# Daneshouse Medical Centre

## Quality Report

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Date of inspection visit: 5 April 2017
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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? | Requires improvement |
| Are services responsive to people's needs? | Inadequate |
| Are services well-led? | Inadequate |

# Summary of findings

## Contents



## Overall summary

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

We carried out an announced comprehensive inspection at Daneshouse Medical Centre on 5 April 2017. Overall the practice is rated as inadequate.

Our key findings across all the areas we inspected were as follows:

- Patients were at risk of harm because systems and processes were not appropriately embedded to keep them safe. For example, patients did not have access to appropriately trained chaperones.
- Staff were not clear about reporting incidents, near misses and concerns and there was limited evidence of learning and consistent communication with staff. We found numerous examples of incidents that had not been recognised as significant events.
- Patient outcomes were lower than local and national averages and there was limited evidence of audits or quality improvement.
- Patients we spoke with were positive about their interactions with staff and said they were treated with compassion and dignity. However, results from the national GP patient survey showed patients rated the practice lower than others for many aspects of care.
- The appointment systems were not effective, with long waits to be seen, so patients did not receive timely care.
- The practice did not have a system in place to effectively manage any complaints received.
- The governance arrangements in place were insufficient to ensure quality care was delivered. Staff were not always fully aware of their roles and responsibilities.
- Policy guidance was inconsistent, with duplicate polices and guidance available which did not always reflect current best practice.

The areas where the provider must make improvements are:

- Introduce reliable processes for reporting, recording, acting on and monitoring significant events, incidents and near misses.

# Summary of findings

- Implement an appropriate system for logging and auditing the location of blank hand written prescription pads.
- Introduce systems for effectively identifying, recording and managing risks and implementing mitigating actions.
- Ensure the policies and guidance available to staff to support them in their roles accurately reflect the work undertaken in the practice and are up to date.
- Establish a comprehensive governance framework so as to allow the practice to effectively assess, monitor and improve the quality and safety of the services provided.
- Establish an accessible system for identifying, receiving, recording, handling and monitoring complaints.

The areas where the provider should make improvement are:

- Ensure all documentation relating to pre-employment checks, including interview notes, are maintained appropriately.
- Consider a more systematic approach to the managerial oversight of staff training.
- Consider implementing a planned programme of clinical audit to ensure completion of full audit cycles so that quality improvement is proactively monitored.
- Consider the use of alerts on the patient record system to notify staff if a patient is also a carer.
- Links should be re-established with the PPG to facilitate further collection of patient feedback. Staff feedback should also be proactively sought.
- Consider more frequent engagement with locality multidisciplinary team meetings.
- Review the appointment and telephone systems to ensure that patients are able to access appointments in a timely manner.
- The business continuity plan should contain more comprehensive information, such as emergency contact details for staff to facilitate the cascade of information.

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

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

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

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

# Summary of findings

## The five questions we ask and what we found

We always ask the following five questions of services.

**Are services safe?**

**Inadequate**

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

- The practice did not have an effective system in place for the identification and analysis of significant events (SEs). A number of SEs had not been recognised as such, meaning the practice was unable to effectively monitor trends. In two of the three SEs we reviewed, the practice was unable to evidence that identified action points had been completed or learning disseminated to the staff.
- The GP safeguarding lead had not received training to the appropriate level at the time of our inspection visit, although this was completed following our inspection. We noted the local authority safeguarding contact numbers contained in practice policies were not current.
- Blank prescription forms and pads were securely stored, however there was no system in place to monitor the location and use of handwritten forms.
- An infection prevention and control audit had been completed the week prior to our inspection by a non-clinical member of staff. However, this did not evidence that action was taken, or that an action plan was in place to address any improvements identified as a result.
- Risks to staff and patients were not effectively identified or monitored. A legionella risk assessment had not been completed at the time of our inspection and the gas safety check for the premises was six months overdue.
- Chaperone availability was limited and not all staff who acted as chaperone had been trained for the role.
- Electrical equipment had not been tested to ensure it was safe to use, and although most clinical equipment had been calibrated to ensure it was functioning correctly, some had been missed.
- While recruitment processes were generally thorough, we did note interview notes were not always held on record.

**Are services effective?**

**Inadequate**

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

- Data showed patient outcomes were low compared to the national average. The practice was a negative outlier for a

# Summary of findings

number of QOF clinical indicators from its 2015/16 results. However, we were shown data from the 2016/17 QOF results that was yet to be independently verified that demonstrated improvements in performance.
- Staff were aware of current evidence based guidance.
- Staff had the skills and knowledge to deliver care and treatment, and the practice could demonstrate that role specific training had been completed by clinical staff.
- While staff had access to appropriate training, we observed limited managerial oversight of training to monitor its timely completion.
- There was limited evidence that audit was driving improvement in patient outcomes.
- Multi-disciplinary working was taking place; the practice invited the health visitor to attend staff meetings. However, the GP had only attended two locality multidisciplinary team meetings in the previous 12 months.
- All practice staff had been recruited within the previous 12 months and so had not had an appraisal. However, we noted that performance reviews following completion of their probationary period had not been undertaken either.

**Are services caring?**

**Requires improvement** 

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

- Data from the national GP patient survey showed patients rated the practice lower than others for many aspects of care.
- The patients we spoke to during our visit said they were treated with compassion, dignity and respect and felt cared for, supported and listened to. However, this was not reflected in the results of the GP patient survey.
- Information for patients about the services available was accessible.
- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.
- While the practice identified patients who were also carers, alerts were not used in the electronic patient records to maximise opportunities to signpost them to relevant help and support.
- Patients told us that access to female clinicians was limited.

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

**Inadequate** 

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

# Summary of findings

- Patients reported considerable difficulty in accessing appointments with a clinician and getting through to the practice by telephone. This resulted in high accident and emergency attendance rates at the local hospital for the practice's patients.
- Appointment systems were not working well so patients did not receive timely care when they needed it. At the time of our inspection there were no routine pre-bookable appointments available to patients.
- There was information to help patients understand the complaints process, but this was not readily available to them.
- There was no systematic approach to the management of complaints. Staff found it difficult to locate documentation relating to complaints that had been lodged, and responses were not always provided within published timeframes.
- There was no evidence that learning from complaints had been shared with staff.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- The practice had forged a relationship with the neighbouring charity hostel for homeless people, and had a small number of its service users registered as patients.

**Are services well-led?**

**Inadequate**

The practice is rated as inadequate for being well-led and improvements must be made.

- The practice did not have a clear vision and strategy. Staff were not always fully aware of their roles and responsibilities.
- While there was a clear leadership structure in place, staff did not always feel supported by management.
- The practice had a number of policies and procedures to govern activity, but these were duplicated and inconsistent. Some contained out of date or inappropriate information. The practice did not consistently follow processes documented in policies and procedures.
- The practice did hold regular staff meetings, but these were not consistently used to communicate key information, such as learning from significant events or complaints.
- The practice had not proactively sought feedback from staff. When patient feedback had been obtained there had been a limited response to address concerns raised.
- The practice did not have an active patient participation group.

# Summary of findings

## The six population groups and what we found

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

**Older people**

Inadequate

The provider was rated as inadequate for safety, effectiveness, responsiveness and for well-led and requires improvement for caring. The issues identified as requiring improvement overall affected all patients including this population group. The practice is rated as inadequate for the care of older people.

- The GP did not routinely attend multidisciplinary meetings to discuss those patients with complex needs or those approaching the end of life.

However:

- Patients over the age of 75 years were offered an annual review appointment to ensure their health needs were being met.
- Home visits and urgent appointments for those with enhanced needs were offered when required.
- The practice followed up on older patients discharged from hospital and ensured that their care plans were updated to reflect any extra needs.

**People with long term conditions**

Inadequate

The provider was rated as inadequate for safety, effectiveness, responsiveness and for well-led and requires improvement for caring. The issues identified as requiring improvement overall affected all patients including this population group. The practice is rated as inadequate for the care of people with long-term conditions.

- Patient outcomes for those with long term conditions were consistently lower than local and national averages.

However:

- Nursing staff had lead roles in long-term disease management and patients at risk of hospital admission were identified as a priority.
- The practice followed up on patients with long-term conditions discharged from hospital and ensured that their care plans were updated to reflect any additional needs.
- All these patients had a named GP and there was a system to recall patients for a structured annual review to check their health and medicines needs were being met.

# Summary of findings

**Families, children and young people**

Inadequate

The provider was rated as inadequate for safety, effectiveness, responsiveness and for well-led and requires improvement for caring. The issues identified as requiring improvement overall affected all patients including this population group. The practice is rated as inadequate for the care of families, children and young people.

- Immunisation rates were low for standard childhood immunisations.

However:

- Patients told us, on the day of inspection, that children and young people were treated in an age-appropriate way and were recognised as individuals.
- Appointments were available outside of school hours and the premises were suitable for children and babies.
- The practice worked with midwives, health visitors and school nurses to support this population group.

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

Inadequate

The provider was rated as inadequate for safety, effectiveness, responsiveness and for well-led and requires improvement for caring. The issues identified as requiring improvement overall affected all patients including this population group. The practice is rated as inadequate for the care of working age people (including those recently retired and students). However:

- The needs of these populations 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, extended opening hours.
- The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group.

**People whose circumstances may make them vulnerable**

Inadequate

The provider was rated as inadequate for safety, effectiveness, responsiveness and for well-led and requires improvement for caring. The issues identified as requiring improvement overall affected all patients including this population group. The practice is rated as inadequate for the care of people whose circumstances may make them vulnerable.

# Summary of findings

- The practice could not demonstrate how it regularly worked with other health care professionals in the case management of vulnerable patients.

However:

- The practice held a register of patients living in vulnerable circumstances including homeless people and those with a learning disability.
- The practice had six patients registered who were service users at the neighbouring charity hostel for homeless people.
- The practice offered longer appointments for patients with a learning disability.
- The practice had information available for vulnerable patients about how to access various support groups and voluntary organisations.
- Staff interviewed knew how to recognise signs of abuse in children, young people and adults whose circumstances may make them vulnerable. They were aware of their responsibilities regarding information sharing and documentation of safeguarding concerns.

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

Inadequate

The provider was rated as inadequate for safety, effectiveness, responsiveness and for well-led and requires improvement for caring. The issues identified as requiring improvement overall affected all patients including this population group. The practice is rated as inadequate for the care of people experiencing poor mental health (including people with dementia).

- Patient outcomes for those experiencing poor mental health were lower than local and national averages for many clinical indicators.

However:

- The percentage of patients diagnosed with dementia whose care had been reviewed in a face to face review in the preceding 12 months was 100% compared to the local average of 85% and national average of 84%.
- Patients at risk of dementia were identified and offered an assessment.
- The practice had information available for patients experiencing poor mental health about how they could access various support groups and voluntary organisations.
- Staff interviewed had a good understanding of how to support patients with mental health needs and dementia.

# Summary of findings

## What people who use the service say

The national GP patient survey results were published in July 2016. The results showed the practice was performing below local and national averages. A total of 358 survey forms were distributed and 69 were returned. This represented a response rate of 19% and was 2% of the practice's patient list.

- 54% of patients described the overall experience of this GP practice as good compared with the clinical commissioning group (CCG) average of 84% and the national average of 85%.
- 46% of patients described their experience of making an appointment as good compared with the CCG average of 71% and the national average of 73%.
- 38% of patients said they would recommend this GP practice to someone who has just moved to the local area compared to the local average of 78% and the national average of 80%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 11 comment cards, eight of which were positive about the standard of care received. Three of the cards were strongly negative about the service, highlighting concerns around difficulties accessing appointments in a timely way and getting through to the practice by telephone. One of the cards making positive comments about the GPs and nurses being caring also included a comment mirroring these concerns about appointment availability.

We spoke with six patients during the inspection. All six patients expressed concerns around difficulty accessing appointments. Patients also told us that access to a female GP was difficult and that staff could be inflexible in meeting the needs of the patients. However, all did say that once they were able to see a GP or nurse, they felt involved in decisions about their care, with treatment options explained well.

## Areas for improvement

**Action the service MUST take to improve**

The areas where the provider must make improvements are:

- Introduce reliable processes for reporting, recording, acting on and monitoring significant events, incidents and near misses.
- Implement an appropriate system for logging and auditing the location of blank hand written prescription pads.
- Introduce systems for effectively identifying, recording and managing risks and implementing mitigating actions.
- Ensure the policies and guidance available to staff to support them in their roles accurately reflect the work undertaken in the practice and are up to date.
- Establish a comprehensive governance framework so as to allow the practice to effectively assess, monitor and improve the quality and safety of the services provided.
- Establish an accessible system for identifying, receiving, recording, handling and monitoring complaints.

**Action the service SHOULD take to improve**

The areas where the provider should make improvement are:

- Ensure all documentation relating to pre-employment checks, including interview notes, are maintained appropriately.
- Consider a more systematic approach to the managerial oversight of staff training.
- Consider implementing a planned programme of clinical audit to ensure completion of full audit cycles so that quality improvement is proactively monitored.
- Consider the use of alerts on the patient record system to notify staff if a patient is also a carer.
- Links should be re-established with the PPG to facilitate further collection of patient feedback. Staff feedback should also be proactively sought.

# Summary of findings

- Consider more frequent engagement with locality multidisciplinary team meetings.
- Review the appointment and telephone systems to ensure that patients are able to access appointments in a timely manner.
- The business continuity plan should contain more comprehensive information, such as emergency contact details for staff to facilitate the cascade of information.

# Daneshouse Medical Centre

**Detailed findings**

## Our inspection team

**Our inspection team was led by:**

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

## Background to Daneshouse Medical Centre

Daneshouse Medical Centre (Old Hall Street, Burnley, BB10 1LZ) is housed in purpose built, single story premises on the outskirts of Burnley. The practice has a small car park, with designated disabled spaces and a ramp to facilitate access for those patients experiencing mobility difficulties.

The practice is presently registered as a partnership, but the provider has recently submitted applications to CQC to update this registration to reflect that they are working as a single handed GP.

The practice delivers primary medical services to approximately 3400 patients through a personal medical services (PMS) contract with NHS England, and is part of the NHS East Lancashire Clinical Commissioning Group (CCG). At the time of our inspection the practice list was closed.

The average life expectancy of the practice population is below national but in line with CCG averages for females and below both the local and national averages for males (81 years for females, compared to CCG average of 81 and national average of 83. For males; 73 years compared to CCG average of 77 and national average of 79). The practice patient population contains a higher proportion of younger people when compared to local and national averages. For example, 9% are aged between 0 and 4 (CCG and national averages 6%), 25% aged between five and 14 years (CCG and national averages of 12%) and 39% aged under 18 (CCG average 22% and national average 21%). Conversely, only 5% of the practice's patient population are aged over 65, compared to the CCG average of 18% and national average of 17%, while 2% are aged over 75 (CCG and national averages 8%).

A higher proportion of the practice's patients are unemployed; 10% compared to the CCG average of 5% and national average of 4%. The practice caters for a lower proportion of patients with a long standing health condition (44% compared to the CCG average of 56% and national average of 53%).

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

The practice is staffed by the lead GP (male), with two long term locum GPs (one male, one female) adding a further 0.4 whole time equivalent GP time each week. The practice employs a practice nurse for two days each week. The clinical team are supported by a practice manager, assistant practice manager and a team of three receptionists / administrative staff.

The practice telephone lines are staffed between 8am and 6.30pm each working day, apart from between 12.30pm and 2pm on a Monday. The practice premises are open from 9am until 6:30pm Monday to Friday, again apart from 12.30 until 2pm on a Monday afternoon. Appointments with the GP are available between 9:30am and 11:40am each morning and between 3.30pm and 5:50pm each afternoon, apart from Wednesday afternoon when appointments start at 4pm. Extended hours appointments are also available between 6:30pm and 7.15pm each Monday and Tuesday

evening, although the practice website did not reflect this accurately. The website stated that extended hours appointments were available on Monday and Thursday evenings.

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

The practice has previously been a teaching practice, but has not had a student placement for over a year. The practice is currently in discussions with other local universities to arrange future placements.

## Why we carried out this inspection

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

## How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations such as the Clinical Commissioning Group to share what they knew. We carried out an announced visit on 5 April 2017. During our visit we:

- Spoke with a range of staff, including the GP, practice nurse, practice manager, assistant practice manager and receptionists and also spoke with patients who used the service.
- Observed how staff interacted with patients in the reception area and talked with carers and/or family members.
- Reviewed a sample of the personal care or treatment records of patients.
- Reviewed comment cards where patients and members of the public shared their views and experiences of the service.
- Looked at information the practice used to deliver care and treatment plans.

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

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

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

- older people
- people with long-term conditions
- families, children and young people
- working age people (including those recently retired and students)
- people whose circumstances may make them vulnerable
- people experiencing poor mental health (including people living with dementia).

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

Inadequate

# Are services safe?

## Our findings

**Safe track record and learning**

The practice lacked an effective system for reporting and recording significant events. The practice held a ring binder where we were told the documentation from significant events were stored. This indicated that three significant event analyses (SEAs) had been documented in the previous 12 months, one in October 2016, another in December 2016 and the third in March 2017. Two of these related to issues around prescription requests, while the third was an event around inappropriate storage of vaccines.

- Staff were not fully clear of the procedure for identifying and recording significant events, but told us they would inform the practice manager of any incidents. There was a recording form available in the practice's significant event folder, although this incident recording form did not support 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). It was not clear from the documentation on record whether patients were informed of the incident as soon as reasonably practicable, received reasonable support, truthful information, a written apology or were told about any actions to improve processes to prevent the same thing happening again.
- Staff told us that learning following the analysis of a significant event would be disseminated at team meetings. While we saw that this was the case for the most recent event involving vaccine storage, we reviewed all minutes from staff meetings held since November 2016 and none of these detailed any feedback from the two events around prescriptions, despite both these SEAs indicating that further training for staff was required. The practice was unable to provide evidence that this training had taken place.
- We viewed minutes from a recent staff meeting that indicated discussion had taken place about a number of other incidents that had come to light alongside the vaccine storage issue, such as emergency medicines being out of date, a large number of unactioned tasks stored on the practice's computer system and inappropriately stored urine samples. While we saw that following this meeting, appropriate actions had been put in place to address these issues, none had been documented as significant events. This meant that the practice was unable to assure us that it had a system in place to effectively monitor trends in incident occurrence and routinely review outcomes to ensure mitigating actions were appropriate.
- The practice manager confirmed to us that there had not been a process in place to document incoming patient safety alerts so as to provide an audit trail that any actions had been completed as necessary. However, we were told the practice planned to adopt a new procedure to address this; no new alerts had been received by the practice since this decision had been made.

**Overview of safety systems and processes**

The practice lacked clearly defined and embedded systems, processes and practices to minimise risks to patient safety.

- There were some gaps in arrangements for safeguarding. While policies were accessible to all staff, the policies contained out of date contact details for further guidance if staff had concerns about a patient's welfare. We noted that updated contact details were available on post-it notes in the nurse's consulting room, but these details had not been transferred to other documents in the practice. The GP was the lead for safeguarding.
- Staff interviewed demonstrated they understood their responsibilities regarding safeguarding and had received training on safeguarding children and vulnerable adults relevant to their role. We did note that two of the six staff training records we viewed did not contain evidence that safeguarding training had been completed, and at the time of inspection the GP was trained to child protection or child safeguarding level two, rather than the level three required as stipulated by the Intercollegiate Guidelines. The GP provided us with evidence that child safeguarding level three had been completed six days after our inspection visit.
- A notice in the consulting rooms advised patients that chaperones were available if required. The practice manager informed us that only the practice nurse or practice manager would act as chaperone and we saw that both 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 practice manager confirmed that she had not completed training for this role. The GP confirmed to us that at times when neither the practice manager or nurse were available, receptionists would be asked to act as chaperone. None of the receptionists were trained for this role and only one of the three had received a DBS check. The other two receptionists had signed a risk assessment to document the decision not to undertake a DBS check; this stated they would not be required to chaperone for patients.

The practice maintained appropriate standards of cleanliness and hygiene, but we did note some gaps in the management of infection prevention and control (IPC).

- We observed the premises to be clean and tidy. There were cleaning schedules and monitoring systems in place.
- The GP was the IPC clinical lead. There was an IPC protocol and staff had received up to date training. An IPC audit had been completed the week prior to our inspection by a non-clinical member of staff. However, this did not evidence that action was taken, or that an action plan was in place to address any improvements identified as a result. We also noted that it had not identified the sharps bin in the GP consultation room as being unsigned and over filled.

There were also some gaps in arrangements for managing medicines, including emergency medicines and vaccines, although on the whole these minimised risks to patient safety (including obtaining, prescribing, recording, handling, storing, security and disposal).

- There were processes for handling repeat prescriptions which included the review of high risk medicines. Repeat prescriptions were signed before being dispensed to patients and there was a reliable process to ensure this occurred. Staff were not fully clear on the timeframe before an uncollected prescription should be actioned.
- 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. For example, the GP told us how he had liaised with the local medicines management team in order to monitor the practice's prescribing of antibiotic medicines, as it had been identified as a high prescriber.
- Blank prescription forms and pads were securely stored, however there was no system in place to monitor the location and use of handwritten forms.
- Patient Group Directions had been adopted by the practice to allow the nurse to administer medicines in line with legislation.

We reviewed six personnel files and found appropriate recruitment checks had been undertaken prior to employment for the most recently recruited staff. For example, proof of identification, evidence of satisfactory conduct in previous employments in the form of references and qualifications. We noted that three of the files lacked items such as application forms or interview notes.

**Monitoring risks to patients**

There were some procedures for assessing, monitoring and managing risks to patient and staff safety, although these were not comprehensive.

- There was a health and safety poster displayed in the reception office.
- The practice had an up to date fire risk assessment but had not carried out regular fire drills. The practice manager was unaware of the existence of the fire risk assessment, which was dated as completed in September 2016 and requiring review in March 2017. There were no designated fire marshals within the practice. The fire safety policy named the practice manager as fire safety lead. However, the practice manager informed us the GP was nominated lead for this area.
- None of the electrical equipment had been portable appliance tested to ensure it was safe to use. The practice manager informed us this was booked to be completed later in the month. While most clinical equipment was checked and calibrated to ensure it was in good working order, we noted that some equipment requiring such calibration had been overlooked; we noted a blood pressure monitor in the GP consultation room which had not been calibrated for three years.

Inadequate

# Are services safe?

- The practice had not completed any risk assessments relating to other health and safety issues in the workplace, such as staff working and premises' rooms. We noted a legionella risk assessment had not been completed (Legionella is a term for a particular bacterium which can contaminate water systems in buildings). The practice manager informed us this was booked to be completed later in the month.
- The building's annual gas safety check was six months overdue (last completed in September 2015). The electrical installation safety check had been completed two days prior to our inspection and the practice were not yet in receipt of the certificate at the time of our visit.
- There were arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system to ensure enough staff were on duty to meet the needs of patients. We saw that the practice was engaged in recruitment activity to employ an additional receptionist, although it was not clear whether this was in reaction to a staff member departing or whether the practice was proactively increasing staffing levels to cope with demand.

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

The practice had adequate arrangements to respond to emergencies and major incidents.

- There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency.
- We saw evidence in five of the six staff files we reviewed that annual basic life support training had been completed and there were emergency medicines available in the treatment room.
- The practice had a defibrillator available on the premises and oxygen with adult and children's masks. A first aid kit and accident book were available.
- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and stored securely.
- The practice had a business continuity plan for major incidents such as power failure or building damage. However, the plan did not include emergency contact numbers for staff and there was no nominated lead to ensure efficient cascade of information in an emergency situation.

Inadequate

# Are services effective?

(for example, treatment is effective)

## Our findings

**Effective needs assessment**

Clinicians were aware of relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines.

- Staff had access to guidelines from NICE and used this information to deliver care and treatment that met patients' needs.
- The practice monitored that these guidelines were followed through audits.

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

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent published results were 72.2% of the total number of points available compared with the clinical commissioning group (CCG) average of 96.5% and national average of 95.3%. The practice had reported an exception rate of 3.7% for the clinical domains, compared to the local average of 11.5% and national average of 9.8% (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).

This practice was a negative outlier for several QOF clinical targets. Data from 2015/16 showed:

- Performance for diabetes related indicators was lower than the local and national averages. For example:
  - The percentage of patients with diabetes on the register in whom the last IFCC-HbA1c was 64mmol/mol or less in the preceding 12 months was 54% compared to the clinical commissioning group (CCG) average of 81% and national average of 78%.
  - The percentage of patients with diabetes on the register in whom the last blood pressure reading (measured in the last year) was 140/80 mmHg or less was 59%, compared to the CCG average of 82% and national average of 78%.
  - The percentage of patients with diabetes on the register whose last measured total cholesterol (measured in the preceding 12 months) was five mmol/l or less was 75% compared to the CCG average of 84% and national average of 80%.
- Performance for mental health related indicators was also generally lower than the local and national averages. For example:
  - The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who had a comprehensive, agreed care plan documented in the record in the preceding 12 months was 74% compared to the CCG average of 88% and national average of 89%.
  - The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses whose alcohol consumption had been recorded in the preceding 12 months was 83% compared to the CCG average of 90% and national average of 89%.
  - The percentage of patients diagnosed with dementia whose care had been reviewed in a face to face review in the preceding 12 months was 100% compared to the CCG average of 85% and national average of 84%.
- The percentage of patients with hypertension in whom the last blood pressure reading measured in the preceding 12 months was 150/90mmHg or less was 75% compared to the CCG average of 84% and national average of 83%.
- The percentage of patients with asthma on the register who had an asthma review in the preceding 12 months that included an appropriate assessment of asthma control was 66%, compared to the CCG average of 77% and national average of 76%.
- The percentage of patients with chronic obstructive pulmonary disease who had a review including an assessment of breathlessness using the Medical Research Council dyspnoea scale in the preceding 12 months was 46%, compared to the CCG average of 91% and national average of 90%.

The practice discussed its QOF performance with us during our inspection visit. The GP explained the practice experienced difficulties with patients attending for review appointments as a large cohort of patients spent a

Inadequate

# Are services effective?

## (for example, treatment is effective)

significant time abroad throughout the year. The GP shared more current QOF figures (not yet independently verified) for the year 2016/17 demonstrating overall performance had improved to 89%. However, this figure did not take into account any exception reporting.

There was limited evidence of quality improvement including clinical audit. There had been two clinical audits commenced in the last two years, but only one of these was a completed audit where the improvements made were implemented and monitored. This audit, initiated in March 2016, had examined the practice's use of Norethisterone (a contraceptive medication used to delay menstruation) and proposed a change to practice following the first cycle to prescribe Medroxyprogesterone as a safer alternative. When the audit was reviewed in September 2016, it was found a further 23 patients had been prescribed Norethisterone over the previous three months, two of which were inappropriate prescriptions due to other health factors.

**Effective staffing**

Evidence reviewed showed that staff had the skills and knowledge to deliver effective care and treatment.

- The practice had an induction programme for all newly appointed staff. This covered such topics as confidentiality and allowed new recruits the opportunity to shadow more experienced colleagues.
- The practice could demonstrate how they ensured role-specific training and updating for relevant staff. For example, for those reviewing patients with long-term conditions.
- Staff administering vaccines and taking samples for the cervical screening programme had received specific training which had included an assessment of competence. Staff who administered vaccines could demonstrate how they stayed up to date with changes to the immunisation programmes, for example by access to on line resources and discussion at practice meetings.
- The practice manager told us that the learning needs of staff would be identified through a system of appraisals, meetings and reviews of practice development needs. However, none of the staff employed by the practice had worked there for longer than a year at the time of our visit, so no appraisals had been completed. We noted that formal performance reviews at the end of new recruits' probationary periods had not been completed.
- Staff had access to appropriate training to meet their learning needs and to cover the scope of their work. This included ongoing support, informal coaching and mentoring, clinical supervision and facilitation and support for revalidating GPs and nurses.
- Staff received training that included: safeguarding, fire safety awareness, basic life support and information governance. Staff had access to and made use of e-learning training modules and in-house training. We noted that mandatory training had been completed by staff in the weeks leading up to our inspection visit. We did not see evidence of a systematic approach to the management of training to ensure it was completed and renewed as needed in a timely manner.

**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.
- We saw that the practice shared relevant information with other services in a timely way, for example when referring patients to other services. However, we noted that referral processes, for example for referrals being made via cancer two week wait pathways, were not fully embedded. Inconsistent processes were used, with differing delivery methods. Referral information was originally written on paper before being sent, with no clear filing system for the paper copies resulting in increased risk of information being lost or misplaced.

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. The GP told us that the health visitor was invited to the practice's monthly staff meetings to facilitate information sharing, and we saw from meeting minutes that they had attended three of the previous five meetings. However, we saw that the GP did not routinely engage with other locality multidisciplinary team meetings when care plans were routinely reviewed and updated for patients with complex needs. We saw meeting minutes confirming the GP had

Inadequate

# Are services effective?

## (for example, treatment is effective)

attended two such meetings in the previous 12 months. The GP informed us that end of life care was delivered as needed and he would liaise with the palliative care team often at the patient's place of residence.

**Consent to care and treatment**

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

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

**Supporting patients to live healthier lives**

The practice identified patients who may be in need of extra support and signposted them to relevant services. For example, patients receiving end of life care, carers, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation.

The practice's uptake for the cervical screening programme was 86%, which was above the CCG average of 82% and the national average of 81%. The practice demonstrated how they encouraged uptake of the screening programme by ensuring a female sample taker was available. There were failsafe systems 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. However, the practice had a low uptake for attendance for national screening programmes for bowel and breast cancer screening. For example 21% of patients aged 60-69 had attended for bowel cancer screening within six months of being invited, compared to the CCG average of 54% and national average of 56%. The percentage of female patients aged 50-70 who had been screened for breast cancer within the last 36 months was 55%, compared to the CCG average of 71% and national average of 73%.

Childhood immunisations were carried out in line with the national childhood vaccination programme. Uptake rates for the vaccines given were lower than CCG and national averages. For example, performance for the vaccines given to under two year olds failed to achieve the 90% target for any indicator and equated to a score of 7.3 (out of a possible score of 10), compared to the national average of 9.1. The percentage uptake for MMR vaccinations given to five year olds ranged from 59% to 95%, compared to the CCG range of 76% to 96% and nationally 88% to 94%.

Patients had access to appropriate health assessments and checks. These included health checks for new patients (offered when the practice list was open to new patients) and NHS health checks for patients aged 40–74. Appropriate follow-ups for the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified. However, three of the patients we spoke to who were eligible for an NHS health check told us they had not been offered one by the practice.

Requires improvement

# Are services caring?

## Our findings

**Kindness, dignity, respect and compassion**

During our inspection we observed that members of staff were courteous and very helpful to patients and treated them with dignity and respect.

- Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- Consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- 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.
- There was limited access to female clinicians, with the practice nurse working two days per week, and a female locum GP working at the practice for half a day each week. Four of the six patients we spoke to during the inspection commented that it was difficult to see a female GP at the practice.

Of the 11 patient Care Quality Commission comment cards we received, eight were positive about the service experienced. Patients said they felt the practice offered a good service and staff were helpful, caring and treated them with dignity and respect.

We spoke with six patients during the inspection visit. They told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. Comments highlighted that staff responded compassionately when they needed help and provided support when required.

However, results from the national GP patient survey showed patients did not always feel they were treated with compassion, dignity and respect. The practice was below average for its satisfaction scores on consultations with GPs and nurses and interactions with staff. For example:

- 68% of patients said the GP was good at listening to them compared with the clinical commissioning group (CCG) average of 88% and the national average of 87%.
- 65% of patients said the GP gave them enough time compared to the CCG average of 87% and the national average of 87%.
- 80% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 92% and the national average of 92%.
- 61% of patients said the last GP they spoke to was good at treating them with care and concern compared to the CCG and national averages of 85%.
- 73% of patients said the nurse was good at listening to them compared with the CCG average of 93% and the national average of 91%.
- 74% of patients said the nurse gave them enough time compared with the CCG average of 93% and the national average of 92%.
- 90% of patients said they had confidence and trust in the last nurse they saw compared with the CCG average of 98% and the national average of 97%.
- 77% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 92% and national average of 91%.
- 68% of patients said they found the receptionists at the practice helpful compared with the CCG average of 85% and the national average of 87%.

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

The patients we spoke to told us they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them. Patient feedback from the comment cards we received was also positive and aligned with these views. We also saw that care plans were personalised.

Children and young people were treated in an age-appropriate way and recognised as individuals.

However, results from the national GP patient survey showed patients did not always respond positively to questions about their involvement in planning and making decisions about their care and treatment. Results were lower than local and national averages. For example:

Requires improvement

# Are services caring?

- 61% of patients said the last GP they saw was good at explaining tests and treatments compared with the CCG average of 86% and the national average of 86%.
- 64% of patients said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 81% and national average of 82%.
- 72% of patients said the last nurse they saw was good at explaining tests and treatments compared with the CCG average of 92% and the national average of 90%.
- 69% of patients said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average of 86% and national average of 85%.

Practice staff were unaware of any action implemented following publication of the GP patient survey to address the concerns raised.

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

- Staff told us that interpretation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patients this service was available. Patients were also told about multi-lingual staff who might be able to support them.
- Information leaflets were available in easy read format.
- The Choose and Book service was used with patients as appropriate (Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital).

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

Patient information leaflets and notices were available in the patient waiting area which told patients how to access a number of support groups and organisations. Information about support groups was also available on the practice website. Support for isolated or house-bound patients included signposting to relevant support and volunteer services.

We found that while the practice coded patients on their system who were carers to create a carer's register, alerts were not set up to notify staff and clinicians that the patient they were interacting with had caring responsibility. This would help ensure carers were routinely signposted to relevant support. The practice had identified 39 patients as carers (1% of the practice list). Written information was available to direct carers to the various avenues of support available to them.

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

Inadequate

# Are services responsive to people's needs?

(for example, to feedback?)

## Our findings

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

The practice demonstrated an understanding of its population profile and had implemented some measures to use this understanding to meet the needs of its population:

- The practice offered extended hours on a Monday and Tuesday evening until 7.15pm for working patients who could not attend during normal opening hours.
- There were longer appointments available for patients with a learning disability; the practice manager informed us that these patients would be offered 15 minute appointment slots.
- Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice. Practice staff told us that very few home visit requests were received. We saw from appointment records that no home visit requests were received in the week prior to our inspection visit.
- The practice took account of the needs and preferences of patients with life-limiting progressive conditions. There were early and ongoing conversations with these patients about their end of life care as part of their wider treatment and care planning.
- Same day appointments were available for children and those patients with medical problems that require same day consultation. However, patients told us they felt that demand outstripped supply for these appointments and they were not always accessible.
- The practice offered a range of online services, such as appointment booking and prescription requests.
- Patients were able to receive travel vaccines available on the NHS as well as those only available privately/ were referred to other clinics for vaccines available privately.
- Interpretation services were available and many of the staff were multi-lingual. However, no hearing loop was available for patients with hearing difficulties.
- The practice was located in a single story premises which facilitated ease of access for those patients experiencing difficulties with mobility.
- The practice was located next door to a local charity hostel for homeless people. The practice had begun to forge links with this organisation, with some of the service users now registered with the surgery. The GP would see these patients in the hostel premises should they find it difficult attending appointments at the practice.
- For those patients accessing the charity hostel who were dependent on drugs, the GP offered services to support their detoxification.
- The practice was also in discussions with the local healthy lifestyles centre with a view to potentially provide Tai Chi classes in the future to support patients with rheumatological conditions.
- The practice had previously established a patient participation group. However, the practice manager confirmed that the last contact with group members was some time in 2015. One of the patients we spoke with during the inspection had been a member of the group and confirmed there had been no liaison from the practice for some time.

**Access to the service**

The practice telephone lines were staffed between 8am and 6.30pm each working day, apart from between 12.30pm and 2pm on a Monday. The practice premises were open from 9am until 6:30pm Monday to Friday, again apart from 12.30 until 2pm on a Monday afternoon. Appointments with the GP were available between 9:30am and 11:40am each morning and between 3.30pm and 5:50pm each afternoon, apart from Wednesday afternoon when appointments started at 4pm. Extended hours appointments were also available between 6:30pm and 7.15pm each Monday and Tuesday evening, although the practice website did not reflect this accurately. The website stated that extended hours appointments were available on Monday and Thursday evenings. Appointments offered were predominantly bookable on the day, with routine pre-bookable appointments only available to be booked up to one week in advance. At lunch time on the day of our inspection visit, there were no pre-bookable appointments available to patients. Staff informed us that later that afternoon the next pair of pre-bookable appointments would be released for booking for a week later.

Results from the national GP patient survey showed that patients' satisfaction with how they could access care and treatment was below local and national averages.

Inadequate

# Are services responsive to people's needs?

## (for example, to feedback?)

- 67% of patients were satisfied with the practice's opening hours compared with the clinical commissioning group (CCG) average of 75% and the national average of 76%.
- 38% of patients said they could get through easily to the practice by phone compared to the CCG average of 72% and national average of 73%.
- 43% of patients said that the last time they wanted to speak to a GP or nurse they were able to get an appointment compared with the CCG average of 74% and the national average of 76%.
- 81% of patients said their last appointment was convenient compared with the CCG average of 93% and the national average of 92%.
- 46% of patients described their experience of making an appointment as good compared with the CCG average of 71% and the national average of 73%.
- 42% of patients said they don't normally have to wait too long to be seen compared with the CCG average of 58% and the national average of 58%.

We were given a consistent message from patients we spoke with during our inspection that appointments were difficult to access. Patients were frustrated that they experienced frequent difficulties contacting the practice by telephone and when they did get through they were often told there were no appointments available. The inspection team liaised with a stakeholder from the local hospital trust, who confirmed that the practice's patients had a high rate of attendance at accident and emergency due to an inability to access GP appointments.

We asked the practice whether any action had been taken to address the issues raised by the GP patient survey results published in July 2016. The practice manager confirmed that no immediate action had been taken, but told us that the practice had conducted its own patient survey in March 2017.

The practice manager discussed how in response to poor patient feedback around access to urgent appointments, the practice had implemented an urgent overflow request list on the computer system, which the GP would review and decide on a course of action for each patient requesting an appointment. However, the practice was not actively monitoring this new system to establish its effectiveness and none of the patients we spoke to were aware of it.

We reviewed the practice's documentation relating to its own patient survey. We found that while the practice's analysis of the results referred to a maximum of 22 respondents to survey questions, the practice only held 17 completed surveys meaning it was difficult for us to accurately validate the practice's response. We did however note that the survey results indicated other areas of patient dissatisfaction which the practice had not acknowledged. For example, 16 out of the 19 patients who responded to a question related to the ability to book appointments in advance stated that the ability to do this was important to them.

The practice had a system to assess:

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

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 lacked an effective system for handling complaints and concerns.

- Its documented 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 identified in the practice's complaints literature who handled complaints at the practice. However, we saw that in some cases responsibility for handling complaints had been delegated to other staff.
- We saw that information was not readily available to help patients understand the complaints system. A complaints form was held behind the reception desk and given to patients on request which detailed the complaints procedure. The practice manager also showed us a complaints leaflet which was stored electronically. No hard copies of this leaflet were available and we noted it contained different information regarding the complaints procedure than the complaints form which receptionists informed us that patients would be provided with.

Inadequate

# Are services responsive to people's needs?

## (for example, to feedback?)

We looked at the two written complaints received by the practice in the last 12 months and found they were not handled consistently. There was not a systematic approach to documenting the management of the complaints. This resulted in staff having difficulty locating correspondence that had been sent in response. Letters sent following receipt of a complaint were stored only in the patient's electronic record. This did not facilitate an effective overview of complaints received in order to monitor trends and ensure they had been responded to appropriately. When patients had completed a complaints form the practice had not recorded the date the complaint was received. The letter template used for responding to complaints did not always record the date the letter was sent. This meant it was difficult to establish an audit trail of the timeliness of the practice's responses. When separate, handwritten notes were located they indicated that referrals on to other agencies, such as the Medical and Defence union of Scotland (a medical defence organisation offering indemnity cover and legal advice for medical professionals) had been made on a date prior to the appointments about which the complaint related. The assistant practice manager had dealt with one of the two complaints, and the practice manager, who was the nominated individual responsible for the management of complaints in the practice, was not fully aware of the outcome.

We established that the practice did not respond to one of the two complaints in the timeframes specified in its complaints policy. No acknowledgment was sent initially, prompting the complainant to write a further letter two weeks later querying the progress of the complaint.

The outcome of the complaints had not been discussed at staff meetings. The practice manager confirmed that verbal discussions regarding complaints were not documented, meaning learning was not maximised and the practice found it difficult to evidence that lessons were learned following complaints. We did note that following a complaint relating to how the content of vaccines may impact on religious beliefs, the practice had displayed an information leaflet on the wall in reception confirming how vaccine contents related to different religions and cultures. We saw this leaflet was displayed in the 'carers noticeboard' section of the waiting area.

# Are services well-led?

Inadequate

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

## Our findings

**Vision and strategy**

The staff were able to articulate the practice's ethos to care for patients as best they could, although no mission statement was documented.

The GP told us he was in advanced discussions to trial a new joint working arrangement with a local hospital NHS trust. The practice shared with us a draft, undated action plan detailing how areas of the practice may be run should this future proposed joint working arrangement come to fruition. The action points identified did not include specified timescales.

**Governance arrangements**

The governance arrangements in place at the practice were not adequate to support the delivery good quality care.

- There was a staffing structure, however, not all staff were fully aware of the roles assigned to them. For example the practice manager told us the GP was the fire safety lead, while the policy document identified the practice manager as holding this role. The infection prevention and control lead had not been involved in the recent IPC audit completed.
- Practice policy documents were not consistent and were not always specific to the organisation. Policy documents were not dated to note when they were created, only when they were last reviewed. As well as electronic policy documents being stored on the shared drive, paper copies were stored in the reception office. The content of the policies differed between the two formats. Some policies contained information which was out of date (for example the electronic copy of the complaints policy referred to the PCT, an NHS organisation which ceased to exist in 2013) or information not relevant to the practice (for example the prescription security protocol referred to a staff member not employed by the practice as well as referencing a different practice name). In addition we saw that the practice did not consistently follow the policies that were in place, for example the prescription handling protocol and the complaints policy.
- Practice meetings were held monthly, although these were not regularly used to disseminate key information such as learning from complaints and significant events.
- While some audits had been initiated, only one was a full clinical audit and this demonstrated limited quality improvement. A programme of continuous clinical and internal audit being implemented could be used to better monitor quality and to make improvements.
- There were no systematic arrangements for identifying, recording and managing risks, issues and implementing mitigating actions. This had resulted in gaps, for example there was no legionella risk assessment in place at the time of our inspection.

**Leadership and culture**

We noted that staff were not fully aware of the working pattern of the practice manager, and when they would be on site to offer support. We were told the practice manager had submitted their resignation, and that the process of recruiting a replacement had been initiated.

The GP told us they prioritised safe, high quality and compassionate care. We received mixed messages from staff as to whether the GP and management staff were approachable and whether they took the time to listen to all members of staff.

From the sample of three documented examples we reviewed we found that the practice lacked adequate systems around how contact with patients was managed when things went wrong with care and treatment:

- The practice was unable to demonstrate it consistently give affected people support, appropriate feedback and a verbal and written apology.
- The practice did not maintain written records of verbal interactions as well as written correspondence.

There was a leadership structure but staff did not consistently feel supported by management.

- Staff acknowledged that the practice was under pressure and that the GP and management were busy as a result. This meant that they were not always approachable if staff needed to raise an issue.
- The practice did not hold multi-disciplinary meetings, such as meetings with district nurses and social workers to monitor vulnerable patients. The GP was invited to such meetings held locally and had attended twice in the previous 12 months. The local health visitor did attend the practice's monthly staff meetings however.

# Are services well-led?

Inadequate

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

- Staff told us the practice held regular team meetings and we saw minutes confirming this. We saw that the minutes from the most recent meeting were available for the staff to view.
- The GP informed us there was an open culture within the practice and staff had the opportunity to raise any issues at team meetings.
- Staff told us of a number of occasions when they had not been paid on time.

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

The practice told us it encouraged and valued feedback from patients and staff. We saw that the practice had conducted a patient survey in March 2017. However:

- The practice had not taken action following the results of the GP patient survey published in July 2016 which highlighted patient dissatisfaction with many aspects of the services offered.
- Following completion of its own patient survey in March 2017, some changes to practice had been made, although these changes were not communicated to patients and they were not sufficient to address the full range of concerns highlighted in the survey results. The practice had not monitored the effectiveness of the changes made in addressing the patients' concerns.
- We were told that interaction with the patient participation group had lapsed, with the last contact being in 2015.
- We were told of examples where staff had offered feedback and suggestions as to how practice might be modified to improve effectiveness. These suggestions were not adopted and no explanation was given as to why. The practice could offer no examples where feedback from staff had resulted in a change to protocols in order to improve the service.

**Continuous improvement**

The GP was exploring the possibility of working collaboratively with a local NHS hospital trust in order to deliver a new model of care to patients, which would facilitate patients being offered more care closer to home.

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>Maternity and midwifery services<br>Surgical procedures<br>Treatment of disease, disorder or injury | Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints<br>The provider had not established an accessible or effective system for identifying, receiving, recording, handling and monitoring complaints.<br>This was in breach of regulation 16(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 |

| Regulated activity | Regulation |
|---|---|
| Diagnostic and screening procedures<br>Maternity and midwifery services<br>Surgical procedures<br>Treatment of disease, disorder or injury | Regulation 17 HSCA (RA) Regulations 2014 Good governance<br>An effective governance framework had not been established so as to allow the practice to effectively assess, monitor and improve the quality and safety of the services provided.<br>The provider had not established an appropriate system to log and audit the location of blank hand written prescription pads.<br>The provider had not introduced reliable processes for reporting, recording, acting on and monitoring significant events, incidents and near misses.<br>The provider had not introduced systems for effectively identifying, recording and managing risks, issues and implementing mitigating actions. |

This section is primarily information for the provider

# Enforcement actions

The policies and guidance available to staff to support them in their roles did not consistently and accurately reflect the work undertaken in the practice.

This was in breach of regulation 17(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014