) responded. Results showed that 87% of these patients were likely or extremely likely to recommend the practice (increased from 75% in January 2016), and 9% of patients were unlikely or extremely unlikely to do so (decreased from 14% in January 2016).

# Conway PMS

**Detailed findings**

## Our inspection team

**Our inspection team was led by:**

a Care Quality Commission lead inspector**.** The team included a second Care Quality Commission inspector, a GP specialist advisor, and a practice manager specialist advisor.

## Background to Conway PMS

The provider operates from its main site Conway Medical Centre (44 Conway Road, Plumstead, SE18 1AH) and a branch site Welling Medical Centre 2 miles away (142-146 Bellegrove Road, Welling, DA16 3QR). It is one of 42 GP practices in the Greenwich Clinical Commissioning Group (CCG) area. There are approximately 4,308 patients registered at the practice. The practice is registered with the Care Quality Commission to provide the regulated activities of diagnostic and screening procedures, family planning services, maternity and midwifery services, surgical procedures and treatment of disease, disorder or injury.

The practice has a personal medical services contract with the NHS and is signed up to a number of enhanced services (enhanced services require an enhanced level of service provision above what is normally required under the core GP contract). These enhanced services include:

- Childhood vaccination and immunisation
- Influenza and pneumococcal immunisations
- Rotavirus and shingles immunisation
- Unplanned admissions

The practice has an above average population of male and female patients aged from birth to four years and from 20 to 34 years, and male patients aged from 50 to 54 years. Income deprivation levels are above the national average for adults registered with the provider, and average for children.

The practice relied solely on locum GPs to provide clinical sessions. The clinical team includes a non-clinical male partner (who is a pharmacist), a male GP partner who does not provide clinical sessions, four male long-term locum GPs and a female long-term locum GP. The GPs provide a combined total of 10 clinical sessions per week (across both sites).

There is a salaried female salaried practice nurse providing six clinical sessions per week, a self-employed female nurse practitioner providing eight clinical sessions per week, and a salaried female specialist diabetes and respiratory nurse providing two clinical sessions per week. There is a practice manager, an assistant practice manager, and eight reception/admin staff supporting the clinical team.

The main site operates over two floors of a converted house. On the ground floor there is a waiting area, a reception office, two consulting rooms and a patient toilet. On the first floor there is a consulting room and staff rooms. There is wheelchair access throughout the ground floor and baby changing facilities available. The main site is open from 8am to 7.00pm on Monday, Tuesday, Wednesday and Friday, and 8am to 2pm on Thursday.

The branch site operates from a one storey purpose-built building. There are two consulting rooms and a wheelchair accessible patient toilet with baby changing facilities that is shared with two private practices on the same premises. It is open from 8am to 7pm on Monday, Tuesday, Thursday and Friday, and 8am to 2pm on Wednesday.

Opening hours appointments with GPs and nurses are available at the following times:

- Monday: 7am to 1pm, 2.30pm to 6pm (7am appointments occur on alternate Mondays between sites).
- Tuesday: 9am to 1pm and 2.30pm to 7pm (7pm appointments occur at the main site only).
- Wednesday: 9am to 1pm and 2.30pm to 6pm (except at the branch site which closes at 2pm on Wednesday).
- Thursday: 9.30am to 1pm and 3.30 to 7pm (except at the main site which closes at 2pm on Thursday).
- Friday: 8.00am to 12pm, 3.30pm to 7pm.

Both sites are closed on weekends and bank holidays but patients are able to access additional GP appointments at two GP access hubs in Thamesmead Health Centre and Eltham Community Hospital. A GP access hub is a GP practice that offers evening and weekend appointments for patients registered with other practices in the area.

The practice directs patients needing urgent care out of normal hours (OOH) to contact the OOH number 111 which directs patients to a local contracted OOH service or Accident and Emergency, depending on the urgency of patients' medical concerns.

## Why we carried out this inspection

We undertook a comprehensive inspection of Conway PMS on 2 February 2016 under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The practice was rated as inadequate for providing safe, responsive and well-led services and was placed into special measures for a period of six months.

We carried out an announced comprehensive follow-up inspection of this service on 13 December 2016 under Section 60 of the Health and Social Care Act 2008 and subsequent regulations as part of our regulatory functions.

This inspection was carried out to ensure that improvements had been made, to assess whether the practice could come out of special measures, and to provide them with a rating of their service.

## How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 13 December 2016.

During our visit we:

- Spoke with a range of staff including the practice manager, three non-clinical staff members, the pharmacist partner, and two long-term locum GPs.
- Spoke with five patients who used the service.
- Observed how patients were being cared for and talked with carers and/or family members.
- Reviewed a sample of the personal care or treatment records of patients.
- Received and reviewed the two Care Quality Commission comment cards we received, where patients and members of the public shared their views and experiences of the service.

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

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

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

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

# Detailed findings

- People experiencing poor mental health (including people with dementia).

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

Inadequate

# Are services safe?

## Our findings

At our previous announced comprehensive inspection on 2 February 2016, we rated the practice as inadequate for providing safe services in respect of deficiencies in the provider's processes for assessing and managing risks, chaperoning, fire safety, medicine administration and staffing levels.

The provider had made limited improvements when we undertook an announced comprehensive follow-up inspection on 13 December 2016, and the provider remains rated as inadequate for providing safe services.

**Safe track record and learning**

During our previous inspection on 2 February 2016 we found that an error identified by a clinician had not been recorded as a significant event. Although it had been investigated and discussed with another clinician, this learning had not been shared more widely.

During this inspection whilst we found there was a system in place for reporting and recording significant events, it was not formalised or used effectively; not all significant events had been recorded and discussed. For example, a member of staff told us that a serious incident, including a fridge reading error (identified by the Care Quality Commission during our previous inspection on 2 February 2016) had not been recorded as a significant event. Staff told us that another incident involving a patient who presented at the practice with an adverse reaction to analgesics (medicines used for pain relief) had not been recorded as a significant event, although it had been discussed with staff.

- Staff told us they would inform the practice manager of any incidents and there was a recording form available on the practice's computer system. The incident recording form supported the recording of notifiable incidents under the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).
- The provider had recorded four significant events in the previous 12 months. We reviewed these and saw evidence that when things went wrong with care and treatment, patients were informed of the incident, received reasonable support and truthful information. The provider had not recorded any incidents that required an apology, but they told us they would apologise wherever necessary.

Of the safety record and incident reports we reviewed, we saw minutes of meetings where these were discussed and saw evidence that lessons were shared to improve safety in the practice. Patient safety alerts had been cascaded to staff, but the provider could not demonstrate it had actioned an alert (released in February 2016) for a prescribed medicine that carried a risk of abnormal pregnancy outcomes.

**Overview of safety systems and processes**

During our previous inspection on 2 February 2016 we found that the provider did not have sufficient systems, processes and practices in place to keep patients safe, particularly in relation to infection control, medicines management, safeguarding training for a nurse, chaperone training and procedure awareness, and two expired Patient Group Directions that had not been renewed (PGDs provide a legal framework that allows some registered health professionals to supply and/or administer a specified medicine to a pre-defined group of patients, without them having to see a GP).

During this inspection we found that there had been some improvement to these systems, but further work was required in some areas:

- Notices in the waiting areas advised patients that chaperones were available if required. All staff who acted as chaperones were trained for the role and had received a Disclosure and Barring Service (DBS) check. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable). However, the provider's chaperone policy stated that chaperones should assist with procedures when required but it did not specify what type of help the chaperones were able to provide.
- There were arrangements in place for managing medicines, including emergency medicines and vaccines (including obtaining, prescribing, recording, handling, storing, security and disposal). Blank prescription pads were stored in a locked room. A long-term locum GP told us that serial numbers of

prescription pads were not logged; however, after the inspection the provider sent us evidence to demonstrate that a system to monitor the use of prescription pads had been in place since several months prior to the inspection. Policies were in place for handling repeat prescriptions (which included the review of high risk medicines); however, we looked at two patient records and found a patient taking Lithium and another taking methotrexate, both high risk medicines, had not always been reviewed appropriately in line with current guidance. The provider told us they were taking steps to address this after our inspection.

The practice carried out regular medicines audits, with the support of the local Clinical Commissioning Group pharmacy teams, to ensure prescribing was in line with best practice guidelines for safe prescribing. It had improved its prescribing trends since our previous inspection.

- Arrangements were in place to safeguard children and vulnerable adults from abuse. These arrangements reflected relevant legislation and local requirements. Policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. A long-term locum GP was the lead member of staff for safeguarding adults and children. The GPs attended safeguarding meetings when possible and told us they would provide reports where necessary for other agencies. Staff we spoke with demonstrated they understood their responsibilities and all had received training on safeguarding children and vulnerable adults relevant to their role. GPs were trained to child protection or child safeguarding level 3, nurses were trained to level 2, and non-clinical staff were trained to level 1 or 2.
- PGDs had been adopted by the practice to allow nurses to administer medicines in line with legislation. These were in date and signed by the relevant parties.
- The practice maintained appropriate standards of cleanliness and hygiene. We observed the premises to be clean and tidy. A long-term locum GP was the infection control clinical lead who liaised with the local infection prevention teams to keep up to date with best practice. There was an infection control protocol in place and all staff had received up to date training. Annual infection control audits were undertaken and we saw evidence that action was taken to address improvements identified.
- Recruitment checks undertaken prior to employment included proof of identification references, qualifications, registration with the appropriate body and DBS checks. We reviewed three personnel files and found appropriate recruitment checks had been undertaken prior to employment.

**Monitoring risks to patients**

During our previous inspection on 2 February 2016 we found that risks to patients had not always been well assessed or well managed in relation health and safety, fire safety and staffing levels.

During this inspection we found that there were procedures in place for monitoring and managing risks to patient and staff safety but there were still concerns over staffing levels and fire safety:

- There was a health and safety policy available with a poster in the reception and manager's office.
- The provider had conducted a new fire risk assessment shortly before our inspection and they carried out regular fire drills. Some risks identified from the fire risk assessment as requiring immediate action, such as the placement of fire door signs on all fire doors, had not been carried out; the practice manager told us this was because they had received the risk assessment report 11 days prior to our inspection. They ensured the signs were in place shortly after the inspection. The provider had smoke detectors but they did not have any fire detection systems in place.
- All electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly.
- The practice had a variety of other risk assessments in place to monitor safety of the premises such as control of substances hazardous to health, infection control, asbestos and Legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings).
- There were still concerns over staffing levels. The provider had recruited an additional long term locum

GP since our last inspection but the GP partner had stopped providing clinical sessions and the total number of clinical sessions available to patients had not increased. Responses to the national GP patient survey published in July 2016 showed that patients were still finding it difficult to get appointments when needed. For example, 46% of respondents were able to get an appointment to see or speak to someone the last time they tried (CCG average 69%, national average 76%).

**Arrangements to deal with emergencies and major incidents**

During our previous inspection, non-clinical staff informed us that they assessed whether patients were in genuine need of urgent care. There was no system in place to monitor the condition of the oxygen cylinder, and there was no defibrillator or associated risk assessment for the branch site. An emergency medicine, Hydrocortisone (used in the treatment of severe anaphylaxis), was not available and the provider had not conducted a risk assessment in relation to this.

During this inspection we found that:

- The provider had carried out a risk assessment that was updated six months before this inspection, stating that they should stock Hydrocortisone; however, this medicine was not available at either site during the inspection and the provider had not carried out a new risk assessment to mitigate its absence. The provider ensured that this medicine was available at both sites shortly after the inspection.
- Other emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. Emergency medicines were checked monthly but these check logs had not been dated or signed to indicate on what date they had been checked, and by whom. All the medicines we checked were in date and stored securely.
- There was an instant messaging system on the computers in all the consulting and treatment rooms, and mobile panic alarms that alerted staff to any emergency. During the inspection, however, non-clinical staff we spoke with were not able to locate the panic alarm for the reception office. Shortly after the inspection, the practice manager sent all staff an email updating them on the importance of ensuring they knew where the alarms were located.
- All staff received annual basic life support training.
- The practice had a defibrillator available at both premises and oxygen with adult and children's masks, along with a system to monitor their condition. A first aid kit and accident book were available.
- The practice had a comprehensive business continuity plan in place for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff.

Inadequate

# Are services effective?

(for example, treatment is effective)

## Our findings

At our previous announced comprehensive inspection on 2 February 2016, we rated the practice as requires improvement for providing effective services in respect of deficiencies in health outcomes for patients, the recording of consent, and staff training.

The provider had made limited improvements when we undertook an announced comprehensive follow-up inspection on 13 December 2016, and the provider is now rated as inadequate for providing effective services.

**Effective needs assessment**

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

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

**Management, monitoring and improving outcomes for people**

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent published result covering the period between 2015 and 2016 was 81.5% of the total number of points available; this was below the local Clinical Commissioning Group (CCG) average of 91.5% and the national average of 94.8%, and had reduced from 89.5% in the previous year. Overall clinical exception reporting had increased from 4.7% in the previous year to 10%, which was slightly above the local CCG average of 6.8% and in line with the national average of 9.2% (exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects).

During our previous inspection on 2 February 2016 we found that the practice was performing below average for indicators related to blood pressure control in patients with diabetes. During this inspection we found that the practice was an outlier for several QOF (and other) clinical targets. Data showed that in the previous 12 months of 2015/2016:

- Performance was still below average for blood pressure control in patients with diabetes. For example, 67% of patients with diabetes had well-controlled blood pressure (CCG average 72%, national average 78%). Exception reporting for this indicator was higher than average at 12% (CCG average 7.4%, national average 9.2%).

  Performance for other diabetes indicators was mostly average, but exception reporting for performing foot examinations was higher than average at 16% (CCG average 5%, national average 8%).
- Performance for indicators related to cancer was significantly below average; 0% of patients diagnosed with cancer in the preceding 15 months had received a review within six months of diagnosis (CCG average 92%, national average 95%).
- Performance for indicators related to depression was significantly below average; 0% of patients with depression had been reviewed between 10 – 56 days of diagnosis (CCG average 79%, national average 83%).
- Performance for asthma indicators was significantly below average; 55% of patients with asthma had received an asthma review (CCG average 74%, national average 76%). Exception reporting for this indicator was 4% (CCG average 4%, national average 8%).
- Performance for indicators related to atrial fibrillation was below average; 77% of patients with atrial fibrillation were treated with anti-clotting therapy (CCG average 83%, national average 87%). This had decreased from 100% in the previous year. Exception reporting for this indicator was below average at 4% (CCG average 16%, national average 10%).
- Performance for hypertension varied. For example, 76% of patients with hypertension had well-controlled blood pressure (in line with the CCG average of 78%, below the national average of 83%). Exception reporting for this indicator was below average at 2% (CCG and national average 4%).

Inadequate

# Are services effective?

## (for example, treatment is effective)

- Performance for dementia indicators was average; 83% of patients with dementia had a face-to-face review of their care (CCG average 87%, national average 84%). This had increased from 76% in the previous year, and exception reporting for this indicator was below average at 0% (CCG average 4%, national average 7%).
- Performance for mental health indicators was average; 87% of patients with schizophrenia, bipolar affective disorder, and other psychoses had a comprehensive, agreed care plan in their record (CCG average 82%, national average 89%). Exception reporting for this indicator was below average at 6% (CCG average 5%, national average 13%).
- Performance for indicators related to chronic obstructive pulmonary disease (COPD) was above average; 95% of patients with COPD had a review of their care (CCG average 84%, national average 90%). However, exception reporting for this indicator was higher than average at 19% (CCG average 5%, national average 12%).
- The provider (who provided an enhanced service for reducing unplanned admissions) had 20 emergency admissions per 1000 population, which was above the local CCG average of 13 and the national average of 15.

We raised these results with a long-term locum GP who informed us that there may have been coding errors in relation to indicators for cancer and depression, but that they were not clear on why the practice was an outlier for other indicators. We were not able to raise these issues with the GP partner as they did not attend the inspection, and the pharmacist partner informed us that they did not deal with clinical governance.

During our previous inspection we found there was some evidence of quality improvement activity. During this inspection, although there was evidence of clinical audit, we found there was no internal audit plan in place; all of the clinical audits we reviewed had been initiated by the local Clinical Commissioning Group.

- There had been seven clinical audits conducted in the previous two years, five of which were completed two cycle audits where the improvements made were implemented and monitored.
- Findings were used by the practice to improve services. For example, following an audit on the treatment of patients with atrial fibrillation with anticoagulant therapy, the practice identified 11 patients that needed intervention. A second cycle of this audit found that nine out of 11 of these patients were given the appropriate treatment in line with NICE guidelines. Anticoagulants are medicines that reduce the body's ability to form clots in the blood.
- The practice participated in local audits, national benchmarking and peer reviews.

**Effective staffing**

During our previous inspection on 2 February 2016 we found that the availability of GPs was limited across the main and branch site; there was no GP available on several mornings and afternoons of the week, and none was available throughout the day on Wednesdays. The provider was unable to demonstrate that all members of staff had received appropriate training to meet their learning needs and to cover the scope of their work. We found that some Patient Group Directions (PGDs) giving the nurse legal authorisation to administer flu vaccines had expired (PGDs provide a legal framework that allows some registered health professionals to supply and/or administer a specified medicine to a pre-defined group of patients, without them having to see a GP).

During this inspection we found that:

- The number of clinical sessions available had not increased since our last visit and the provider relied solely on locum GPs.
- The provider had ensured that all staff members had access to and made use of e-learning training modules and in-house training. Staff were up to date with training that included infection control, mental capacity, chaperoning, safeguarding, fire safety awareness, basic life support and information governance. The provider could demonstrate how they ensured role-specific training, such as for those reviewing patients with long-term conditions.
- All of the PGDs we reviewed were up to date and signed. Staff administering vaccines and taking samples for the cervical screening programme had received specific training which had included an assessment of

competence. Staff that administered vaccines could demonstrate how they stayed up to date with changes to immunisation programmes, for example by access to on line resources and discussion at practice meetings.

- The learning needs of the majority of staff were identified through a system of appraisals, meetings and reviews of practice development needs; however, an appraisal for a non-clinical member of staff was out of date by eight months, and the provider told us they had not conducted any appraisals for two nurses. These appraisals were completed after the inspection.
- Staff had access to ongoing support, one-to-one meetings, clinical supervision and facilitation and support for revalidating GPs.
- The practice had an induction programme for all newly appointed staff. This covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality.

**Coordinating patient care and information sharing**

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

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

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

**Consent to care and treatment**

During our previous inspection on 2 February 2016 we found that consent had not always been appropriately recorded by all staff. The provider conducted additional consent audits for relevant staff after that inspection.

During this inspection we found that staff sought patients' consent to care and treatment in line with legislation and guidance.

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

**Supporting patients to live healthier lives**

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

- A health trainer, employed by Public Health England, attended the practice every Thursday to provide advice on diet and exercise to patients that needed it. The provider showed us evidence that the health trainer had supported an overweight patient in losing 24 kilograms over a period of a year. The provider told us they had opted in hosting the health trainer as part of a local scheme in 2011, to improve outcomes for patients.
- Patients requiring smoking cessation advice were referred to a health care assistant at a private GP practice on the same premises as the branch site. This service was provided at no extra cost to patients.

The practice's uptake for the cervical screening programme had reduced from 85% in the previous year to 74% for 2015/2016; this was below the local Clinical Commissioning Group (CCG) average of 82% and national average of 81%. We raised this result with a locum GP but we were not provided with any mitigating factors, or of any plans in place to improve.

- There was a policy to offer telephone reminders for patients who did not attend for their cervical screening test.

Inadequate

# Are services effective?

## (for example, treatment is effective)

- There were systems in place to ensure results were received for all samples sent for the cervical screening programme and the practice followed up women who were referred as a result of abnormal results.

The provider told us it encouraged its patients to attend national screening programmes for bowel and breast cancer screening.

- In the previous three years, 58% of females aged 50 to 70 were screened for breast cancer; this was in line with the CCG average of 62% and below the national average of 73%.
- In the previous two and a half years, 42% of patients aged 60 to 69 were screened for bowel cancer; this was below the CCG average of 48% and the national average of 58%.

Childhood immunisation rates for the vaccinations given to children aged less than two years were below average. We raised these results with a long-term locum GP who informed us that they were not sure why the figures were below average:

- 80% of children aged 1 year had received the full course of recommended vaccines (expected standard 90%).
- 82% of children aged two years had received the pneumococcal conjugate booster vaccine (expected standard 90%).
- 85% of children aged two years had received the haemophilus influenzae type b and meningitis C booster vaccine (expected standard 90%).
- 81% of children aged two years had received the measles, mumps and rubella vaccine (expected standard 90%).

Childhood immunisation rates for the vaccinations given to children aged under five years were mostly in line with local and national averages, but were below the national average for one indicator:

- 85% of children aged five years had received the MMR dose 1 vaccine (CCG average 86%, national average 94%).
- 88% of children aged five years had received the MMR dose 2 vaccine (CCG average 84%, national average 88%).

Patients had access to appropriate health assessments and checks; however, annual review rates for some long-term conditions such as asthma and atrial fibrillation were below local and national averages.

Inadequate

# Are services caring?

## Our findings

At our previous announced comprehensive inspection on 2 February 2016, we rated the practice as requires improvement for providing caring services in respect of deficiencies in the provider's processes for providing patient information, identifying and supporting carers, demonstrating care for vulnerable people, maintaining patient confidentiality and respecting patients' privacy.

The provider had made limited improvements when we undertook an announced comprehensive follow-up inspection on 13 December 2016, and the provider is now rated as inadequate for providing caring services.

**Kindness, dignity, respect and compassion**

During our previous inspection on 2 February 2016 we identified several instances where the confidentiality, dignity and respect of patients had not been maintained in relation to record keeping and the conduct of staff when dealing with patients.

During this inspection, although we observed that members of staff were courteous and very helpful to patients and treated them with dignity and respect, patients' confidential information was compromised:

- An administration room on the first floor of the main site was left open throughout the inspection. Towards the end of our inspection we found an open box in this room with large amounts of documents containing patient-identifiable information (such as contact details, medicine lists, medical diagnoses, dates of birth, and hospital discharge letters) awaiting shredding. This room was easily accessible by patients attending consultations on the first floor, and other unauthorised personnel. We brought this to the attention of practice staff. We observed that the provider had secure units in place on the premises for the storage of confidential information to be destroyed, but these units had not been used for the documents mentioned above. A member of staff informed us that all confidential waste was collected by a contractor but this was not in line with the provider's policy for handling waste which stated that confidential documents should be shredded and disposed of in household bins. We had highlighted the security of confidential patient information as a concern at our previous inspection. Shortly after the inspection the practice manager told us they had moved the documents to a more secure location and they had placed a sign informing practice staff not to leave patient-identifiable documents in the administration room.
- Curtains or privacy screens were provided in some consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments. One consultation room had no curtain or screen available, but the provider assured us the door would be locked during examinations.
- Consulting and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- Reception staff knew when patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs; this facility had not been advertised during the previous inspection. During this inspection we found a poster in the waiting room informing patients that the room was available.

We received two patient Care Quality Commission comment cards and both were positive about the service experienced. Patients commented that they felt the practice offered a good service and that staff were helpful and caring. We spoke with five patients who told us they were satisfied with the care provided by the practice.

Results from the national GP patient survey published in July 2016 showed the practice was significantly below local Clinical Commissioning Group (CCG) averages for general satisfaction scores, and below average on consultations with GPs and nurses and encounters with receptionists. The majority of scores had either not improved or had declined since our previous inspection.

- 49% of patients would recommend the practice to someone who was new to the area (CCG average 75%, national average 80%).
- 53% of patients described their overall experience of the practice as fairly good or very good (CCG average 82%, national average 85%).
- 75% of patients said they found the receptionists at the practice helpful (CCG average 87%, national average of 87%).

Inadequate

# Are services caring?

- 74% of patients said the last GP they saw or spoke to gave them enough time (CCG average 82%, national average 87%).
- 78% of patients said the last GP they saw or spoke to was good at listening to them (CCG average 86%, national average 89%).
- 71% of patients said the last GP they saw or spoke to was good at treating them with care and concern (CCG average 81%, national average 85%).
- 83% of patients said they had confidence and trust in the last GP they saw or spoke to (CCG average 88%, national average 92%).
- 80% of patients said the last nurse they saw or spoke to gave them enough time (CCG average 87%, national average 92%).
- 85% of patients said the last nurse they saw or spoke to was good at listening to them (CCG average 86%, national average 91%).
- 81% of patients said the last nurse they saw or spoke to was good at treating them with care and concern (CCG average 85%, national average 91%).
- 87% of patients said they had confidence and trust in the last nurse they saw or spoke to (CCG average 95%, national average 97%).

We raised these survey results with the provider. They had held a meeting in October 2016 during which, the practice manager informed us, they had addressed staff attitude with the administrative team. They also informed us that their results from the National Health Service's Friends and Family Test were improving; the November results of this test showed that 87% (out of 76 responses) showed that patients were likely or extremely likely to recommend the practice, 9% of patients were unlikely or extremely unlikely to do so. Comparative data for the local Clinical Commissioning Group and England had not been published at the time of this inspection.

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

All of the five patients we spoke with told us they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them. We saw that care plans were personalised.

Results from the national GP patient survey published in July 2016 were below local Clinical Commissioning Group (CCG) and national averages in relation to patients feeling involved in planning and making decisions about their care and treatment. The majority of scores had not improved or had declined since our previous inspection.

- 72% of patients said the last GP they saw was good at explaining tests and treatments (CCG average 83%, national average 86%).
- 65% of patients said the last GP they saw was good at involving them in decisions about their care (CCG average 77%, national average 82%).
- 79% of patients said the last nurse they saw was good at explaining tests and treatments (CCG average 86%, national average 90%).
- 69% of patients said the last nurse they saw was good at involving them in decisions about their care (CCG average 81%, national average 85%).

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

- Staff told us that translation services were available for patients who did not speak or understand English as a first language; however a long-term locum GP we spoke with was not aware of this; the practice manager sent us evidence that they had emailed practice staff shortly after the inspection, informing them of interpreter services that were available for patients.
- We saw notices in the reception areas at both sites informing patients this service was available; these notices were written in English but shortly after the inspection the practice manager added this information in Guajarati, Hindi, Nepali, Punjabi and Turkish to make them more accessible to their patient demographic.
- Information leaflets were available in easy read format.

**Patient and carer support to cope emotionally with care and treatment**

Inadequate

# Are services caring?

Patient information leaflets and notices which told patients how to access a number of support groups and organisations were available in the waiting areas. Information about support groups was not available on the practice's website at the time of our inspection.

The practice's computer system alerted GPs if a patient was also a carer. The provider had identified 34 patients as carers prior to the inspection and a further patient during the inspection; this totalled less than 1% of the practice list and had not improved since our previous inspection. The practice manager told us that carers were identified through ad-hoc discussions with patients. Leaflets available to direct carers to the various avenues of support available to them. Shortly after our inspection, the practice manager placed signs in the waiting area asking patients that had caring responsibilities to identify themselves to staff, so that they could be offered support.

Staff told us that if families had suffered bereavement, they were offered rapid access to a GP consultation, where they would be offered advice on how to find a support service.

Inadequate

# Are services responsive to people's needs?

(for example, to feedback?)

## Our findings

At our previous announced comprehensive inspection on 2 February 2016, we rated the practice as inadequate for providing responsive services in respect of deficiencies in the provider's processes for responding to feedback from patients regarding difficulty accessing care, and providing care for vulnerable people.

The provider had made limited improvements when we undertook an announced comprehensive follow-up inspection on 13 December 2016, and the provider remains rated as inadequate for providing responsive services.

**Responding to and meeting people's needs**

During our previous inspection we found that there was no GP available on several mornings or afternoons of the week, and none throughout the day on one day of the week. A nurse or nurse practitioner was always available but there were limitations on the care they were able to provide. There was no hearing loop available at the branch site, no baby changing facilities at either site, no practice website, and the emergency pull cord in the accessible patient toilet at the main site did not work. The GP partner told us the practice would only provide immediate care for homeless patients, but they would not register them as patients because they were challenging, and that the needs of these people could be better met in local walk-in clinics.

During this inspection the provider informed us that a long-term locum GP was now available on Wednesday afternoons at the branch site and Thursday afternoon at the main site to complete administrative tasks and provide support to the nurses. However, they were not scheduled to provide clinical sessions to patients at these times, and the number of clinical sessions available to patients had not increased since our previous inspection. Responses to the national GP patient survey published in July 2016 showed that patients were still finding it difficult to get appointments when needed. For example, 46% (declined from 50% in January 2016) of respondents were able to get an appointment to see or speak to someone the last time they tried (CCG average 69%, national average 76%).

Patients were able to access additional GP appointments at two GP access hubs in Thamesmead Health Centre and Eltham Community Hospital where they could pre-book appointments on weekday evenings and on weekends.

The provider had installed a hearing loop and baby changing facilities, and they had created a policy stating that they would accept registrations from homeless people. They had created a register for homeless people, although there were none registered at the time of our inspection.

The provider had a website, but the inspection team found that several areas of the site were not functioning when accessed from devices other than the provider's computer, and some of the information regarding opening times did not tally with information the provider gave us. The emergency pull cord had not been fixed, but the provider installed a new one shortly after our inspection.

- The practice offered a 'Commuter's Clinic' on Monday mornings from 7am, and on Tuesday, Wednesday and Friday evenings until 7pm for working patients who could not attend during normal opening hours.
- There were longer appointments available for patients with a learning disability.
- Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice.
- Same day appointments were available for children and for patients with medical problems that required same day consultation.
- Patients were able to receive travel vaccines available on the NHS. They were directed to other clinics for vaccines that were only available privately.
- There were disabled facilities, hearing loops, and translation services available. The hearing loop at the main site was not advertised to inform patients it was available, but this was addressed shortly after our inspection.

The practice reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. The practice recently joined a scheme involving a group of seven local practices, an organisation called Citizens UK and three local Patient Participation Groups (PPGs). The scheme works with the local authority to involve people in well-being projects such as gardening for patients with diabetes and/or

hypertension, and the PPG members formed support groups for practice patients with long-term conditions. Clinicians from the member practices provided informative talks on the management of various long-term conditions.

**Access to the service**

The main site was open from 8am to 7pm Monday, Tuesday, Wednesday and Friday, and 8am to 2pm Thursday. The branch site was open from 9am to 7pm Monday to Friday, and 9am to 2pm Wednesday. Both sites were closed on weekends and bank holidays but patients were able to access additional GP appointments at two GP access hubs in Thamesmead Health Centre and Eltham Community Hospital. A GP access hub is a GP practice that offers evening and weekend appointments for patients registered with other practices in the area.

Appointments were available at the following times:

- Monday: 7am to 1pm, 2.30pm to 6pm (7am appointments occur on alternate Mondays between the main and branch sites).
- Tuesday: 9am to 1pm and 2.30pm to 7pm (7pm appointments occur at the main site only).
- Wednesday: 9am to 1pm and 2.30pm to 6pm (except at the branch site which closes at 2pm on Wednesday).
- Thursday: 9.30am to 1pm and 3.30 to 7pm (except at the main site which closes at 2pm on Thursday).
- Friday: 8.00am to 12pm, 3.30pm to 7pm.

The practice manager told us that appointments could be booked up to six weeks in advance, but reception staff told us there was maximum limit of four weeks. Daily urgent appointments were available for people that needed them.

Results from the national GP patient survey published in July 2016 showed that patients' satisfaction with how they could access care and treatment was below local Clinical Commissioning Group (CCG) and national averages since our last inspection, significantly so for access to appointments when needed. The majority of scores had either not improved or had declined since our last inspection.

- 46% of patients were able to get an appointment to see or speak to someone the last time they tried (CCG average 69%, national average 76%). During our previous inspection, two out of eight patients told us they were not able to get appointments when needed. During this inspection, all five of the patients we spoke with said they had not experienced any difficulties in this regard. The practice manager told us during our previous inspection that they had increased the number of telephone consultations available in 2015, and there had been no changes to this during this inspection. They told us that they had recruited an additional locum GP to increase the availability of appointments since the previous inspection, although several staff members told us that the GP partner was no longer providing clinical sessions at either site. We observed that the number of clinical sessions available to patients had not increased since our last inspection.
- 50% of patients described their experience of making an appointment as good (CCG average 70%, national average 73%). The provider had a new website but inspection team members noted that the appointment booking section of the website was not accessible from various devices.
- 58% of patients said they could get through easily to the practice by phone (CCG average 74%, national average 73%). The practice manager told us that a new telephone system with a queue facility had been implemented in July 2016 but they stated at the time of our inspection that it was too early to assess the impact of this change.
- 64% of patients were satisfied with the practice's opening hours (CCG average 72%, national average 76%).
- 47% of patients felt they did not normally have to wait too long to be seen after arriving for their appointment (CCG average 51%, national average 58%).
- 45% patients said they always or almost always see or speak to their preferred GP (CCG average 56%, national average 60%). Although still below average, this was a significant improvement from 7% in the previous year. The practice manager told us that they had expressed to the administrative team the importance of patients being able to see their preferred GP, and they had placed a leaflet in the waiting area to inform patients of who the practice's GPs were.

The practice had a system in place to assess whether a home visit was clinically necessary, and the urgency of the need for medical attention.

Inadequate

# Are services responsive to people's needs?

## (for example, to feedback?)

- GPs contacted the patient or their carer in advance of home visits to gather information to allow for an informed decision to be made on prioritisation according to clinical need.
- In cases where the urgency of need was so great that it would be inappropriate for the patient to wait for a GP home visit, alternative emergency care arrangements were made.
- Clinical and non-clinical staff were aware of their responsibilities when managing requests for home visits.

**Listening and learning from concerns and complaints**

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

- Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England.
- The practice manager was the designated responsible person who handled all complaints in the practice.
- We saw that easily accessible information was available to help patients understand the complaints system.

We looked at four complaints received in the previous 12 months and found they were handled in a timely manner and with transparency. Lessons were learnt from individual concerns and complaints and also from analysis of trends and action was taken to as a result to improve the quality of care. For example, following a complaint regarding dissatisfaction with treatment received, the provider offered the patient a meeting to discuss their concerns and discussed the complaint with the clinician involved.

# Are services well-led?

Inadequate

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

## Our findings

At our previous announced comprehensive inspection on 2 February 2016, we rated the practice as inadequate for providing well-led services in respect of deficiencies in the provider's processes for assessing and managing risks, taking action to improve areas of low performance, ensuring that policies were practice-specific, and ensuring that staff were aware of their roles.

The provider had made limited improvements when we undertook an announced comprehensive follow-up inspection on 13 December 2016, and the provider remains rated as inadequate for providing well-led services.

**Vision and strategy**

During our previous inspection we found that the practice's mission statement was not displayed and staff were not aware of its values. The provider had a strategy in place but it was not effective enough to ensure that appropriate actions were taken to address and make improvements.

During this inspection we found that although the provider had displayed their mission statement in the waiting areas to keep patients informed of it, staff we spoke with were not clear on its values. The provider addressed this shortly after the inspection. The provider did not provide, when requested, evidence of a strategy or supporting business plans to ensure that the vision and values and were regularly monitored. They submitted a financial outlook summary after the inspection, but this mainly addressed areas concerning financial planning. They told us that the practice was undergoing changes since the absence of the GP partner, such as the proposed addition of a long-term locum GP as a partner, and that this had hindered the development of up-to-date business plans. They also informed us that they had applied to join a scheme run by the Royal College of General Practitioners, designed to support providers that are in special measures; the scheme was available and running but the provider had failed to access this support at the time of our inspection

**Governance arrangements**

During our previous inspection we found that the governance framework did not support the delivery of the strategy and good quality care. Staff were not aware of their own roles and responsibilities and non-clinical staff told us they informally assessed patients' need to be seen urgently. Some staff were not aware of the availability of some policies and several policies were not fit for purpose. There was no effective system in place for managing risks, infection control and medicine management processes were inadequate, and there was an absence of training for several staff members. Two authorisation documents allowing the nurse to administer vaccines were not up to date and therefore not fit for purpose. Actions implemented by the provider to make improvements had not been effective

During this inspection, although we found that the provider had made limited improvements despite us highlighting several areas of concern which needed addressing.

- Two policies were still not fit for purpose. For example, we reviewed the policy for use of chaperones which stated that chaperones should assist with procedures if required. Clinical assistance during procedures should only be provided by individuals that have been suitably trained, but the policy did not specify what type of help the chaperones were able to provide. We also reviewed the policy for training, experience and qualification of staff which stated that the practice should conduct a simulation exercise at a minimum frequency of every six months, in order to prepare staff for dealing with emergency procedures. We were informed by a member of staff that although staff had received basic life support training, the simulation exercises did not occur. These policies were updated shortly after the inspection.
- A clinician was not aware that translation services were available for patients that did not speak or understand English: this was addressed shortly after the inspection.
- Systems in place to protect patient confidentiality were still not effective: we found large amounts of patient-identifiable documents that had been left unsecured in a room easily accessible to unauthorised personnel.
- Results from the national GP patient survey published in July 2016 showed that some responses on consultations with nurses were below average but the performance of two nurses had not been formally assessed, and had not been adequately reviewed for the practice manager. The provider conducted up-to-date appraisals for these members of staff shortly after our inspection.

# Are services well-led?

Inadequate

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

- There was a lack of comprehensive understanding of the performance of the practice, in relation to Quality and Outcomes Framework (QOF) and other clinical indicators, and no action plans or strategy in place to make improvements. The provider told us after the inspection that they had agreed to allocate two sessions per week to a long-term locum GP to spend on managing QOF performance.
- Although there was evidence of quality improvement achieved through audits led by the local Clinical Commissioning Group, there was no evidence of any strategic internal clinical audit plan in place to review and improve clinical performance.
- Arrangements for identifying, recording and managing risks, issues and implementing mitigating actions were not always effective.

**Leadership and culture**

During our previous inspection we found that the provider did not have effective leadership in place, and the partners were not always visible in the practice. The provider informed us that they had plans to add a long-term locum GP to the partnership team.

During this inspection we found deficiencies in the practice's leadership and the partners were still largely absent. Staff informed us that the practice's GP Partner was no longer working at the practice, and that the non-clinical partner provided financial oversight. There was no assurance that the GP Partner would resume work at the practice and the Care Quality Commission had not received any notifications or relevant applications in relation to the addition of the long-term locum GP as a partner at the time of this inspection. The role of clinical lead for various aspects of the service had been assigned to the locum GP, which raised concerns with the inspection team over the stability of this arrangement. There was no business plan or documented strategy in place to address changes to the governance arrangements.

The provider was aware of and had systems in place to ensure compliance with the requirements of the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment). This included support training for all staff on communicating with patients about notifiable safety incidents. The partners encouraged a culture of openness and honesty. The practice had systems in place to ensure that when things went wrong with care and treatment:

- The practice gave affected people reasonable support, truthful information and a verbal and written apology.
- The practice kept written records of verbal interactions as well as written correspondence.

Staff felt supported by management; they told us the manager and GPs were approachable and always took the time to listen to all members of staff.

- Staff told us the practice held regular team meetings that were documented.
- Staff said they felt respected, valued and supported by the practice manager and GPs. All staff were involved in discussions about how to run and develop the practice, and the manager encouraged staff to identify opportunities to improve the service delivered by the practice.

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

During our previous inspection we found that although the practice had sought patients' feedback, responses to the national GP patient survey published in January 2016 showed the practice was rated below average for aspects of care in relation to access to appointments and preferred GPs. The practice had not implemented an effective plan of action to address this and make the necessary improvements.

During this inspection we found that feedback from the July 2016 GP patient survey was below average for several responses and had either declined or had not improved since our last inspection. Actions taken to improve access to appointments had not improved patient satisfaction in this regard, and the provider stated that it was too early to assess the impact of other actions taken to improve telephone access.

The provider had gathered feedback from patients through the patient participation group (PPG) of seven active members, and through surveys and complaints received. The PPG met regularly, carried out patient surveys and submitted proposals for improvements to the practice management team. For example, the provider had

# Are services well-led?

Inadequate

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

increased the number of telephone consultations available; however, patient satisfaction with access to appointments was below local and national averages by between 23% and 30% at the time of our inspection.

- The practice had gathered feedback from staff through informal discussions, meetings and appraisals; however two nurses had not been involved in the provider's appraisal process. Staff we spoke with told us they felt involved and engaged to improve how the practice was run, and that they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management.

**Continuous improvement**

There was minimal focus on continuous learning and improvement within the practice. The provider was not addressing core issues which could improve the quality and safety of the service, particularly in relation to staffing levels, governance arrangements, risk monitoring and management, respecting the privacy of service users, and improving patient outcomes. The provider had made some attempts, however, to improve aspects of the service, such as upgrading the telephone system, introducing a hearing loop and baby changing facilities, and increasing the availability of telephone consultations.

This section is primarily information for the provider

# Requirement notices

## Action we have told the provider to take

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

| Regulated activity | Regulation |
|---|---|
| Diagnostic and screening procedures<br>Family planning services<br>Maternity and midwifery services<br>Surgical procedures<br>Treatment of disease, disorder or injury | Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment<br>**How the regulation was not being met:**<br>The provider did not assess, monitor, manage and mitigate risks to the health and safety of service users.<br>• They provider failed to ensure appropriate monitoring of some service users taking high-risk medicines.<br>• The provider failed to assess the risk of the broken emergency alarm system in the disabled toilet.<br>• Staff were not able to locate the alarm system designated for use in emergencies.<br>• There was no effective system in place to ensure that safety alerts were appropriately actioned.<br>• The provider had not carried out a risk assessment to mitigate the risk of the absence of an emergency medicine.<br>This was in breach of regulation 12 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. |

This section is primarily information for the provider

# Enforcement actions

## Action we have told the provider to take

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

| Regulated activity | Regulation |
|---|---|
| Diagnostic and screening procedures<br>Family planning services<br>Maternity and midwifery services<br>Surgical procedures<br>Treatment of disease, disorder or injury | Regulation 17 HSCA (RA) Regulations 2014 Good governance<br>**How the regulation was not being met:**<br>• The provider and registered person failed to maintain securely records in respect of service users.<br>• The provider and registered person failed to assess, monitor and improve the quality of the services provided in the carrying on of the regulated activities (including the experience of service users in receiving their services).<br>• The provider and registered person failed to evaluate the performance of some staff members.<br>• The provider and registered person failed to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others that may be at risk.<br>This was in breach of regulation 17 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. |