

# Constable Country Rural Medical Practice

## Quality Report

Constable Country Rural Medical Practice  
Constable Country Medical Practice  
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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?

Requires improvement 

Are services well-led?

Inadequate 

# Summary of findings

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## Overall summary

### Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Constable Country Medical Practice on 10 March 2015. Overall the practice is rated as inadequate.

Specifically we found the practice was inadequate for providing a safe, effective and well led service. We found the practice requires improvement for providing caring and responsive services. We examined patient care across the following population groups: older people; those with long term medical conditions; mothers, babies, children and young people; working age people and those recently retired; people in vulnerable circumstances who may have poor access to primary care; and people experiencing poor mental health. We found the provider was rated as required improvement for caring and responsive for each of these population groups. They were rated as inadequate for safe, effective and well led. All of the population groups are also rated as inadequate as the concerns which led to our ratings across each of the domains also apply to each of the population groups.

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

- Some patients were satisfied with the appointment system. Some patients reported that it was difficult to get through on the telephone and some patients were dissatisfied with the length of time they waited after arriving for their appointment.
- Data showed patient outcomes were average for the locality. Although some audits had been carried out, we saw no evidence that audits were consistently driving improvement in performance to improve patient outcomes.
- Non clinical staff were responsible for assessing risks to patient safety with no clinical oversight or accountability to ensure appropriate actions had been taken to safeguarding patient safety.
- Not all practice staff were aware of how to report safety incidents and near misses that occurred.
- Records were not accurately maintained to reflect significant incidents and there were not effective systems in place to ensure learning was shared to mitigate the risk of reoccurrences.

# Summary of findings

- Patients did not have their clinical care reviewed in accordance with the practice policy.
- The practice failed to promote an open and transparent culture for staff to report concerns and there was limited evidence of the practice learning from complaints.
- Patients said they were treated with compassion, dignity and respect.
- Information about services and how to complain was available.
- Urgent appointments were usually available on the day they were requested. However patients said that they sometimes had to wait two weeks for non-urgent appointments.
- The practice had not proactively sought feedback from staff or patients.

**There were areas of practice where the provider needs to make improvements.**

**Importantly the provider must:**

- Implement effective systems for the management of risks to patients and others against inappropriate or unsafe care. This should include arrangements for managing significant events, safety alerts and audits etc. Complete clinical audits to identify that care is being provided in line with standards.
- Ensure that there are documented checks of the cleaning that is undertaken. Infection control audits need to be undertaken, with actions identified and completed.

- Ensure that processes are in place for sharing the learning from significant events and complaints with all staff.
- Ensure there are adequate systems in place for the disposal of patient prescribed medicines.
- Ensure that safe and clinically supervised systems are in place for reviewing of all patient correspondence and actioned in a timely way and that clinical coding of patient data is accurate.

In addition the provider should:

- Conduct risk assessments for staff undertaking chaperone duties.
- Complete clinical audits to identify that care is being provided in line with standards.
- Ensure clinical staff have a clear understanding of how to ascertain parental responsibility and understand what is required for a child to be considered to be Gillick competent.

On the basis of the ratings given to this practice at this inspection, I am placing the provider into special measures. This will be for a period of six months. We will inspect the practice again in six months to consider whether sufficient improvements have been made. If we find that the provider is still providing inadequate care we will take steps to cancel its registration with CQC.

**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?

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

There were systems in place relating to staffing and recruitment checks, management of the premises and equipment and unforeseen events. The practice did not have adequate systems to identify risks and improve patient safety. We found non-clinical staff were responsible for assessing risks to patient safety with no clinical oversight or accountability to ensure appropriate actions had been taken to safeguarding patient safety. Not all practice staff were aware of how to report safety incidents and near misses that occurred. Practice records were not accurately maintained to reflect significant incidents and there were not effective systems in place to ensure learning was shared to mitigate the risk of reoccurrences. Patients did not have their clinical care reviewed in accordance with the practice policy. Staff reported and we found the practice failed to promote an open and transparent culture for staff to report concerns and there was limited evidence of the practice learning from complaints.

Inadequate



### Are services effective?

The practice is rated as inadequate for providing effective services. Data showed that care and treatment was not delivered in line with recognised professional standards and guidelines. The practice could not demonstrate how patient outcomes were met as the practice did not have an effective system in place for completing clinical audit cycles. The practice had missed an important opportunity to review the care and treatment provided by the team, seek ways to improve it and evidence that audit was driving improvement in performance for patient outcomes. Patient information received by the practice was assessed by non-clinical staff with no clinical oversight to ensure issues were identified and actioned in a timely and appropriate manner. Despite this, the practice had achieved a high uptake for childhood immunisations and were performing above the CCG group average for low A&E attendance for patients over 75. Systems for obtaining consent were robust to ensure patients were giving fully informed consent.

Inadequate



### Are services caring?

The practice is rated as requires improvement for providing caring services, as there are areas where improvements should be made. Data showed that patients rated the practice lower than others for some aspects of care. However some patients did rate the practice

Requires improvement



# Summary of findings

positively in particular around the care provided by the nursing team. The majority of patients said they were treated with compassion, dignity and respect. However, not all felt cared for, supported and listened to. Accessible information was provided to help patients understand the care available to them. We observed staff treated patients with kindness and respect and offered support to patients when they attended the practice.

## Are services responsive to people's needs?

The practice is rated as requires improvement for providing responsive services. Although the practice had reviewed the needs of its local population, it had not put in place a plan to secure improvements for all of the areas identified. Feedback from patients reported that access to a named GP and continuity of care was not always available quickly, although urgent appointments were usually available the same day. 39% of complaints received were identified as clinical complaints and had not been referred as a clinical significant event. The practice was equipped to treat patients and meet their needs. Patients could get information about how to complain in a format they could understand. However, there was no evidence that learning from complaints had been shared with staff.

**Requires improvement**



## Are services well-led?

The practice is rated as inadequate for well-led. Most practice staff told us that they shared a vision to deliver high quality personalised care. Nevertheless, several members of staff identified a lack of clinical leadership to support them to achieve their goals. The culture at the practice was not entirely open and transparent. There was an inadequate approach to monitoring service delivery, ensuring patient safety and securing improvement. Minutes of meetings were stored on the computer system for staff to access, however not all staff were aware of the location and there were no systems in place to confirm that staff had read them and therefore nothing to confirm that learning outcomes had been seen by all staff. The practice did not have an active patient participation group (PPG). However they were working with Health Watch and were recruiting for a new PPG.

**Inadequate**



# 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

Patients over the age of 75 had a named GP who was responsible for the coordination of their care. Home visits were available for older people who were unable to attend the practice. Longer appointments were available when required. Health promotional advice and support was given to patients and their carers if appropriate and leaflets were seen at the practice. These included signposting older patients and their carers to support services across the local community. Older patients were offered vaccines such as the flu vaccine each year.

The provider was rated as requires improvement for caring and responsive, this includes patients in this population group. The provider was rated as inadequate for safe, effective and well led. The concerns which led to these ratings apply to everyone using this practice, including this population group.

Inadequate



### People with long term conditions

The practice had processes in place for the referral of patients with long term conditions that had a sudden deterioration in health. Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. Patients had a named GP and annual review to check that their health and care needs were being met. Patient registers were kept to ensure needs were met. We saw that multi-disciplinary team working in the case management of people with long term conditions and on end of life care were undertaken. However minutes from multidisciplinary meetings did not detail discussion and outcome for patients discussed at these meetings

The provider was rated as requires improvement for caring and responsive, this includes patients in this population group. The provider was rated as inadequate for safe, effective and well led. The concerns which led to these ratings apply to everyone using this practice, including this population group.

Inadequate



### Families, children and young people

We saw evidence that children and young people were treated in an age-appropriate way when assessing ability to make decisions. However not all clinical staff we spoke with had a clear understanding of how to ascertain parental responsibility or were able to confirm a clear understanding of Gillick competencies. (These help clinicians to identify children aged under 16 who have

Inadequate



# Summary of findings

the legal capacity to consent to medical examination and treatment). The premises were suitable for families, children and young people because there was easy access to the waiting room and consultation rooms, with baby changing facilities throughout the premises. The local midwifery services and health visitors provided clinics within the same building

The provider was rated as requires improvement for caring and responsive, this includes patients in this population group. The provider was rated as inadequate for safe, effective and well led. The concerns which led to these ratings apply to everyone using this practice, including this population group.

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

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 ensure these were accessible, flexible and offer continuity of care. A range of health promotion, online services and screening services that reflects the needs of this population group was available at the practice. Patients we spoke with told us only 10% of appointments were pre-bookable appointments and it was difficult to obtain appointments. The practice did not offer extended hours appointments. However nurse appointments for pre-bookable and urgent appointments were available from 8am Monday to Friday. We found there was lack of a clear management structure, and the practice did not have adequate systems in place to monitor and improve quality and identify risk.

The provider was rated as requires improvement for caring and responsive, this includes patients in this population group. The provider was rated as inadequate for safe, effective and well led. The concerns which led to these ratings apply to everyone using this practice, including this population group.

**Inadequate**



## **People whose circumstances may make them vulnerable**

The practice held a register of patients with a learning disability and 63.6% of these patients had received an annual health check in the past 12 months. Longer appointments were offered for people with a learning disability. Staff knew how to recognise signs of abuse in vulnerable adults and children. However not all staff we spoke with were aware of their responsibility regarding information sharing, documentation of significant events and how to raise these as a concern.

**Inadequate**



# Summary of findings

The provider was rated as requires improvement for caring and responsive, this includes patients in this population group. The provider was rated as inadequate for safe, effective and well led. The concerns which led to these ratings apply to everyone using this practice, including this population group.

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

The practice maintained a register with patients who experienced poor mental health. They followed up on non-attendance by the patient group including people with dementia. The GPs were aware of the Mental Capacity Act 2005 and their duties in fulfilling it. However, members of the nursing staff we spoke with were not confident in their understanding or application of the legislation in order to meet and safeguard patient needs. We saw care plans were in place from the community mental health team and multi-disciplinary team working in the case management of people experiencing poor mental health. However minutes from multidisciplinary meetings did not detail discussion, decisions and the outcome for patients.

The provider was rated as requires improvement for caring and responsive, this includes patients in this population group. The provider was rated as inadequate for safe, effective and well led. The concerns which led to these ratings apply to everyone using this practice, including this population group.

**Inadequate**





# Summary of findings

## What people who use the service say

We spoke with six patients during our inspection. Three patients told us they had been able to get routine appointments. However the remaining three reported difficulties getting an appointment. Most of the patients reported difficulty in getting through to the practice by telephone to make an appointment. Three patients we spoke with told us that they had to wait a long time to see the GP once they had arrived for their appointment.

Two patients told us they had not experienced any problems requesting a repeat prescription. Patients reported that all the staff were friendly and helpful. Two patients we spoke with told us they felt a particular member of staff at the practice was dismissive and unapproachable. We raised this with the practice at the time of our inspection and were told the practice had responded to all complaints they received. However one comment card we received stated the practice had not responded to questions or emails.

Another patient was dissatisfied as they stated they used to complain to the patient participation group, but this no longer existed. PPGs are a way in which patients and GP surgeries can work together to improve the quality of the service.

We collected six Care Quality Commission comment cards from a box left in the practice a week before our inspection. Three of the comments on the cards were positive about the care and treatment received at the practice, but four of the comments on the cards raised concerns at the availability of appointments. One of the comment cards reported the practice manager did not respond to questions or emails and another card expressed concerns at the lack of nurse availability at the surgery.

## Areas for improvement

### Action the service **MUST** take to improve

- Implement effective systems for the management of risks to patients and others against inappropriate or unsafe care. This should include arrangements for managing significant events, safety alerts and audits etc. Complete clinical audits to identify that care is being provided in line with standards.
- Ensure that there are documented checks of the cleaning that is undertaken. Infection control audits need to be undertaken, with actions identified and completed.
- Ensure that processes are in place for sharing the learning from significant events and complaints with all staff.

- Ensure there are adequate systems in place for the disposal of patient prescribed medicines.
- Ensure that safe and clinically supervised systems are in place for reviewing of all patient correspondence and actioned in a timely way and that clinical coding of patient data is accurate

### Action the service **SHOULD** take to improve

- Conduct risk assessments for staff undertaking chaperone duties.
- Complete clinical audits to identify that care is being provided in line with standards.
- Ensure clinical staff have a clear understanding of how to ascertain parental responsibility and understand what is required for a child to be considered to be Gillick competent.

# Constable Country Rural Medical Practice

## Detailed findings

### Our inspection team

#### Our inspection team was led by:

Our inspection team was led by a CQC inspector. The team included a GP specialist advisor and a practice manager specialist advisor.

## Background to Constable Country Rural Medical Practice

Constable Country Medical Practice provides primary medical services Monday to Friday from 8am to 6.30pm. The practice does not provide extended hours appointments, but pre booked and urgent appointments are available from 8am Monday to Friday with a nurse practitioner. The practice provides medical services to approximately 10,990 patients living in East Bergholt, Capel St Mary and the surrounding villages. The building provides good access for patients with accessible toilets and neighbouring car parking facilities.

The practice has a team of six GPs meeting patients' needs. Five GPs are partners meaning they hold managerial and financial responsibility for the practice. In addition, there are two nurse practitioners, three practice nurses, two healthcare assistants, two phlebotomists, a data team lead and lead receptionist, the practice also employs a practice manager, deputy practice manager, lead secretary/practice

manager's personal assistant, medical secretaries and a team of reception and administration staff. Constable Country Medical Practice is a training practice and GP registrars provide clinics throughout the year.

Patients using the practice also have access to community staff including the community matron, district nurses, community psychiatric nurses, health visitors, counsellors, support workers, health visitors and midwives.

The practice provides services to a diverse population age group, in a semi-rural location.

Outside of practice opening hours a service is provided by another health care provider by patients dialling the national 111 service.

Routine appointments are available daily and may be booked up to six weeks in advance. Urgent appointments are made available on the day and telephone consultations also take place.

There is a branch surgery at Capel St Mary which we did not include in our inspection.

## Why we carried out this inspection

We inspected this service as part of our comprehensive inspection programme. We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether

# Detailed findings

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

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

## How we carried out this inspection

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

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

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

- Older people

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

Before inspecting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced inspection on 10 March 2015. During our inspection we spoke with a range of staff including two GP partners, practice nurses, health care assistants, reception and administrative staff, the practice manager and deputy practice manager. We spoke with patients who used the service. We talked with family members and reviewed personal care or treatment records of patients. We reviewed six comment cards where patients and members of the public shared their views and experiences of the service.

We looked at records and documents in relation to staff training and recruitment. We conducted a tour of the premises and looked at records in relation to the safe maintenance of premises, facilities and equipment.

# Are services safe?

## Our findings

### Safe track record

There were procedures in the practice for dealing with alerts and significant events. This required staff to record any incident or situation sufficiently out of the ordinary to warrant a permanent record, and perhaps with the potential to prompt learning or change. However systems and processes to identify risks and improve patient safety were not robust. Not all practice staff were aware of how to report safety incidents and near misses that occurred. We found there was a culture of staff not understanding the need to report significant events. For example, where staff had been left to work alone without appropriate clinical supervision. Safety alerts were not passed onto all staff in line with the practice policy and in a systematic manner. There was no evidence of shared learning internally or externally.

We saw evidence of seven significant events which had been recorded between February 2014 and February 2015. However we found that two further significant events had not been included in the summary of significant events and there was no structured learning outcomes from these two significant events.

There were inadequate systems in place for managing safety alerts reflecting a lack of clinical leadership. We found that the systems in place for disseminating safety alerts and discussing the implications for practice performance were not in line with the practice policy on safety alerts. We found there was no GP lead responsible for clinical safety alerts. We found that clinical safety alerts were assessed by a non-clinical member of staff who determined if the information required clinical action such as the review of patients' medication.. For example we found that two recent safety alerts had not been referred to the clinical team for action. There was no evidence of any actions on MHRA alerts that required actioning. The Medicines and Healthcare products Regulatory Agency (MHRA) monitor the safety and quality of medicines after they have been licensed so that swift and appropriate action can be taken to protect patients, should the need arise. They also look at any new data that comes to light about a medicine and can update the product information

if necessary. Where safety alerts had been brought to the clinicians' attention we saw no evidence of the GPs actioning the safety alerts at a practice level or the dissemination of safety information among staff.

This demonstrated that the practice did not have effective systems in place to enable regular assessment and monitoring of the quality of the services provided to protect patients and others against the risks of inappropriate or unsafe care and treatment.

### Learning and improvement from safety incidents

The practice policies for dealing with alerts and significant events detailed written procedures for action and learning. For example 'learning from events as a team, to discuss and put change or procedure in place to improve' and 'appropriate clinical alerts/guidance will be shared with healthcare professionals at the practice.' There was no evidence of any action taken for medicine and patient safety alerts. Patient safety alerts are issued when potentially harmful situations are identified and need to be acted on. Safety alerts were assessed by a non-clinical member of staff, but there was no process for checking that these had been seen and actioned appropriately within the practice. For example we spoke with one GP who told us they could not remember a safety alert action and had not dealt with any of the recent alerts. The practice confirmed a recent nationally issued medicines alert had not been acted on by the practice, as a non-clinician decided no action was required. The process for ensuring any action required was undertaken, was inadequate.

Information made available to us did not demonstrate that systems were in place for staff to formally raise issues for consideration and learning. Systems for reporting, recording and monitoring significant events, incidents and accidents were not sufficiently robust to ensure shared learning by all staff. There was no process to formally review actions from past complaints, safety alerts and significant events.

There was limited evidence that the practice staff had learnt from significant events. The significant event protocol detailed the outcomes of significant/critical event reporting to include; learning from the event as a team and discussion and operate and discuss incidents in an open environment. We were told that clinical and practice meetings were held, we saw records of a data team meeting in February 2015. However staff told us there was no clinical input to team meetings. The minutes of these

## Are services safe?

meetings were saved on the computer for all staff to read, however some staff could not remember where they were saved, others told us they did not always look at them, there was no systems in place to ensure that minutes had in fact been read by everyone and therefore nothing to show that lessons had been learnt or that changes to procedures were made. The members of the nursing team we spoke with told us they had not had a team meeting for over a year. Evidence of effective dissemination of safety issues or shared learning amongst the team was inadequate.

### **Reliable safety systems and processes including safeguarding**

The practice had systems to manage and review risks to vulnerable children, young people and adults. Staff we spoke with told us they had completed safeguarding training on line. We looked at the staff training log and saw that all staff had received safeguarding adults training. We also found that all staff with the exception of two newer members of staff had received safeguarding of children training and this included all clinicians. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information. However, not all staff were aware of how to properly document safeguarding concerns or how to contact the relevant agencies in working hours and out of normal hours. Not all staff knew where the safeguarding procedures were or how to access contact details.

The practice had appointed a GP lead in safeguarding vulnerable adults and children. We were told that they had been trained to level three in safeguarding children, which is the required level. The GPs we spoke with could demonstrate they had the knowledge to enable them to fulfil this role. Not all the staff we spoke with were aware who the lead GP was, but all staff told us they would speak to the deputy practice manager or a nurse if they had a safeguarding concern.

There was a chaperone policy, and notices informing patients of this service were displayed in the practice. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). We were told by the practice manager that reception/administration staff acted as a chaperone. The reception/administration staff we spoke with who acted as a chaperone were able to confirm this

and described the training they received. For example, where to stand to be able to observe the examination. We spoke with the practice manager who told us all clinical staff had undergone criminal records checks; however non-clinical staff that performed chaperone roles had not undergone criminal records checks. The practice had not undertaken any risk assessment in relation to the level of criminal records checks required of the reception/administrative staff who undertook chaperoning duties. The level of criminal records checks undertaken is dependent on the type of work and an enhanced DBS provides additional checks to help identify whether people are suitable to work with children and vulnerable adults.

### **Medicines management**

Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates.

The nurses and the health care assistant administered vaccines using directions that had been produced in line with legal requirements and national guidance. We saw up-to-date copies of both sets of directions and evidence that nurses and the health care assistant had received appropriate training to administer vaccines. Members of the nursing staff were qualified as independent prescribers, they told us they received regular supervision and support in their role as well as updates in the specific clinical areas of expertise for which she prescribed.

We checked medicines and vaccinations stored in the treatment rooms and medicine refrigerators and found they were stored appropriately and were within their expiry date. Some medicines and vaccines are required to be stored at specific temperatures in refrigerators to ensure their effectiveness. Staff were aware of the need to maintain these temperatures and records were kept of regular checks of the fridge temperature. This provided assurance that the vaccines were stored within the recommended temperature ranges and were safe and effective to use. A pharmacist from the local Clinical Commissioning Group was attached to the practice and assisted them to monitor and review their medicine management systems. Therefore, identifying financial savings.

There were appropriate arrangements in place for repeat prescribing so that patients were reviewed appropriately to ensure medications remained relevant to their health needs. Patients were notified when their medication

## Are services safe?

reviews were due. We saw evidence that patients on high risk medicines were appropriately monitored in line with national guidance and appropriate action taken based on the results.

We saw that prescriptions were reviewed and signed by a GP before they were given to the patient. Staff told us blank prescription forms were held securely. However we found a pile of blank prescriptions forms had been left unattended left on the desk in one consultation room. Staff told us they did not maintain any logs to demonstrate that all prescription forms or pads could be accounted for.

Staff told us expired and unwanted medicines were disposed of in line with waste regulations. However we found a number of retained patient prescribed injectable and other medicine. These were retained in the treatment room safe. We saw eight boxes of partially used and injectable medicines with patients' names clearly marked on the boxes. On one box of ten Lidocaine we saw the patients name had been blanked out with ink, others boxes had the prescription label and name of the patient and the date of issue on the box. A number of these displayed a date of issue from as early as 2012 and 2013 to September 2014. We explained to the registered manager and the practice manager that medicines should not be retained when no longer required or in use by the patients they were issued to. The registered manager told us that when they used an injectable medicine, they issued a prescription to the pharmacy for a replacement. The practice manager told us they would remove all retained prescribed medicines from the practice.

### **Cleanliness and infection control**

We observed the premises to be clean and tidy. Patients we spoke with and comments we received highlighted that the patients found the practice clean and had no concerns about cleanliness or infection control. We were told by the practice manager that there were cleaning schedules in place and cleaning records were kept by the external cleaning company. The practice manager told us that they completed a check of the general cleanliness of the building and any comments or concerns were recorded in a cleaning book in reception. However, there were no systems in place to monitor and record the quality of the cleaning being undertaken.

The member of staff with responsibility for infection control was an unregistered health professional and did not have any support from a member of the clinical team. This

meant that the level of expertise and the impact on clinical practice was limited. We noted the phlebotomist room did not have a sink. We asked the member of staff how they would wash their hands between patients and we were told they had to wait for a neighbouring treatment room or bathroom to be available. We addressed this with the practice manager who confirmed following our inspection that further phlebotomy from this room would cease and future phlebotomy would be conducted from a suitably equipped treatment room until suitable hand washing facilities could be installed in the original room. We asked to see an audit of infection control on the day of the inspection. We were told an infection control audit had been undertaken by the infection control lead, however the practice were unable to produce evidence of these audits. The practice could not demonstrate that infection control risks had been identified and actions taken to ensure patient safety against the risk of infection were therefore inadequate. An infection control audit was completed by a member of the clinical team following the inspection. This highlighted areas for action, for example hand washing facilities in the phlebotomy room and the use of personal protective equipment for clinicians where appropriate.

Staff we spoke with had a general knowledge around cleanliness and infection control. Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in other treatment rooms throughout the building.

The practice had a policy for the management, testing and investigation of legionella (a bacterium that can grow in contaminated water and can be potentially fatal). A risk assessment had been carried out on 7 March 2014; this had identified areas of risk and an action plan for water checks and testing. We saw evidence that regular testing of the water outlets was carried out.

### **Equipment**

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly. The practice manager told us that equipment was calibrated and tested for electrical safety and displayed stickers which confirmed that dates this had been undertaken. They confirmed that the calibration had taken place very recently and they were awaiting the certificate for this. We saw a certificate which

## Are services safe?

confirmed that electrical safety testing had been undertaken and was next due on 20 November 2015. We saw that stickers had been put on equipment to show that they had been calibrated and tested for electrical safety.

### Staffing and recruitment

Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, employment references, qualifications, registration with the appropriate professional body and criminal records checks through the Disclosure and Barring Service (DBS). The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. The deputy manager told us there was an arrangement in place for some members of staff, including nursing and administrative staff, to cover each other's annual leave.

Some staff we spoke with told us there were sometimes not enough staff to maintain the smooth running of the practice or to keep patients safe, sometimes due to high levels of sick leave. We discussed an example of where a member of staff had been left to provide clinical support to a patient without qualified supervision or support. One comment on the comments cards we received raised concerns regarding the lack of nurses available at the practice and having to attend A&E on two separate occasions to have minor injuries dressed. Some of the staff we spoke with reported they felt vulnerable and put upon when working on their own at the branch surgery. We were told appointment times for some clinical staff had been reduced from 15 minutes to ten minutes without any prior consultation.

The deputy manager told us there were members of staff who would cover the reception and administration team, but not all staff had this written into their contract. We were told the practice had recently introduced a reviewed sickness leave policy to address these issues and had recently recruited two nurses to increase the nursing team.

Non-clinical staff were sometimes asked to act as a chaperone. They had received training, but had not undergone criminal records checks or risk assessment to determine whether they were suitable to work with children and vulnerable adults

### Monitoring safety and responding to risk

The practice was located in a health centre that was shared with other services and was maintained and cleaned by a cleaning team. We saw evidence that maintenance was undertaken as required, for example for gas, electric and fire safety systems. There was a process in place for staff to report any faults or problems and they confirmed that issues were dealt with in a timely manner.

We found that staff recognised changing risks for patients using the service and were able to respond appropriately. Staff were able to give examples of how they would identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies.

There was a health and safety policy and the practice manager took the lead for health and safety in the practice. Formal risk assessments for the environment and premises were in place. For example health and safety and fire risk assessments had been undertaken and a risk log detailed the outcomes and actions required. However not all risk assessments had been completed to identify any significant risks and the measures required to reduce harm occurring. The practice did not regularly monitor risks to patients, staff and visitors to the practice. For example there were no infection control audits, non-clinical staff who acted as a chaperone had received training, but had not undergone criminal records checks or risk assessment to determine whether they were suitable to work with children and vulnerable adults. There were no audits of safety alerts or data entry which would monitor and identify any risks so that measures could be put place to reduce the risk of harm to patients. The practice had a system in place for reporting, recording and monitoring significant events, though a number of staff we spoke with were not clear about this.

Safety processes were in place for the checking of electrical equipment and fire safety equipment. We found there had been a recent fire drill.

## Are services safe?

### Arrangements to deal with emergencies and major incidents

Records showed that all staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest and anaphylaxis. Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, adverse weather and access to the building. The document also contained relevant contact details for staff to refer to. For example, contact details of a heating company to contact if the heating system failed.

The practice had carried out a fire risk assessment that included actions required to maintain fire safety. Records showed that staff were up to date with fire training and that fire drills had been carried out.



# Are services effective?

(for example, treatment is effective)

## Our findings

### Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs, and these were reviewed when appropriate. Clinical staff told us they were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. However, we found that safety alerts were not passed onto all clinical staff in line with the practice policy and in a systematic manner. There was no evidence of shared learning internally or externally.

The GPs told us they lead in specialist clinical areas such as heart disease and asthma and the practice nurses supported this work. The practice nurses carried out reviews for patients with long term conditions. Staff told us and the nurses confirmed they were happy to ask and provide colleagues with advice and support.

The senior practice manager showed us data from the local CCG of the practice's performance for prescribing, which was comparable to similar practices. The practice used computerised tools to identify patients with complex needs who had multidisciplinary care plans documented in their case notes. Nominated members of the administration team oversaw patient long term condition registers. Staff used the computerised record system to identify patients who were eligible for healthcare and medicine reviews and invited the patient for a review.

National data showed that the practice was in line with referral rates to secondary and other community care services for all conditions. The GPs we spoke with used national standards for the referral of patients with suspected cancers referred and seen within two weeks. We were told that all hardcopy post received from secondary care was forwarded to the GPs. However discharge notifications were assessed by the administration team and those they felt did not need further action were filed to the patients records. Staff told us they could ask the GP's for advice but there was no formal clinical oversight or audit to identify and address any errors should the patient needs of not been understood and acted upon appropriately.

Discrimination was avoided when making care and treatment decisions. Interviews with GPs and nurse showed that the culture in the practice was that patients were cared for and treated based on need and the practice took account of patient's age, gender, race and culture as appropriate.

### Management, monitoring and improving outcomes for people

The practice did not have an effective system in place for completing clinical audit cycles. We were given evidence of one audit taking place in the last 12 months, only the first cycle had been completed, Therefore, the practice had not sufficiently reviewed the care and treatment provided by the team and considered ways to improve it.

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, and managing child protection alerts and medicines management. There was a protocol for repeat prescribing which was in line with national guidance. In line with this, staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP.

Designated administration staff checked that all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used. We saw that non clinical staff were tasked with read coding patient information and determining whether a GP needed to review patient information that was received from hospitals. The practice had no assurance system in place to ensure staff were accurately coding patient information and ensuring they received timely and appropriate care. For example, we reviewed patient records. We found that five patients with complex health needs had not been recalled for required clinical review following a read coding error. The practice had conducted read code searches on patient records. Where discrepancies had been identified these had been discussed as data integrity issues and the coding had been corrected. However, the potential clinical consequences for the patients had not been understood, reviewed and addressed by clinicians such as during their meetings.

The practice had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss the care and support needs of patients and their families.

# Are services effective?

(for example, treatment is effective)

However the minutes from the multidisciplinary meetings did not detail discussion for each patient on the register, it did not reflect the outcomes from the meeting or the impact on patient care and treatment.

The practice participated in local benchmarking run by the CCG. This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area. This benchmarking data showed the practice had outcomes that were comparable to other services in the area. For example information provided by the CCG showed the practice had performed above the local average in reducing A&E admissions for patients over 75.

## Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending courses such as annual basic life support. All GPs were up to date with their yearly continuing professional development requirements and all either have been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

All staff undertook annual appraisals that identified learning needs from which action plans were documented. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses. For example, one member of staff told us about the leadership and management skills course they were undertaking, another member of staff told us about the chaperoning training they had undertaken. Staff files we reviewed showed that where poor performance had been identified appropriate action had been taken to manage this.

As the practice was a training practice, doctors who were training to be qualified as GPs were offered extended appointments and had access to a senior GP throughout the day for support. We received positive feedback from the trainees we spoke with.

Practice nurses were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties. For example, they had completed training on administration of vaccines and cervical

cytology. We found that healthcare assistants felt they were not supported in their role at the practice branch surgery, we were told of an incident where a member of staff working unsupervised had acted in desperation in making decisions regarding treatment for a patient. We were told they were not receiving any clinical supervision or support appropriate to the work they were being expected to perform.

Patient reported experiencing difficulties with the availability of the nursing team at both the main practice and the branch surgery. One CQC comment card reported a patient having to go to A&E on two occasions following minor injuries as there were no nurses available at the practice to perform dressings. We discussed this with the deputy manager who outlined the recent recruitment of nurses to the practice and the expectation.

## Working with colleagues and other services

The practice received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from communications with other care providers on the day they were received. We were told that all hardcopy post was forwarded to the GPs. However discharge notifications were triaged by the administration team and those they felt did not need further action were filed to the patients records. We were told the administration team would identify any patient data that should be added to the patient's record. For example, recordings of height, weight, blood pressure and test results. We were told any patients with a diagnosis of mental health who had been discharged or discharged themselves would not be highlighted to the GP, unless it was a new diagnosis. Staff told us this was not overseen by the GPs. Audit of discharge correspondence had not been undertaken by a clinical member of staff to ensure that errors had not occurred. There was a risk that important information might not be reviewed and acted upon by a clinician.

The practice held multidisciplinary team meetings monthly to discuss the needs of complex patients, for example those with end of life care needs or children living in vulnerable circumstances. These meetings were attended

# Are services effective?

(for example, treatment is effective)

by district nurses and palliative care nurses. Meeting minutes reviewed did not include decisions made to ensure that patients received effective and coordinated care, or learning outcomes.

## Information sharing

Governance of patient records required improvement. An electronic patient record was used to coordinate, document and manage patients' care. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference. Non clinical staff were tasked with deciding whether each piece of hospital correspondence needed to be reviewed by a GP. There was therefore a risk that patient correspondence would not be correctly allocated to GPs for review, correctly coded and that patients' notes had not been added accurately.

For patients requiring emergency hospital admission, there was a policy of providing a printed copy of a summary record for the patient to take with them to A&E. The practice has also signed up to the electronic Summary Care Record. (Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours). Electronic systems were also in place for making referrals through the Choose and Book system. (The Choose and Book system enables patients to choose which hospital they will be seen in and to book their own outpatient appointments in discussion with their chosen hospital).

Non-clinical staff were expected to code patients' records without an effective system in place to do this. We looked at the summarising notes protocol for the practice which was very brief. Staff confirmed that administrative staff were read coding without supervision or audit checks from a clinical staff member. A practice list of preferred codes had been agreed and maintained. However this was not supported by random spot checks, quality audits or regular discussion of the coding in meetings. There was therefore a risk that read coding errors were made and not detected. We were given evidence which showed that read code errors had resulted in some patients not being recalled to see their GP at the appropriate time. We noted that these errors had been actioned and corrected, but had only been discussed at the data team meeting and that there was no clinical input or discussion at clinical meetings in resolving this issue. Correct coding of patient data is an integral part of good clinical governance and an essential part of clinical

risk management. It must be accurate, informative and relevant. Incorrect coding will lead to incorrect data which has the potential to seriously compromise patient safety and important data sharing with other agencies, within the terms of the Data Protection Act.

## Consent to care and treatment

The GPs we spoke with described the processes to ensure that written informed consent was obtained from patients whenever necessary, for example when patients needed minor surgery. We were told that verbal consent was recorded in patient notes where appropriate. Patients we spoke with confirmed that their consent was obtained before they received care and treatment. The Mental Capacity Act is designed to protect people who cannot make decisions for themselves or lack the mental capacity to do so. The GPs were aware of the Mental Capacity Act 2005 and their duties in fulfilling it. However members of the nursing staff we spoke with did not demonstrate a clear understanding of the key parts of the legislation and were not able to describe how they implemented it in their practice.

Clinicians we spoke with were able to demonstrate an understanding of the legal requirements when treating children. Staff told us how consent was obtained prior to immunisations or vaccinations being given. However not all clinical staff we spoke with had a clear understanding of how to ascertain parental responsibility or were able to confirm a clear understanding of Gillick competencies. (These help clinicians to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment).

## Health promotion and prevention

The practice did not offer routine health checks to all new patients registering with the practice. The administration team told us any health concerns noted from the new patient questionnaire were highlighted to a GP and the patient would be asked to come in and see a GP. Staff showed us and told us about the new patient's registration pack which included a new patient health questionnaire, consent of patient care data information sharing and an opt out request for patients from the NHS Summary Care Record. Clinical staff told us about the patient consultations where they first met with adults and children

# Are services effective?

(for example, treatment is effective)

and welcomed them to the practice. We were told this was when they discussed with patients their past medical and family histories, medication, lifestyles and/or any health or work related risk factors.

The practice offered NHS Health Checks to all its patients aged 40-75 and these checks were undertaken by the practice nurse. The practice showed us the results of the work they had undertaken in admissions avoidance. The performance of the practice in this area was the subject of regular monitoring by the CCG and data reflected that targets were being achieved and in some areas such as A&E attendance, the practice were performing above the CCG group average for the past two years.

The practice identified patients requiring additional support. They kept a register of all patients with a learning disability and were aware of the numbers that had registered with them. These patients attended appointments for their annual review of their condition and on-going treatment was followed up by the practice. Care plans in place were regularly reviewed. We saw that of the 33 patients who were registered as having a learning disability at the practice, 21 had received health and medication reviews in the previous 12 months. Nurses we spoke with told us they undertook these health checks. However other clinicians we spoke with gave differing reports as to which members of staff completed the health checks. The practice had registers of patients who had been diagnosed with mental health problems, dementia, and long term conditions such as hypertension and diabetes. We spoke with one member of staff who told us nominated members of the administration team oversaw patient long term condition registers. Staff used the computerised record system to identify patients who were eligible for healthcare reviews, vaccinations and cervical screening. The data from Public Health at June 2013 showed that the uptake of cervical smears taken reached

by the practice was 78.8% which was below the regional and national target. We saw non-attendance was addressed with patients who did not attend for cervical smears.

The practice offered a full range of immunisations for children and flu vaccinations in line with current national guidance. We saw the practice had achieved 100% uptake for many childhood vaccinations. The Public Health target coverage rate is 95% for all childhood (1 – 5 years) immunisations. The practice exceeded the target for each immunisation. The practice was pro-active in identifying patients through posters in the surgery the information screens in reception, letters to patients and telephone calls. Travel vaccinations were also available and the practice was a recognised yellow fever centre. There was a clear policy for following up non-attenders.

Up to date information on a range of topics and health promotion literature was readily available to patients at the practice and on the practice website. This included information about support services, such as smoking cessation advice. Patients were encouraged to take an interest in their health and to take action to improve and maintain it. This included advising patients on the effects of their life choices on their health and well-being.

The practice proactively identified patients, including carers who may need on-going support. The practice offered signposting for patients and their relatives and carers to organisations such as: the Alzheimer's society and Help the Aged.

There was a range of health promotion information available at the practice. This included information on safeguarding vulnerable patients, requesting a chaperone, victim support and support for patients and their carers on the noticeboards and information monitors in the reception area.

# Are services caring?

## Our findings

### **Respect, dignity, compassion and empathy**

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national Ipsos MORI patient survey 2014. The evidence from this survey showed patients were not completely satisfied with how they were treated. Of those patients that responded to the survey, 94% reported the nurses were good at treating them with care and concern, however only 64% of those responding reported the GPs as being good at treating them with care and concern, with 11% reporting the GPs to be poor or very poor at treating them with care and concern. 93% responded that the nurses were good at giving them enough time and 94% reported the nurses as being good at listening to them. However of those responding to the survey, 64% reported the GPs were good at giving them enough time and 71% responded the GPs were good at listening to them. With 11% reporting GPs were poor or very poor at giving them enough time and listening to them. 79% reported they had confidence in the last GP they saw; with 21% reporting they had no confidence at all. By comparison nationally 5% of patients responding to the survey reported they had no confidence at all in the last GP they saw, with 4% of patients responding for the CCG area.

Patients completed CQC comment cards to tell us what they thought about the practice. We received six completed cards. Patients said they felt the GPs were friendly and staff were helpful and caring. They said staff treated them with dignity and respect. Patients we spoke with on the day of our inspection told us reception staff were polite and helpful. However, five of the six patient comments concerns related to insufficient consultation time with the GP's.

We saw that consultations and treatments were carried out in the privacy of a consulting room. Disposable curtains were provided in consulting rooms and treatment rooms so that patient privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation / treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. This was respected at all times when staff were delivering care, in

staff discussions with people and those close to them, and telephone conversations and in written records. Facilities were available for patients to speak confidentially to clinical and non-clinical staff.

The practice switchboard was located away from the reception desk and was shielded which helped keep patient information private. We saw this system in operation during our inspection and noted that it enabled confidentiality to be maintained.

Staff told us that if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected, they would raise these with the practice manager or deputy manager.

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

We asked patients if they felt involved in making informed decisions about their care or their family members where appropriate. Two of the patients we spoke with told us they did not feel they were given enough time and information about their illness. Other patients we spoke with told us they felt options were explained to them to enable them to understand the choices available and potential outcome of any decision. Staff told us they provided both verbal and written information to assist patients to understand their assessment, diagnosis and treatment options. Where appropriate patients were referred to other sources of information such as websites and community support groups to assist them.

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

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

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

Notices in the patient waiting room, on the TV screen and practice website told patients how to access a number of support groups and organisations. Staff told us when a new patient registered at the practice they were asked if they were a carer and offered appropriate support. The practice identified patients who were also carers on the computer system. Staff and clinicians were automatically alerted to

## Are services caring?

patients who were also carers. This ensured that GPs and clinical staff were aware of the wider context of the patients' health needs. We were shown the written information available for carers to ensure they understood the various avenues of support available to them.

We spoke with a GP about how they supported patients and carers to cope emotionally with care and treatment.

The GP told us that they discussed patients and carers emotional needs as part of a consultation and would either visit or signpost them to services available. We saw a template letter the GPs used when writing to families following bereavement.

# Are services responsive to people's needs?

(for example, to feedback?)

## Our findings

### Responding to and meeting people's needs

The practice kept registers for patients who had specific needs including those with dementia, mental health conditions, learning disabilities and those with life limiting conditions who were receiving palliative care and treatment. These registers were used to monitor and respond to the changing needs of patients.

Staff told us each long term condition register had a nominated member of the administration team to oversee the register. For example, rheumatoid arthritis, mental health and atrial fibrillation. The role of the team was to ensure patients on the registers were recalled for a health and medication check when required. In the previous year for all QOF domains, the points achieved by this practice as a percentage of the maximum QOF points available was 82.25%. This was 6.1 points below the CCG average and 11.2 below national average. The practice manager told us they were on track and working towards a high achievement for QOF result for the current year. Staff told us if they had any questions or concerns regarding their role they could liaise with the management or nursing team.

Staff told us patients could request to see a GP of their choice and this was accommodated where possible. Home visits were available for older people, those with long term conditions and those with limited mobility. Telephone consultations took place when appropriate and time was allocated to these each day so all patients received a call back. Although patient appointments were generally of ten minutes duration, the practice recognised when these needed to be extended for patients with complex needs. This included making a double appointment available for people with learning disabilities who required a health check or when dealing with multiple issues. Patients we spoke with told us the nurses listened and explained things to them and gave them the time they needed. Staff told us patients over 75 years of age had a named GP to ensure continuity of care for the elderly. The practice worked collaboratively with other agencies and regularly shared information to ensure timely communication of changes in care and treatment.

Patients were able to request repeat prescriptions on-line or to attend the practice personally. The practice had a palliative care register. There were regular internal as well

as multidisciplinary meetings to discuss patients, their families and their care and support needs. However, not all meetings had been minuted adequately to evidence the outcome of discussion and decision making.

### Tackling inequity and promoting equality

The practice understood and responded to the different needs of patients from different ethnic backgrounds and those who may be vulnerable due to social or economic circumstances. The practice provided equality and diversity training through e-learning. Staff we spoke with confirmed that they had completed the equality and diversity training. The practice manager told us that the majority of patients were English speaking and that they had very few patients from ethnic minority communities. Patients who needed extra support because of their complex needs were allocated a longer time for their appointments. We saw specific tailored care plans to meet the needs of patients with learning disabilities and for those affected by dementia as well as those with long term medical conditions.

The practice services for patients were situated on the ground floor. There was lift access to the upper floors where patients could access other services such as midwifery services. We saw the waiting areas were large enough to accommodate patients with wheelchairs and prams and allowed for access to the treatment and consultation rooms. There were accessible toilets and baby changing facilities available.

The appointment check-in facility in the practice was set up to reflect the most common languages in the area. Staff had access to an interpretation and translation service. They were able to demonstrate an awareness of culture and ethnicity and understood how to be respectful of patients' views and wishes. We saw evidence of staff supporting people who were unable to use the booking-in screen or read the appointment information monitor in the reception area.

The practice manager was not aware of a protocol for patients who were homeless as we were told there were none in the area.

### Access to the service

Appointments were available from 8am to 6.30 pm on weekdays. The practice did not offer extended opening hours. However pre-bookable nurse practitioner appointments were available from 8am Monday to Friday.

# Are services responsive to people's needs?

(for example, to feedback?)

We were told approximately 10% of GP appointments were available in advance. However we were told there was often a wait of two weeks to see any GP. Information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits and how to book appointments through the website. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients.

Staff told us longer appointments were available for patients who needed them and those with long-term conditions. This also included appointments with a named GP or nurse. Home visits were made to those patients who needed one.

The practice had recently installed a call management software system, this system provided up to the minute information for staff on telephone calls coming into the practice. Staff were able to monitor calls that had been responded to, calls waiting and any calls that may have been missed. We saw that staff had managed over 350 calls to the practice during the previous Monday. The practice manager told us this was new to the practice and was being used to audit the volume of calls the staff dealt with, any issues around missed or waiting telephone calls and any changes to reception staffing levels that may be required as a result of demand at peak times. The last national GP patient survey showed that 56% of patients who responded to the survey stated that it was not at all or not very easy to get through to the practice by telephone, the remaining 44% stated they had found it easy to get through on the telephone.

Patients completed CQC comment cards to tell us what they thought about the practice. We received six completed cards, five of these raised concerns about access for appointments and time with GPs. We also spoke with six patients on the day of our inspection; three patients told us they could not easily get an appointment. Five patients we spoke with told us they could not get through easily on the telephone and when they did get through the appointments had been filled.

Staff told us that patients in urgent need of treatment had often been able to make appointments on the same day of

contacting the practice. However three of the six comment cards we received raised concerns over accessibility for both urgent and routine appointments and telephone access for appointments in the morning. One card stated it was difficult to see a GP of choice, another card expressed concerns regarding the lack of nurses available. Patients that we spoke with told us they were not always able to see the same GP, or be seen on the same day and often had to sit and wait for their appointment times. The practice manager told us they had tried various appointment systems, however the general feedback from patients had been that the majority of appointments available should be the provision of on the day appointments. The practice manager and deputy manager told us they were hopeful that the recent recruitment of nurses to the practice would improve appointment access.

## Listening and learning from concerns and complaints

The practice had a complaints handling procedure and the practice manager was the designated staff member who managed the complaints. Details about the complaints process were included on the practice website and in the practice booklet to help patients understand the system. These did not include where to go if the patient was not satisfied with the response received from the practice. However this was detailed on the patient complaint form and leaflet available in the reception area.

Patients we spoke with were not aware of the process to follow if they wished to make a complaint. Three of the patients we spoke with told us they felt uncomfortable and unable to make a complaint to the practice manager.

We saw that 61 complaints had been recorded by the practice during 2014/2015. Of these 67% were written complaints and 32.8% were verbal. Audits of written complaints had identified trends with 46% regarding general practice administration and 39% regarding clinical issues. We looked at three complaints received in the last 12 months and found these had been handled in a timely way. A quarter of the clinical complaints had been upheld although, there was no evidence of oversight or involvement by a GP and none had been investigated as a clinical significant event. Therefore patients could not be assured sufficient clinical scrutiny had been conducted of their complaint.

There was no system in place to analyse and learn from complaints received in the practice. The practice were not



## Are services responsive to people's needs? (for example, to feedback?)

able to demonstrate that formal meetings had been attended by clinical and non-clinical staff to discuss the complaints, ensure they were handled appropriately, analysed and lessons learned.

Staff spoken to were not able to give examples of any lessons learnt from complaints and could not confirm if these were discussed at the practice meetings.

# 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

Most practice staff told us that they shared a vision to deliver high quality personalised care. Nevertheless, several members of staff identified a lack of clinical leadership to support them to achieve their goals. Some staff we spoke with told us that their daily aim was to provide a good service for patients, whilst others described a task orientated approach where speedy delivery of objectives was key.

### Governance arrangements

The practice had a number of (mainly generic) policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the practice. We looked at six of these policies and procedures. Not all the policies we looked at were dated for example the scanning protocol and the significant/critical event toolkit. Others were dated as published in February 2015 and amended February 2015, therefore it was unclear if these were reviewed annually or were recently created. The data entry protocol was brief.

The responsibility for clinical leadership was carried by one of the partners. Clinical meetings were held, minutes of these were saved on the computer for staff to read. However some staff could not remember where they were saved, others did not always look at them, and there was no system in place to ensure that minutes had in fact been read by everyone and therefore nothing to show that lessons had been learnt or that changes to procedures were made. We were told nurse meetings had not taken place for over a year. We saw the minutes of the last nurse meeting had been held on 19 June 2014. There were clear gaps in ensuring that clinical staff were appropriately supported to deliver safe and effective care to patients.

We found practice meetings were infrequent or not conducted. This meant that clinical support staff, locum GPs and administrative staff had limited opportunity to contribute to or benefit from quality improvement decisions. We reviewed practice meeting minutes dated 17 February 2015 discussions related to performance but no clinical staff were in attendance. Meeting minutes were stored on the computer for staff to access, not all staff were

aware of the location and there were no systems in place to confirm that staff had read, understood and actioned them appropriately to ensure patient safety and secure improvement.

Governance of safety alerts were inadequate. A non-clinician was tasked with deciding which safety alerts should or should not be actioned. At our inspection we could find no evidence that patient safety alerts had been acted upon in a timely manner. This evidence reflected an inadequate approach to monitoring service delivery, ensuring patient safety and securing improvement.

Information governance arrangements were inadequate. Non-clinical staff were coding patients' records without an effective system in place to do this. Coding errors had been identified and discussed, but only at the data team meeting and not at clinical meetings. Correct coding of patient data is an integral part of good clinical governance and an essential part of clinical risk management. It must be accurate, informative and relevant. Incorrect coding will lead to incorrect data which has the potential to seriously compromise patient safety and important data sharing with other agencies, within the terms of the Data Protection Act.

The practice did not provide minutes to demonstrate that governance meetings were held in order to discuss performance, quality and risks. Staff confirmed that such meetings did not take place.

We saw one audit that had been undertaken in the last 12 months, but only one cycle had been completed. The practice had missed an important opportunity to review the care and treatment provided by the team and seek ways to improve it.

The practice did not have arrangements for identifying, recording and managing risks. As practice wide team meetings took place infrequently and were not minuted, the practice could not demonstrate that risks had been discussed at practice level. We discussed this with the senior partner who confirmed that nurses and practice wide meetings had been stopped.

### Leadership, openness and transparency

Some staff we spoke with did not feel that there was effective clinical leadership at the practice, due to

# Are services well-led?

Inadequate 

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

insufficient support and encouragement to report concerns they had. There was no evidence of regular practice-wide staff meetings which meant that opportunities for raising and sharing concerns were limited.

This suggested the practice failed to promote an open, transparent and learning culture. . We were told about a clinical incident which had not been reported to managers or partners and so had not been investigated. This constituted an on-going risk to patient safety.

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

The practice confirmed they took part in the Friends and Family test and they had a suggestion box on the practice website. However, they did not currently have a Patient Participation Group (PPG). PPGs are a way for patients and GP surgeries to work together to improve services, promote health and improve quality of care. However we saw they were actively working with Health Watch to recruit to a new PPG. We looked at the results of the national annual patient survey 2014 and found overall patient satisfaction with the practice was below the national and CCG average.

The practice obtained feedback from staff through staff supervisions and general discussions. However, there was an absence of formal practice wide meetings to capture and reflect on team concerns and staff felt in sufficiently valued and supported to engage in the process.

We spoke to six patients on the day of our inspection; three patients told us they did not feel they were able to raise concerns with the practice, due to a lack of approachability of some staff. We raised this with the practice, we were told the practice had responded to all complaints they received. However, this was not supported in a comment card received where a patient alleged their concerns had not been responded to.

Staff told us that there was a whistleblowing policy and most staff knew where they should go to outside the practice if they felt they could not raise concerns internally.

Whistleblowing is the process by which staff can raise concerns they may have about the practice and the conduct of other members of staff. This enables concerns raised to be investigated and acted on to help safeguard patients from potentially unsafe or inappropriate care.

## **Management lead through learning and improvement**

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. However, some staff told us they did not receive regular supervision or an opportunity to raise concerns and/or discuss their development needs. We identified that healthcare assistants did not receive clinical supervision from the clinical team.

The practice was a GP training practice and had two deanery-approved GP trainers. The practice was accredited as a teaching practice for Cambridge University, UEA and Imperial College. We saw recent training at the practice for UEA students had focused on women's health and paediatrics. Longer appointments were provided for patient consultations, the students and the training GP to facilitate reflection and feedback. We reviewed comments from medical students who had attended the practice. These included comments regarding the helpfulness of the practice in giving the opportunity for independent consultation, being given 30 minutes per appointment and receiving support through clinical debriefs. One student commented that all the GPs who had worked with them were very encouraging and supportive

The practice had completed reviews of some significant events. However we identified several complaints and other clinical incidents that failed to have clinical input and should have been investigated as significant events. Learning from complaints and incidents was also not integral to the practice with no formal means of sharing learning, checking understanding and ensuring improvements.

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	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment
Family planning services	The registered persons must ensure that staff providing care and treatment to service users have the qualifications, competence, skills and experience to do so safely.
Maternity and midwifery services	Clinical staff working in isolation did not have the appropriate supervision to ensure they were competent in the duties they were expected to perform.
Surgical procedures	Clinical staff did not have sufficient knowledge or understanding of how to ascertain parental responsibility or were able to confirm a clear understanding of Gillick competencies.
Treatment of disease, disorder or injury	The registered person must ensure there are systems in place for the proper and safe management of medicines. The provider must ensure there are adequate systems in place for the disposal of patient prescribed medicines.
	This was in breach of regulations 13, 21 and 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12 (1),(2)(a)(b)(c) and (g) 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 Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	<p>Regulation 17 HSCA (RA) Regulations 2014 Good governance</p> <p>The provider did not have effective systems in place for the management of risks to patients and others against inappropriate or unsafe care. This included arrangements for managing significant events and safety alerts.</p> <p>The provider was failing to follow the process set out in the practice information governance policy by failing to monitor and provide clinical oversight of patient correspondence and read coding of patient information.</p> <p>The provider was failing to follow the processes set out in the practice policy by failing to monitor the quality of information held by the practice. There were no systems in place to ensure staff were supported through supervision.</p> <p>A clear management and leadership structure was not in place. There were inadequate systems to monitor the quality and safety of the service so that learning and improvement was continuous.</p> <p>There were no systems in place to ensure consistent learning through complaint and significant event analysis was taking place and shared with staff.</p> <p>We have issued a warning notice under Regulation 17</p> <p>This was in breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.</p>