The Clarence Medical Centre

Quality Report

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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

Contents

Overall summary

Letter from the Chief Inspector of General Practice

CQC inspected the practice on 4 November 2014. We found some areas of concern and had asked the provider to make improvements.

We undertook this announced comprehensive inspection on 9 September 2015 of Clarence Medical Centre, to check whether there had been any improvements and found that whilst some of our concerns had been addressed we found overall the practice had not improved and we identified further concerns.

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 in place to keep them safe. For example, there was no clear infection control lead and the practice had not undertaken an infection control audits since January 2014.
- Staff were not clear about reporting incidents, near misses and concerns and there was no evidence of learning and communication with staff.
- There was insufficient assurance to demonstrate people received effective care and treatment. For example, QOF data for this practice showed that overall it was performing below national standards and we did not see any evidence that the practice had any systems to monitor outcomes for patients
- Patients were positive about their interactions with staff and said they were treated with compassion and dignity.
- Urgent appointments were usually available on the day they were requested. However patients said sometimes it was very difficult to get through to the practice when phoning to make an appointment.
- The practice had no clear leadership structure and limited formal governance arrangements.

The areas where the provider must make improvements are

Summary of findings

- Ensure clear systems are in place for reporting and recording significant events.
- Ensure there are formal governance arrangements in place including systems for assessing and monitoring risks and the quality of the service provision as we found there was an unguarded electric halogen heater in the nurse's room which presented a serious risk to patients, especially children.
- Take action to address identified concerns with infection prevention and control practice as we found there was no clear infection control lead and no audits had been undertaken since January 2014
- Put systems in place to ensure all clinicians are kept up to date with national guidance and guidelines as we found the GPs were unfamiliar with the dangers of prescribing high risk medication.
- Ensure there are formal arrangements in place for reviewing patients with long term conditions
- Ensure clinical audits are undertaken in the practice, including completed clinical audit or quality improvement cycles.
- Ensure the GPs understand the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005.
- Clarify the leadership structure and ensure there is leadership capacity to deliver all improvements.

Action the provider SHOULD take to improve:

- Clarify who the safeguarding lead for the practice is and ensure all staff are aware of it.
- Develop cleaning records or schedules for the practice.

I am placing this practice in special measures. Practices 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 practice 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 vary the provider's registration to remove this location or cancel the provider's registration.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Inadequate

The practice is rated as inadequate for providing safe services and improvements must be made. Staff were not clear about reporting incidents, near misses and concerns. The practice did not have a clear system in place for reporting and recording significant events and incidents. There was no evidence that these were systematically analysed and that lessons learnt were communicated to ensure safety was improved.

Patients were at risk of harm because systems and processes were not in place in a way to keep them safe. An environmental risk assessment had been carried out, however on the day of our inspection we found equipment that presented a risk to patients. The practice had also not undertaken an infection control audit since January 2014.

We found the GPs were unfamiliar with the dangers of prescribing high risk medication. For example, we saw that they had prescribed a high dose of methotrexate for a patient and had not been carrying out blood testing.

Are services effective?

Inadequate

The practice is rated as inadequate for providing effective services and improvements must be made. Data showed that care and treatment was not delivered in line with recognised professional standards and guidelines. Patient outcomes were hard to identify as little or no reference was made to audits or quality improvement and there was no evidence that the practice was comparing its performance to others; either locally or nationally. There was minimal engagement with other providers of health and social care. Basic care and treatment requirements were not met.

Are services caring?

Requires improvement

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 such as involving them in decisions. The majority of patients said they were treated with compassion, dignity and respect.

Are services responsive to people's needs?

Requires improvement

The practice is rated as requires improvement for providing responsive services. Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day. Patients could

Summary of findings

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. The premises were accessible to patients with disabilities and the toilets were accessible to wheelchair users. The practice had extended hours opening one day a week. However, the practice did not hold a register of patients living in vulnerable circumstances except patients with a learning disability and did not have systems in place to review patients with long term conditions.

Are services well-led?

Inadequate

The practice is rated as requires improvement for being well-led. There was a documented leadership structure and most staff felt supported by management. However, it did not have a clear vision and strategy, and staff we spoke with did not appear to understand the vision and values and were not clear about their responsibilities in relation to these. We were told the practice held monthly governance meetings which were attended by the partners and the practice manager however; there were no minutes available for us to confirm this. Although the practice was aware of their QOF scores there was no evidence to demonstrate they used it to improve their performance. The QOF data for this practice showed it was performing below national standards in some areas. The practice did not have any completed clinical audits in the last 12 months. The practice had not proactively sought feedback from staff or patients

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 practice is rated as rated as inadequate for the care of older people.

The practice had a list of older people who were housebound whom they would visit regularly. However, although patients over 75 years had a named GP they did not have a register for older people who have complex needs or required additional support.Longer appointments were available for older people when needed, and this was acknowledged positively in feedback from patients. Nationally reported data showed that outcomes for patients for conditions commonly found in older people were mixed, for example dementia diagnosis was 100% whilst flu vaccinations for over 65s was 45%.

People with long term conditions

Inadequate

The practice is rated as inadequate for the care of people with long term conditions.

We found there were no systems in place to review patients with long term conditions. The GPs told us they would review these patients opportunistically when they attended the practice

The practice kept a register of these patients and longer appointments were available when needed. Very few of these patients had a named GP and personalised care plan. Structured annual reviews were not undertaken to check that patients' health and care needs were being met. The practice did not run any specific clinics for patients with these conditions and data we reviewed prior to our inspection showed the practice were not performing well in relation to the care and management of patients with diabetes. The GP told us they would give opportunistic diabetic care to patients in this group when they attended the surgery.

Families, children and young people

Inadequate

The practice is rated as inadequate for the care of families, children and young people. There were no systems to identify and follow up patients in this group who were living in disadvantaged circumstances and who were at risk. The practice did not carry out child immunisations at the practice, patients were sent to the local health centre. The practice did not have any effective processes in place to monitor take up of childhood vaccinations. The system in place relied on parents bringing the red book for admin staff to update the records. However, practice staff had completed child protection training

Summary of findings

Working age people (including those recently retired and students)

Inadequate

The practice is rated as inadequate for the care of working-age people (including those recently retired and students). The practice offered extended opening hours for appointments from Monday to Friday, patients could book appointments online. Health promotion advice was offered and limited accessible health promotion material available through the practice. The practice invited patients over 40 years of age to have an NHS health check but we were told the uptake was relatively low.

People whose circumstances may make them vulnerable

Inadequate

The practice is rated as inadequate for the care of people whose circumstances may make them vulnerable. The practice did not hold a register of vulnerable patients except patients with a learning disability. It had carried out some annual health checks for people with a learning disability, but there was no evidence that these were structured or had been followed up.

The practice had not worked with multi-disciplinary teams in the case management of vulnerable people. Most staff knew how to recognise signs of abuse in vulnerable adults and children and were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

People experiencing poor mental health (including people with dementia)

Inadequate

The practice is rated as inadequate for the care of people experiencing poor mental health (including people with dementia). They had a register for patients experiencing poor mental health and had scored 100% in their QOF results for dementia. It had not worked with multi-disciplinary teams in the case management of people experiencing poor mental health. Further, they did not have a system in place to follow up patients who had attended accident and emergency (A&E) where they may have been experiencing poor mental health. There was no evidence to confirm that people with poor mental health were called for annual physical health checks.

Summary of findings

What people who use the service say

We spoke with 12 patients during our inspection and received 30 completed Care Quality Commission (CQC) patient feedback cards. We looked at the completed CQC comment feedback cards and all were positive about the practice.

All the patients we spoke with during the inspection told us they were satisfied with the overall quality of care and support offered by the practice from both clinical and non-clinical staff. Patients said the care was good and staff were friendly, professional and accommodating and that all staff treated them with dignity and respect.

Most of the patients we spoke with had been registered with the practice for many years and told us staff were patient and understanding and the GPs gave consistently good care. The national GP patient survey found that 71% of respondents described their overall experience of the practice as good as compared to the CCG average of 78% and the national average of 85%. Further, 63% said that they would recommend the practice to someone new as compared to the CCG average of 68% and the national average of 78%.

Areas for improvement

Action the service MUST take to improve

- Ensure clear systems are in place for reporting and recording significant events.
- Ensure there are formal governance arrangements in place including systems for assessing and monitoring risks and the quality of the service provision as we found there was an unguarded electric halogen heater in the nurse's room which presented a serious risk to patients, especially children.
- Take action to address identified concerns with infection prevention and control practice as we found there was no clear infection control lead and no audits had been undertaken since January 2014
- Put systems in place to ensure all clinicians are kept up to date with national guidance and guidelines as we found the GPs were unfamiliar with the dangers of prescribing high risk medication.
- Ensure there are formal arrangements in place for reviewing patients with long term conditions
- Ensure clinical audits are undertaken in the practice, including completed clinical audit or quality improvement cycles.
- Ensure the GPs understand the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005.
- Clarify the leadership structure and ensure there is leadership capacity to deliver all improvements.

Action the service SHOULD take to improve

- Clarify who the safeguarding lead for the practice is and ensure all staff are aware of it.
- Develop cleaning records or schedules for the practice
- Provide curtains in consulting rooms so that patients' privacy and dignity can be maintained during examinations, investigations and treatments.

The Clarence Medical Centre

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, a second inspector and an expert by experience. All specialist members of the inspection team were granted the same authority to enter registered persons' premises as CQC inspectors.

Background to The Clarence Medical Centre

Clarence Medical Centre provides GP primary care services to approximately 1200 people living in Kilburn in the London Borough of Brent. The practice is staffed by two GPs, both male, one nurse, a practice manager and two administrative staff. The practice held a General Medical Services (GMS) contract and was commissioned by NHSE London. The practice was registered with the Care Quality Commission to provide the regulated activities of diagnostic and screening procedures, treatment of disease, disorder and injury and maternity and midwifery services.

The practice opening hours were 8.30am to 8pm Mondays and 8.30am to 6.30pm Tuesday to Friday. The out of hours services were provided by an alternative provider. The details of the 'out of hours' service were communicated in a recorded message accessed by calling the practice when it was closed and details could also be found on the practice website. The practice provided health promotion services including a flu vaccination programme and cervical screening.

The national census data stated 18% of the borough's population was white British, 18% white non-British (among which are large, Polish and Irish communities), 8% black Caribbean, 8% black African (amongst which are a large Somalian community) with various other ethnicities (including Indian, Pakistani, Chinese and Sri Lankan) making up the remaining 48 percent. Around 62% of children under 16 in Brent were classified as living in poverty in 2011, higher than the overall percentage for London (27%) and England (21%). The practice's catchment area of Kilburn has five small areas which fall into the 20% most deprived nationally.

Why we carried out this inspection

In November 2014 CQC carried out an inspection of the practice where we found the practice required improvement for providing safe, caring, and responsive and well led services and was inadequate for providing effective care.

We undertook this announced comprehensive inspection of Clarence Medical Centre to check whether there had been any improvements to meet legal requirements since our inspection in 2014.

How we carried out this inspection

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

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

Detailed findings

We 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
- Mothers, babies, children and young people
- The working-age population and those recently retired
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing mental health problems

Before our inspection, we reviewed a range of information we hold about the service and asked other organisations such as Healthwatch, to share what they knew about the service. We carried out an announced visit on 9 September 2015. During our visit we spoke with a range of staff (doctors, nurse, practice manager and receptionists) and spoke with patients who used the service. We reviewed policies and procedures, records, various documentation and Care Quality Commission (CQC) comment cards where patients shared their views and experiences of the service.

Inadequate

Are services safe?

Our findings

Safe track record and learning

The practice did not have a clear system in place for reporting and recording significant events. Staff we spoke with were aware of their responsibilities to raise concerns and told us they were encouraged to log any significant event or incident in an incident log book and bring it to the attention of the practice manager. However, when we checked the log book we noted that there had not been any significant event or incident logged since our last inspection in November 2014. One GP gave us an example of incident that had had occurred this year but this was not written down. There was no evidence of wider discussion with team regarding learning point and no minutes of meetings with incidents or significant events on agenda.

The practice manager had told us that national patient safety alerts would be sent directly to them and they would then circulate to doctors. However, they were unable to give us an example of a recent one they had received.

Overview of safety systems and processes

We found there was limited monitoring of safety.

- Some arrangements were in place to safeguard patients from abuse that reflected relevant legislation and local requirements and policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. All staff had received relevant role specific training on safeguarding children and adult protection and were aware of their responsibilities to share information with the relevant agencies. Contact details were displayed on the walls in reception. The GPs told us they attended safeguarding meetings when possible and always provided reports where necessary for other agencies. However, we found there was some confusion as to who the safeguarding lead for the practice was. We noted the policy stated it was one of the GPs and this was confirmed by the non-clinical staff, but the GP who was named in the policy told us it was the practice manager. Further, we were given an example of a safeguarding case and when we reviewed the case notes for evidence of alerts we found no alert on the records.
- A chaperone policy was in place and there were visible notices on the waiting room noticeboard and in consulting rooms. If nursing staff were not available to act as a chaperone, administration staff had been asked to carry out this role. We were told, and saw evidence to confirm that chaperone training had been undertaken by these staff members and they had been Disclosure and Barring Service checked.
- The practice had a health and safety policy which staff were required to read as part of their induction which was accessible on all computer desktops for all staff. However, we found it was last reviewed in September 2012 and important information was missing such as who the Health and Safety lead for the practice was and there was no reference to any audits.
- Staff we spoke with told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. Electrical equipment testing (PAT) and calibration of relevant equipment was last carried out in June 2014, but we were told it had been scheduled for the week after our inspection but we did not see any evidence to confirm this. Although the practice had completed an environmental risk assessments in the last year they had not carried out a fire safety risk assessments and we found an unguarded electric halogen heater in the nurse's room which presented a serious risk to patients, especially children. The heater was not on at the time of our visit and we asked the practice manager to remove this immediately.
- We observed the premises were clean and tidy. However, there were no cleaning records or schedules which showed how often the practice was cleaned. The practice manager told us new cleaners had recently been employed and that they worked five days a week. There was an infection control policy which had not been reviewed since July 2013 and it did not contain any information about the need to complete audits. No infection control audits had been undertaken since January 2014 and that had been carried out by the CCG. The policy stated one GP partner was the lead however, we were told by the practice nurse that they were the lead and had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. All staff had received infection control training in October 2014.

Inadequate

Are services safe?

- Medicines were stored in medicine refrigerators in the nurse's treatment rooms. There was a policy for ensuring medicines were kept at the required temperatures. There were records to confirm that temperature checks of the fridges were carried out daily to ensure that vaccinations were stored within the correct temperature range. However, we saw that fridge temperature checks had been missed on several days during the nurses' recent holiday and we were told this was the responsibility of the practice manager. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.
- We found the GPs were unfamiliar with the dangers of prescribing high risk medication. For example, we saw that they had prescribed 10mg of methotrexate for a patient and had not been carrying out blood testing, nor was there any evidence of a shared care arrangement with the local hospital in line with the NPSA guidance from 2007. Further, the GP was unfamiliar with local antibiotic prescribing guidelines and the prescribing of cephalosporins and quinolones was higher than other practices in the CCG area.
- Recruitment checks were carried out and the five files we reviewed showed that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service.
- The practice manager told us they did not have any formal arrangements for planning and monitoring the number and mix of staff needed to meet patients' needs. During our inspection in November 2014 administrative staff told us that staff that had recently left had not been replaced and that on occasions this could put a strain on reception staff, as they had to cover each other when staff were on holidays. At this inspection we noted that all administrative hours had been reduced further and as a result the practice manager was only working 15 hours a week, which was down from 30 hours last year. The impact of this was that systems and processes such as incident reporting and risk assessing had not been monitored and/or maintained. There was also no procedure in place to appropriately manage expected of unexpected absences; therefore patients were at risk of harm because the systems and processes had weaknesses.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Staff records showed all staff had received training in basic life support which was updated every two years. An automated external defibrillator and oxygen were available on site. All staff asked knew the location of this equipment and records we saw confirmed they were 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, anaphylaxis and hypoglycaemia. Processes were also in place to check emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

A Practice Disaster Handling Plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. This covered areas such as long or short term loss of access to the building, loss of the computer system, loss of access to paper medical records, loss of the telephone system and loss of water, gas and electricity supply. The document also contained relevant contact details for staff to refer to. For example, contact details of a heating company to contact in the event of failure of the heating system.

Inadequate

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs told us they used 'Medical mentor' on EMIS web to look up national guidelines and access patient information leaflets. They said they also googled NICE guidelines when required. However, we found they were unfamiliar with local antimicrobial guidelines and we did not see any evidence that local or national guidelines were discussed and implemented in a systematic way. One GP told us that informal discussions occurred frequently between the GPs about particular cases. Further, there was no system in place for reviewing patients with long term conditions. The GPs told us they would review these patients opportunistically when they came to the surgery.

Management, monitoring and improving outcomes for people

The practice participated in the Quality and Outcomes Framework (QOF). (This is a system intended to improve the quality of general practice and reward good practice). However, we did not see any evidence that the practice used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. Current results were 75.3% of the total number of points available which was 17.6% below the CCG average and 18.2% below the national average. They had 3.6% exception reporting. The QOF data showed:

- Performance for diabetes related indicators was 56.7%, which was 29% below the CCG and 33% below the national average.
- The percentage of patients with hypertension having regular blood pressure tests was 75.6% which was 15% below the CCG and 12% below national average.
- Performance for mental health related illness was 70% which was 19% below the CCG and 20% below the national average.
- The dementia diagnosis rate was 100% which was 4% above the CCG average and 6% above the national average.

There was very limited monitoring of people's outcomes of care and treatment, including no completed clinical audits. The GPs showed us details of three clinical audits, including one for patients on new oral anticoagulants, another for patients on medicines to manage diabetes and a third relating to medication reviews for patients with Osteoporosis in order to optimise treatment and to reduce the risk of falls. The purpose or the criteria for the audits were not recorded. All the documents we were shown were the first step to identify patients. All were single phase clinical audits which were incomplete. The second phase had not been completed. There were no notes of any discussion about the audit. There was no timeline to suggest that a second cycle of audit would be completed, neither was there any plan to disseminate learning from the audits once they were completed.

We found the practice did not have any other means of demonstrating how they were improving the quality of care.

Effective staffing

There were systems in place to support staff to acquire the skills, knowledge and experience to deliver effective care and treatment.

- The practice had an induction programme which covered a range of topics such as health and safety, infection control, safeguarding and fire safety.
- The learning needs of staff were identified through a system of appraisals. Staff had access to appropriate training to meet these learning needs and to cover the scope of their work. For example, reception staff told us they had attended customer services and empathy and compassion training. Most non-clinical staff had had an appraisal within the last 12 months.
- One GP had an appraisal in March 2015 and was due to be revalidated in November 2015. We asked the GPs whether they attended any clinical training or updates to develop their knowledge and enable them to deliver good quality care and were told they did not.

Coordinating patient care and information sharing

Blood results, X ray results, letters from the local hospital including discharge summaries, out of hour's providers and the 111 service were received both electronically and by post. We noted the GPs waited for the paper version to come to the surgery by post to action them and although there was no evidence of a backlog on the day of our inspection, the paper version comes 2-3 days after the electronic communication which can cause delays in patients being referred to other services and providing any

Inadequate

Are services effective?

(for example, treatment is effective)

urgent treatment that patients may need. All relevant staff were however, aware of their responsibility in passing on, reading and actioning any issues arising from communication.

The practice did not hold multidisciplinary team meetings; however they told us they exchanged information with palliative care nurses in relation to specific cases. We saw some evidence of this in the records we checked. The GPs were unfamiliar with the Gold Standard Framework and face to face discussions amongst the clinicians and the palliative care team and district nurses did not occur on a regular basis.

Consent to care and treatment

The GPs told us they would get verbal consent for minor procedures such as elbow injections, but we did not see any evidence in the records we checked to confirm this. There was also no evidence of any patient's mental capacity being assessed and recorded. We found the GPs did not understand the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005.

Health promotion and prevention

There was no focus on prevention and early identification of health needs and staff are reactive, rather than proactive in supporting people to live healthier lives. Although patients in need support in relation to palliative care were identified and referred for appropriate support, there was no evidence of this occurring for any other patient group such as those at risk of developing a long-term conditions.

Cervical screening was offered to woman in line with the national guidelines. The practice's uptake for the cervical screening programme was 81%, which was comparable to the CCG average of 82% and the national average of 82%. The practice sent text message reminders for patients and would follow up patients who did not attend for cervical smears. The nurse was responsible for following-up patients who did not attend for cervical screening.

Childhood immunisations did not take place in the practice; patients were referred to the local health centre for all childhood vaccinations, which was a local arrangement. The practice did not have any effective processes in place to monitor take up of childhood vaccinations. The system in place relied on parents bringing the red book for admin staff to update the records. Consequently recording of immunisations on the system was incomplete. Flu vaccination rates for the over 65s were 45%, and at risk groups 4%. These were well below CCG averages of 72% and 52% respectively.

Patients had access to appropriate health assessments and checks. These included health checks for new patients and NHS health checks for people aged 40–74. Appropriate follow-ups on the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.

Requires improvement

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We observed throughout the inspection that members of staff were courteous and very helpful to patients both attending at the reception desk and on the telephone and that people were treated with dignity and respect. There were foldable screen provided in consulting rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard. Reception staff knew when patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.

All of the 12 patient CQC comment cards we received were positive about the service experienced. Comment cards highlighted that staff responded compassionately when they needed help and provided support when required. Patients said they felt the practice offered a good service and staff were helpful, caring and treated them with dignity and respect. We also spoke with two members of the patient participation group (PPG) on the day of our inspection. They told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

We reviewed the most recent data available for the practice about patient satisfaction. This included information from the national GP patient survey from 2014 and the friends and family survey. The evidence from both these sources showed patients were satisfied with their experience at the practice. For example,

- 71% of patients who responded described their overall experience as good as compared to the local average of 78% and the national average of 85%.
- 80% of practice respondents said the GP was good at listening to them as compared to the local average of 85% and the national average of 88%.
- 79% said the GP gave them enough time as compared to 81% and 83% respectively for the CCG and the national average
- 73% said the last nurse they spoke to was good at treating them with care as compared to the local average of 84% and the national average of 90%.
- 87% patients said they found the receptionists at the practice helpful which were comparable to the CCG and national averages

Care planning and involvement in decisions about care and treatment

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

Results from the national GP patient survey we reviewed showed patients mainly responded positively to questions about their involvement in planning and making decisions about their care and treatment and results were in line with local and national averages. For example, 78% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 82% and national average of 86%. However, only 68% said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 77% and national average of 81%

Staff told us that translation 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

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

The practice's computer system alerted GPs if a patient was also a carer. Carers were asked to complete a carer's forms where appropriate and there were written information available for carers to ensure they understood the various avenues of support available to them.

GP's told us they would offer personal support to families who had suffered bereavement by offering a patient consultation at a flexible time and location to meet the family's needs. However, they said they had not signposted any patient to a support service. Patients we spoke with who had had a bereavement confirmed they had received support and said they had found it helpful.

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice were aware of the needs of its local population, however we found they still had not had not put in place a plan to secure improvements for the areas identified, for example specifically patients with diabetes who represented a large percentage of the population. The GP's told us the main focus of the practice was to provide routine medical and clinical services.

The practice had a list of older people who were housebound whom they would visit regularly. However, although patients over 75 years had a named GP they did not have a register for older people who have complex needs or required additional support. Further, we found there were no systems in place to review patients with long term conditions. The GPs told us they would review these patients opportunistically when they attended the practice.

They had a register for patients experiencing poor mental health and had scored 100% in their QOF results for dementia. The GPs told us they could recognise patients who presented in crisis and would contact the community mental health teams for urgent advice if necessary and had referred patients for psychological therapy.

The practice had a Patient Participation Group (PPG) who met regularly. Representatives from this group told us they met quarterly, but were unable to give us any examples of issues they had raised with the practice that had been addressed.

The premises were accessible to patients with disabilities, for example there was a ramp that led to the front door of the practice and the toilets were accessible to wheelchair users.

Access to the service

The practice was open from 8.30am to 8pm on Mondays and 8.30am to 6.30pm Tuesday to Fridays. The telephones were staffed from 8.00am to 6.00pm Mondays to Fridays and a recorded message was available at all other times giving out of hours contact details. Appointment slots were available throughout the opening hours, except between 12.30 and 1.30 daily, when the practice was closed for lunch. Longer appointments were also available for patients who needed them and those with long-term conditions. Urgent appointments were also available for people that needed them.

Feedback from the national GP survey published in 2014 was positive about the appointment system. For example;

- 78% of respondents described their experience of making an appointment as good compared to the CCG average of 66% and the national average of 73%
- 72% were satisfied with the surgery's opening hours compared to the CCG average of 71% and the national average of 75%

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Their complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. The practice manager was the designated person who handled all complaints in the practice.

We saw that information was available to help patients understand the complaints system, for example posters were displayed on notice boards and a summary leaflet was available and given to patients when they registered. Patients we spoke with were aware of the process to follow should they wish to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice.

We were told that they had not received any complaints since our inspection in November 2014.

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 practice did not have a clear vision and strategy to deliver high quality care and promote good outcomes for patients. The GPs said the vision was to give a good service, good treatment and good care, and to respond to concerns. However, this was not documented anywhere. Staff we spoke with were vague about the vision and values and were not clear about their responsibilities in relation to these.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff via the desktop on any computer within the practice. Staff we spoke with confirmed they had read the key policies such as safeguarding, health and safety and infection control. All five policies and procedures we looked at had been reviewed at least bi-annually.

We were told the practice held monthly governance meetings which were attended by the partners and the practice manager. They said they discussed performance, quality and risks. However, they were no minutes available for us to confirm this.

There was no monitoring of performance. Although the practice was aware of their QOF scores there was no evidence to demonstrate they used it to improve their performance. The QOF data for this practice showed that overall it was performing below national standards particularly in areas such as Chronic kidney disease, COPD and diabetes. There was a clear failure on behalf of the registered manager to monitor the quality of practice and ensure there were safe processes in place to deliver good care. They did not have an on-going programme of clinical audits to identify where action should be taken to improve the care provided.

The practice did not have any completed clinical audits in the last 12 months. They showed us three clinical audits that had been started in the last year; however these were not completed audits. There was no evidence of the practice having improved patient outcomes through monitoring the quality of the service they provided.

There was no effective system for identifying, recording and managing risks. We saw an environmental audit had been started in September 2015, however it was not clear as to what risks had been identified and how/when these would be addressed.

Leadership, openness and transparency

There was an absence of clear leadership and there was a lack of clarity about authority to make decisions. There was some confusion as to who the safeguarding lead for the practice was. We noted the policy stated it was one of the GPs and this was confirmed by the non-clinical staff but the GP who was named in the policy told us it was the practice manager. Further, staff were not clear about who the infection control lead was and we were told the last infection control audit had been carried out in January 2014 by the PCT

Staff told us that regular team meetings were held every three months and that there was an open culture within the practice. They said they had the opportunity to raise any issues at team meetings and were confident in doing so and felt supported if they did. Staff said they felt respected, valued and supported, particularly by the partners in the practice.

We also found all non-clinical staff had had their contractual hours reduced since our last inspection in November 2014 which had resulted in key systems and processes not being maintained appropriately. For example, the recording, reporting and monitoring of incidents and significant events.

Practice seeks and acts on feedback from its patients, the public and staff

The practice did not have any systems in place to gather feedback from patients. Although there was a patient participation group (PPG) they had not carried out any patient surveys or submitted proposals for improvements to the practice management team. A patient survey had not been carried out since 2012. Further, the practice manager told us they had not received any complaints since November 2014.

Staff told us they could give feedback and discuss any concerns or issues with colleagues and management. They also told us they felt involved and engaged to improve how the practice was run. However, they could not give any example of where the practice had listened to staff.

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 Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider did not have suitable arrangements in place to ensure to ensure they were administering medicines in a way that was proper and safe. Fridge temperature checks had been missed on several days during the nurses' recent holiday and the GPs were unfamiliar with the dangers of prescribing high risk medication and were unfamiliar with local antibiotic prescribing guidelines. Regulation 12(1)(g)

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment The provider did not have appropriate systems in place to effectively monitor and prevent abuse of patients. There was some confusion as to who the safeguarding lead for the practice was and we were given an example of a safeguarding case and when we reviewed the case notes for evidence of alerts we found no alert on the records. Regulation 13(2)

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 Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider did not have systems and processes in place to assess, monitor and improve the quality and safety of the services provided, monitor and mitigate the risks or to seek and act on feedback from relevant persons. There was no clear process for reporting, recording, investigating and monitoring incidents and near misses. There was no program of clinical audit to evaluate and improve outcomes for service users and no oversight of clinical performance. There was no formal process to seek feedback from service users about the service they received. There was no clear leadership structure in place and the provider had no vision or strategy for the practice. Regulation 17 (1)(a)(b)(e).