Heathway 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

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Heathway Medical Centre on Thursday 26 May 2016. 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, appropriate recruitment checks on staff had not been undertaken prior to their employment, there were no records of infection control audits, and patient notes were not stored securely.
- Staff understood their responsibilities to raise incidents, near misses and concerns. However, the practice did not have systems or processes in place to record, analyse or share learning from significant events or complaints.
- 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.
- The practice had a number of policies and procedure to govern activity; however these were generic, incomplete or did not contain relevant information.
- The practice did not hold regular practice or governance meetings and issues were discussed with staff on an ad hoc basis.
- Patients were positive about their interactions with staff and said they were treated with compassion and dignity.
- Patients told us that the appointments system was not working and they experienced long waiting times to be seen.
- Clinical staff assessed patient's needs and delivered care in line with current evidence based guidance. Staff had been trained to provide them with the skills, knowledge and experience to deliver effective care and treatment.

The areas where the provider must make improvements are:

- Establish effective systems for managing and mitigating risks to the service, for example significant events and in relation to infection control.

Summary of findings

- Ensure that all documents and processes used to govern activity are practice specific and are up to date. This includes safeguarding arrangements, and the use of patient specific directions when authorising clinical staff to administer vaccines.
- Ensure there is a programme to meet the learning and development needs of all staff to keep them up to date with their roles.
- Ensure recruitment arrangements include all necessary employment checks for all staff, including those outlined in Schedule 3.
- Ensure there is a programme of quality improvement activity, including clinical audits.
- Ensure systems are in place to seek and act on feedback, including complaints from patients and staff for the purpose of evaluating and improving services.

The areas where the provider should make improvement are:

- Improve processes for making appointments.
- Consider documenting discussions and decisions of all practice meetings including clinical, multidisciplinary, practice and significant events discussions to evidence the on-going care and treatment of patients and improvement of service.
- Review systems to identify carers in the practice so their needs can be identified and met.
- Develop, document and communicate to all staff the practice vision, strategy and supporting business plan and their responsibilities in relation to this.

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

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

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

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Inadequate

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

- Staff understood their responsibilities to raise concerns, and to report incidents and near misses. However, the practice did not demonstrate that significant events were thoroughly recorded, analysed or that learning was shared effectively with staff. Patients did not receive reasonable support or a verbal and written apology.
- Patients were at risk of harm because systems and processes were not in place in a way to keep them safe. For example, there were no records of DBS checks for nursing staff, there were no records of infection control audits, the healthcare assistant was administering vaccines and medicines without a patient specific prescription or direction from the GP, there was no system to monitor blank prescriptions, patient records were not kept securely and we found appropriate recruitment checks were not being carried.
- There was insufficient attention to safeguarding children. There was no register for children at risk and therefore no procedure to follow these children up. The child safeguarding policy had not been updated since 2011 and did not contain the relevant contacts for further guidance.
- The practice did not have adequate arrangements in place to respond to emergencies and major incidences. For example, clinical and non-clinical staff did not have formal basic life support training, the practice did not have a defibrillator and while there was one in a practice in the same building there was no agreement to use it and there was an incomplete generic business continuity plan which did not have any practice specific details and had not been updated since 2012.

Are services effective?

Inadequate

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

- Data showed patient outcomes were comparable to the CCG and national average. However, exception reporting for a number of long term conditions was significantly higher than CCG and national averages.

Summary of findings

- 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 limited recognition of the benefit of an appraisal process for staff and there were no systems in place to identify any additional training that may be required.
- The practice did not demonstrate a comprehensive induction programme for all newly appointed staff, or how they ensured role-specific training and updating for relevant staff. Staff told us they had a commitment to their own continued development and learning.
- Multidisciplinary working was taking place but was generally informal and record keeping was limited or absent.

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 from the national GP patient survey showed patients rated the practice similar to others for some aspects of care. However, we found satisfaction scores related to reception staff to be lower. For example, 76% of patients said they found the receptionists at the practice helpful compared to the CCG average of 84% and the national average of 87%.
- The majority of patients said they were treated with compassion, dignity and respect. However, not all felt they were given enough time in appointments to make informed decisions.
- There was insufficient information available to help patients understand the services available to them and the practice leaflet did not have up to date information about the practice on it.
- The practice did not identify carers and was not able provide any specific information or support to them.

Are services responsive to people's needs?

Requires improvement

The practice is rated as requires improvement for providing responsive services.

- Patients could get information about how to complain in a format they could understand. However, the practice did not demonstrate that complaints were recorded, investigated and or that learning was shared effectively with staff. The practice did not provide evidence that all complaints were dealt with satisfactorily or in a timely way.

Summary of findings

- Results from the national GP patient survey showed that people were satisfied with how they could access care and treatment and this was comparable to the national average. However, there were mixed results for people's satisfaction on getting an appointment when they needed. For example, 68% of patients said they could get an appointment when they wanted to (compared to national average 76%). Eight comment cards we received, said people could not get appointments when they need them.
- The practice had good facilities and was equipped to treat patients and meet their needs.

Are services well-led?

Inadequate

The practice is rated as inadequate for being well-led.

- The management team had a vision to deliver high quality care and promote good outcomes for patients, but this was not well documented or evidenced. Staff did not know what the vision was. The practice did not provide a business strategy despite us requesting to see it.
- The practice had a number of policies and procedures to govern activity, but these did not have up to date or relevant information and were overdue their review date.
- Arrangements for identifying, recording and managing risks, issues and implementing mitigating actions were not in place.
- The practice did not hold governance meetings and issues were discussed at ad hoc meetings. There were no records of meetings.
- The practice had not proactively sought feedback from staff or patients and did not have a patient participation group.
- Staff told us they had not received regular performance reviews and did not have clear objectives.

Summary of findings

The six population groups and what we found

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

Older people

Inadequate

The provider was rated as inadequate for safe, effective and well-led and requires improvement for caring and responsive. The issues identified as inadequate overall affected all patients including this population group. There were, however, examples of good practice.

- The practice offered care to meet the needs of the older people in its population.
- The practice was responsive to the needs of older people, and offered home visits and urgent appointments for those with enhanced needs.

People with long term conditions

Inadequate

The provider was rated as inadequate for safe, effective and well-led and requires improvement for caring and responsive. The issues identified as inadequate overall affected all patients including this population group. There were, however, examples of good practice:

- The practice had significantly higher exception reporting for some clinical indicators. (Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects). This included, the exception reporting for chronic obstructive pulmonary disease (COPD) was 30% (CCG average of 5% and national average of 11%). Hypertension was 29% (CCG and national average of 4%). Asthma was 17% (CCG average of 3% and national average of 7%).
- Performance for diabetes related indicators was similar to the CCG and national average. For example, 100% of diabetic patients had had their last blood sugar reading of 64 mmol/mol or less in the last 12 months (CCG average of 72% and national average of 78%). However, the exception reporting was 54%, which was significantly higher than CCG average of 15% and national average of 12%.
- 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.
- People with a long term condition did not have a named GP, however they did have a an annual review to check their health

Summary of findings

and medicines needs were being met. For those patients with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Inadequate

The provider was rated as inadequate for safe, effective and well-led and requires improvement for caring and responsive. The issues identified as inadequate overall affected all patients including this population group. There were, however, examples of good practice:

- There were no systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had been referred to safeguarding or child protection leads.
- The practice's uptake for the cervical screening programme was 86%, which was comparable to the CCG average of 80% and the national average of 82%. However, the exception reporting was 18%, which was higher than the CCG average of 7% and national average of 6%.
- Patients told us that children and young people were treated in an age-appropriate way.
- Appointments were available outside of school hours and the premises were suitable for children and babies.
- Immunisation rates for the standard childhood immunisations were mixed. For example, childhood immunisation rates for the vaccinations given to five year olds ranged from 56%-86%.

Working age people (including those recently retired and students)

Inadequate

The provider was rated as inadequate for safe, effective and well-led and requires improvement for caring and responsive. The issues identified as inadequate overall affected all patients including this population group. There were, however, examples of good practice:

- The practice was proactive in offering online services as well as a range of health promotion and screening that reflects the needs for this age group. But there was limited accessible health promotion material available through the practice.
- The practice offered extended opening hours on Monday evening until 7.00pm and Wednesday evening until 8.00pm.
- NHS Health checks were available to this population group but this was not actively promoted
- Travel vaccinations were available.

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People whose circumstances may make them vulnerable

Inadequate

The provider was rated as inadequate for safe, effective and well-led and requires improvement for caring and responsive. The issues identified as inadequate overall affected all patients including this population group. There were, however, examples of good practice:

- Some staff knew how to recognise signs of abuse in vulnerable adults and children, but they were not aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies out of normal working hours.
- The practice did not have a carer's list and there were no systems in place to alert GPs if a patient was also a carer. There were no specific arrangements to support this group of patients.
- The practice registered all patients, including those without a fixed address.
- Although the practice did not have a register of patients with a learning disability, staff told us they knew this group of patients and offered them longer appointments.
- The practice regularly worked with other health care professionals in the case management of vulnerable patients.
- The practice informed vulnerable patients about how to access various support groups and voluntary organisations.

People experiencing poor mental health (including people with dementia)

Inadequate

The provider was rated as inadequate for safe, effective and well-led and requires improvement for caring and responsive. The issues identified as inadequate overall affected all patients including this population group. There were, however, examples of good practice

- Performance for dementia related indicators was similar to CCG and national average. For example, 96% of people diagnosed with dementia had had a face-to-face care plan review in the last 12 months, compared to the CCG and national average of 84%.
- Performance for mental health related indicators was similar to the CCG and national average. For example, 100% of patients on the mental health register had had a comprehensive, agreed care plan documented in their records in the last 12 months, compared to the CCG average of 89% and national average of 88%.
- The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those with dementia.

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- The practice had a system in place to follow up patients who had attended accident and emergency where they may have been experiencing poor mental health.

Summary of findings

What people who use the service say

The national GP patient survey results were published on January 2016. The results showed the practice was performing in line with local and national averages. Three-hundred and seventy-four survey forms were distributed and 106 were returned. This represented 3% of the practice's patient list.

- 76% of patients found it easy to get through to this practice by phone compared to the national average of 73%.
- 68% of patients were able to get an appointment to see or speak to someone the last time they tried compared to the national average of 76%.
- 88% of patients described the overall experience of this GP practice as good compared to the national average of 85%.
- 68% of patients said they would recommend this GP practice to someone who has just moved to the local area compared to the national average of 79%.

As part of our inspection, we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 45 comment cards, of which 33 were positive about the service experienced. Patients said they felt the practice offered a good service and staff were helpful, caring and treated them with dignity and respect. However, there were 13 cards that contained less positive comments, which related to difficulties with appointment booking and waiting times, and difficulties in communicating with both clinical and non-clinical staff.

We spoke with two patients during the inspection. Both patients said they were satisfied with the care they received and thought staff were approachable, committed and caring. However, they said they were unhappy about the lengthy waiting times and the difficulty in making appointments.

Heathway Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector**.** The team included a GP specialist adviser and a practice manager specialist adviser. There was also an observer on the inspection.

Background to Heathway Medical Centre

Heathway Medical Centre is in a purpose built building, shared with another GP practice, located in a residential area in Dagenham. The building is managed by NHS Properties. There is suitable patient access to the premises and patient parking, including disabled parking. At the time of our inspection there were 3800 patients registered with the practice. They also take care of 60 residents from a care home. These patients are elderly and require specialist care in dementia, Alzheimer's and Parkinson's disease. Primary medical care is provided under a General Medical Services (GMS) contract within NHS Barking and Dagenham Clinical Commissioning Group (CCG).

The practice is registered with the Care Quality Commission (CQC) to provide the regulated activities of: treatment of disease, disorder or injury; surgical procedures; diagnostic and screening procedures; family planning services; and maternity and midwifery services at one location.

There is a female lead GP. There is one female salaried GP and they are supported by one male locum GP. The GPs undertake a combined total of 18 sessions per week. There are two part time nurses and one part time healthcare assistant. Non-clinical staff includes, a practice manager and four administrative staff.

The practice was open between 8.00am and 6.30pm Monday to Friday. Appointments are from 8.30am to 11.30am every morning and 2.30pm to 6.30pm daily, with the exception of Thursday, when the practice closed at 4.00pm. The practice extended hours appointments were offered on Monday evening until 7.00pm and Wednesday evening until 8.00pm. Out of hours service is provided by a different provider and can be accessed by calling the practice out of hours telephone number which is on the practice website and practice leaflet.

Information published by Public Health England rates the level of deprivation within the practice population group as two on a scale of one to 10. Level one represents the highest levels of deprivation and level 10 the lowest.

Why we carried out this inspection

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

Heathway Medical Centre was not inspected under the previous inspection regime.

Detailed findings

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 26 May 2016. During our visit we:

- Spoke with a range of staff (GPs, nurses, practice manager and reception and administration staff) and spoke with patients who used the service.
- Observed how patients were being cared for and talked with carers and/or family members.
- Reviewed an anonymised sample of the personal care or treatment records of patients.
- Reviewed comment cards where patients and members of the public shared their views and experiences of the service.

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

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

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

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

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

Inadequate

Are services safe?

Our findings

Safe track record and learning

There was a lack of systems in place for reporting and recording significant events.

- Staff told us they would inform the practice manager of any incidents. However, there was no recording form available and the practice was only able to show us one recorded significant event, although they could give us examples of two other significant events that had occurred in the past 12 months. For example, following a missed diagnosis the practice changed their protocol to offer patients with certain medical conditions an annual X-ray.
- The practice manager told us they did not have a process in place where they carried out a thorough analysis of the significant events. The practice did not demonstrate that significant events were thoroughly recorded or analysed. It was not clear who had responsibility for the oversight of significant events.
- We were told that serious incidents were discussed at clinical meetings but the practice could not provide evidence to demonstrate actions were taken to improve patient safety following these discussions in relation to any of the incidents. There was no system in place to cascade learning to staff that were unable to attend these meetings and there were no minutes of meetings to indicate that these discussions were taking place.
- The practice could not show us evidence that when things went wrong with care and treatment, patients were informed of the incident, received reasonable support, truthful information, a written apology or were told about any actions to improve processes to prevent the same thing happening again.
- We reviewed how the practice managed national patient safety alerts and found there was no formal process for the dissemination of these alerts. Clinical staff told us relevant alerts were emailed directly to them and they would action if necessary. There was no audit trail as part of the system to verify that information had been shared and actioned. Clinical staff were unable to tell us what the most recent alert was that they had received.

Overview of safety systems and processes

The practice did not have effective systems, processes and practices in place to keep patients safe and safeguarded from abuse.

- There were some arrangements in place to safeguard children and vulnerable adults from abuse. There was a child safeguarding policy but this was generic. The policy had details of local authorities from 2011, which were no longer relevant and contained no details of who to contact in the practice for further guidance if staff had concerns about a patient's welfare. There was no adult safeguarding policy. There was a lead member of staff for safeguarding and staff knew who this person was. The GPs told us they did not attend safeguarding meetings but always provided reports where necessary for other agencies. The lead GP told us they did not have a procedure to follow up at risk children and their electronic recording system did not allow them to flag this up as an alert on the child's record. The practice did not have a child protection register for staff to know who heir at risk children were. This information was embedded in the patient notes. Staff had received training on safeguarding children and vulnerable adults relevant to their role online and told us that they would always raise any concerns with the safeguarding lead. GPs were trained to child protection or child safeguarding level 3 and we saw evidence of one nurse having completed level 2 training however, there were no training records for the second nurse.
- There were notices in the clinical rooms to advise patients that chaperones were available if required. We were informed by the practice that only clinical staff undertook chaperoning duties. However, there was no evidence that nursing staff had received a Disclosure and Barring Service (DBS) check. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).
- We observed the premises to be clean and tidy. However, we found that the seats in the waiting area were damaged and torn. The practice manager told us that this had been a long-standing concern, which they had raised with the building management; however, they had not come to an agreement about who would replace or repair the seats. Staff were not clear about who the infection control lead was for the practice.

There was no evidence of liaison with the local infection prevention teams to keep up to date with best practice. There was no infection control protocol in place and annual infection control audits were not undertaken.

- Medicines and vaccines were stored securely (including obtaining, prescribing, recording, handling, storing, security and disposal). Processes were in place for handling repeat prescriptions, which included the review of high risk medicines. The practice could not demonstrate to us that they carried out regular medicines audits, with the support of the local CCG pharmacy teams, to ensure prescribing was in line with best practice guidelines for safe prescribing. Blank prescription forms and pads were securely stored but there were no systems in place to monitor their use. Patient Group Directions had been adopted by the practice to allow nurses to administer medicines in line with legislation. (PGDs are written instructions for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment).
- However, the health care assistant was administering vaccines and medicines without a patient specific prescription or direction (PSD) from a prescriber. The practice were unaware that this was a legal requirement. PSDs are written instructions from a qualified and registered prescriber for a medicine including the dose, route and frequency or appliance to be supplied or administered to a named patient after the prescriber has assessed the patient on an individual basis.
- Patient records were not stored securely. We saw patient's notes were stored in the practice manager's office, which was accessed by the building cleaning staff.
- We reviewed the practice recruitment policy, which was generic. We reviewed six personnel files and found some recruitment checks had been undertaken prior to employment. For example, four files contained proof of identification; however, there were no records of references. Clinical staff files did not have details of qualifications, registration with the appropriate professional body, medical indemnity insurance or up to date appropriate checks through the Disclosure and Barring Service.

Monitoring risks to patients

Risks to patients were assessed and managed.

- There were procedures in place for monitoring and managing risks to patient and staff safety. There was a health and safety policy available with a poster in the reception office but did not identify local health and safety representatives. The building manager was responsible for building maintenance, including fire risk assessment, health and safety and Legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings). We found the Legionella risk assessment had identified a number of actions; however, we did not see evidence that these had been completed. All electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly.
- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system in place for all the different staffing groups to ensure enough staff were on duty.

Arrangements to deal with emergencies and major incidents

The practice did not have adequate arrangements in place to respond to emergencies and major incidents.

- We saw evidence to show some staff had completed online basic life support training. However, we did not see evidence of any member of staff having received formal basic life support training.
- The practice had oxygen available with adult and children masks, however not all staff knew were the oxygen was stored. There was a defibrillator available on the premises but this belonged to the other practice in the building. Staff did not have access to the room the defibrillator was in and the practice had not made any arrangements with the other practice to enable them to use the defibrillator in case of an emergency. A first aid kit and accident book were available.
- Emergency medicines were easily accessible to staff in a secure area of the practice and staff knew of their location. Medicines we checked were stored securely, however we found one emergency medicine was out of date from 2014. The healthcare assistant told us that all medicines were checked weekly; however, there was no evidence of this being recorded.

Inadequate

Are services safe?

- The practice had an incomplete, generic business continuity plan, which did not contain any practice specific information. The plan did not include emergency contact numbers for staff and we saw that it had not been reviewed since 2012.
- There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency.

Inadequate

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

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

- Staff had online access to guidelines from NICE and GPs told us they used this information to deliver care and treatment that met patients' needs. Clinical staff attending monthly update sessions at the CCG, where latest guidance was discussed.
- The practice could not provide evidence that they monitored these guidelines were followed through risk assessments, audits or random sample checks of patient records.

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent published results were 97.9% of the total number of points available. The practice had significantly higher exception reporting for some clinical indicators. (Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects). This included, the exception reporting for chronic obstructive pulmonary disease (COPD) was 30% (CCG average of 5% and national average of 11%). Hypertension was 29% (CCG and national average of 4%). Asthma was 17% (CCG average of 3% and national average of 7%). The exception reporting for diabetes was also high. The practice was not able to provide us with an explanation as to why the exception reporting was high, or demonstrate what measures they were implementing to improve clinical outcomes for patients.

Data from 2014/15 showed:

- Performance for diabetes related indicators was similar to the CCG and national average. For example, 100% of diabetic patients had had their last blood sugar reading of 64 mmol/mol or less in the last 12 months compared to the CCG average of 72% and national average of 78%. However, the exception reporting for this description was 54%, which was significantly higher than CCG average of 15% and national average of 12%.
- Performance for mental health related indicators was similar to the CCG and national average. For example, 100% of patients on the mental health register had had a comprehensive, agreed care plan documented in their records in the last 12 months, compared to the CCG average of 89% and national average of 88%.
- Performance for dementia related indicators was similar to CCG and national average. For example, 96% of people diagnosed with dementia had had a face-to-face care plan review in the last 12 months, compared to the CCG and national average of 84%.

There was no evidence of quality improvement, including a lack of clinical audits.

- There had been one clinical audit carried out in the last two years, however this was not a completed audit and there was no evidence of improvements made, implemented or monitored as a result of the audit.
- The practice could not provide evidence that they participated in local audits, peer review or research.

Effective staffing

Staff had the skills, knowledge and experience to deliver effective care and treatment.

- The practice had a generic induction programme for all newly appointed staff. This covered such topics as health and safety and confidentiality. However, the practice manager told us this was not used and we did not see evidence of the induction programme documented in any staff files.
- The practice could not demonstrate how they ensured role-specific training and updating for relevant staff. The practice management team did not have any oversight of what training staff had or needed. For example, staff had completed online training on infection control, however the practice manager was unsure if staff had completed this and found it difficult to access the online training tool.
- Staff administering vaccines and taking samples for the cervical screening programme had attending specific training. We saw a nurse had attended update training on cervical screening. Staff who administered vaccines

could demonstrate how they stayed up to date with changes to the immunisation programmes, for example by access to on line resources and discussions at CCG meetings.

- There were no systems in place to identify the learning needs of staff. Staff had access to online training and took responsibility of their own learning needs to cover the scope of their work. We did not see evidence of ongoing support, one-to-one meetings, coaching or mentoring. We did not see evidence of any staff having received an appraisal within the last 12 months.
- The practice had recently gained access to online training from 17 May 2016 and we saw non-clinical staff had completed training on this that included safeguarding, fire safety awareness, and basic life support and information governance. We saw very little evidence of staff undertaking training prior to this. We did not see evidence of clinical staff having had training in fire safety, infection control, and basic life support or information governance.

Coordinating patient care and information sharing

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

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

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

Consent to care and treatment

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

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

Supporting patients to live healthier lives

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

- Patients receiving end of life care, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation. We were told that patients were signposted to the relevant service.
- Smoking cessation advice was available from the local pharmacy.

The practice's uptake for the cervical screening programme was 86%, which was comparable to the CCG average of 80% and the national average of 82%. There was a policy to offer telephone reminders for patients who did not attend for their cervical screening test. The practice demonstrated how they encouraged uptake of the screening programme by ensuring a female sample taker was available. The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening. There were failsafe systems in place to ensure results were received for all samples sent for the cervical screening programme and the practice followed up women who were referred as a result of abnormal results.

Childhood immunisation rates for the vaccinations given were mixed compared to CCG and national averages. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 77% to 87% and five year olds ranged from 56% to 86%.

Patients had access to appropriate health assessments and checks. These included health checks for new patients and

Inadequate

Are services effective?

(for example, treatment is effective)

NHS health checks for patients aged 40–74. Appropriate follow-ups for the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.

Requires improvement

Are services caring?

Our findings

Kindness, dignity, respect and compassion

We observed members of staff were courteous and very helpful to patients and treated them with dignity and respect.

- Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- We noted that consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- Reception staff knew when patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.

Patients completed Care Quality Commission comment cards to tell us what they thought about the practice. We received 45 patient CQC comment cards, of which 33 were positive about the service experienced. Patients said they felt the practice offered a good service and staff were helpful, caring and treated them with dignity and respect. However, there were 13 cards which contained less positive comments, which related to difficulties with appointment booking and waiting times (eight), and difficulties in communicating with both clinical and non-clinical staff (four).

We spoke with two patients on the day of inspection. They also told us they were satisfied with the care provided by the practice but they were unhappy about the lengthy waiting times and the difficulty in making an appointment.

Results from the national GP patient survey showed patients felt they were treated with compassion, dignity and respect. The practice was comparable to CCG and national averages for its satisfaction scores on consultations with GPs and nurses. For example:

- 89% of patients said the GP was good at listening to them compared to the clinical commissioning group (CCG) average of 81% and the national average of 89%.
- 85% of patients said the GP gave them enough time compared to the CCG average of 79% and the national average of 87%.
- 94% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 90% and the national average of 95%.
- 85% of patients said the last GP they spoke to was good at treating them with care and concern compared to the national average of 85%.
- 95% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the national average of 91%.

However, we found areas which the practice was below average for its satisfactions scores related to reception staff and if they would recommend the practice to people in the area. For example:

- 76% of patients said they found the receptionists at the practice helpful compared to the CCG average of 84% and the national average of 87%.
- 68% of patients said they would definitely or probably recommend this practice to someone who moved to the local area compared to the national average of 79%.

Care planning and involvement in decisions about care and treatment

On the day of our inspection patients told us they felt involved in decision making about the care and treatment they received. They told us they felt listened to and supported by some staff. However, they all had mixed feelings with regard to being given sufficient time during consultations, in order to make an informed decision about the choice of treatment available to them. CQC comment cards from patients also aligned with these views, patients commented that they felt they were not always given enough time during appointments, and felt restricted by the 10-minute appointment slots and the one condition per appointment rule. Although this did not support the findings in the GP patient survey.

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

- 88% of patients said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 79% and the national average of 86%.
- 85% of patients said the last GP they saw was good at involving them in decisions about their care compared to the national average of 82%.
- 93% of patients said the last nurse they saw was good at involving them in decisions about their care compared to the national average of 85%.

Requires improvement

Are services caring?

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

- Staff told us that translation services were available for patients who did not have English as a first language. However, we did not see notices in the reception area to inform patients this service was available.
- There was a lack of information available to people about services in the reception area. Where there were posters, it was not clear if the information was for this practice or the neighbouring practice, which they shared the reception area with.
- There was some information about other clinics available to people, but this was on a board behind the reception desk. For example a family planning clinic poster.

Patient and carer support to cope emotionally with care and treatment

Patient information leaflets and notices were limited in the patient waiting area. However, we did see a poster about the Carers Hub, which told patients how to access the support group and organisations.

The practice did not have a carer's list and there were no systems in place to alert GPs if a patient was also a carer. GPs told us that they would sign post carers to local services. We did not see evidence of written information to direct carers to the various avenues of support available to them.

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

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found no evidence that the practice reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services.

- The practice offered extended opening hours on Monday evening until 7.00pm and Wednesday evening until 8.00pm. This was intended for working patients who could not attend during normal opening hours, but was not restricted to this group.
- There were longer appointments available for patients with a learning disability.
- There were multi-disciplinary team (MDT) meetings with community nurses to discuss patients receiving palliative care.
- Home visits were available for older patients and patients who had clinical needs, which resulted in difficulty attending the practice.
- Same day appointments were available for children and those patients with medical problems that require same day consultation.
- Patients were able to receive travel vaccinations available on the NHS and were referred to other clinics for vaccines available privately.
- There were disabled facilities and translation services available. However, there was no induction loop to assist patients with a hearing impairment.
- People with no fixed address were able to register with the practice.
- Patients were able to book appointments and order repeat prescriptions on the practice website.

Access to the service

The practice was open between 8.00am to 12.30pm in the morning 2.30pm to 6.30pm in the evening, Monday to Friday. Appointments were from 8.30am to 11.30am every morning and 2.30pm to 6.30pm daily, with the exception of Thursday, when the practice closed at 4.00pm. The practice extended hours appointments were offered on Monday evening until 7.00pm and Wednesday evening until 8.00pm. Telephone consultations were available daily at the end of morning GP sessions. In addition to pre-bookable appointments that could be booked up to four weeks in advance, urgent appointments were also available for people that needed them. The out of hours service is provided by a different provider and could be accessed by calling the practice out of hours telephone number which is on the practice website and practice leaflet. People can also be seen at the Hub, between 6.30pm and 10.00pm, which is located in the same building as the practice.

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

- 85% of patients were satisfied with the practice's opening hours compared to the national average of 78%.
- 76% of patients said they could get through easily to the practice by phone compared to the national average of 73%.

People told us on the day of the inspection that they were able to get appointments when they needed them. However, eight CQC comment cards said that people could not get appointments when they needed them. This aligned with the results from the GP patient survey, which showed patients outcome was lower than national average:

- 68% of patients saw or spoke to a GP or nurse the last time they wanted to get an appointment compared to the national average of 76%.

The practice had told us that they aware of this and that this was due to the sudden increase in the practice list size over the past year. The practice manager told us they had approximately 700 new patients registered in the past 12 months. They also told us they were registering patients who had been previously turned down by other local practices. The practice manager showed us four examples of where people had not been able to register at another practice due to a number of reasons, including no proof of address. However, this practice registered everyone.

Listening and learning from concerns and complaints

The practice did not have an effective system in place for handling complaints and concerns.

- There was a generic complaints policy and procedures in line with recognised guidance and contractual obligations for GPs in England. However, the practice manager told us they were not being followed or used.

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

- The practice manager was the designated responsible person who handled all complaints in the practice. We were told that in most cases complaints could be resolved verbally and there was no record kept of these.
- We saw that information was available to help patients understand the complaints system in the practice leaflet.

We asked to see examples of complaints received in the last 12 months. Due to a lack of record keeping, it was only possible to review four complaints, which the practice manager had not reviewed and had found on the day of inspection. These complaints dated back from July 2015 to the most recent, March 2016. Three complaints were about the clinical care and treatment provided by GPs. For example, we saw a complaint about a person who had attended GP appointments with a medical concern, but was told by the GP that they would not need treatment. However, the patient went to another health service and was treated there. There was no evidence of any action, supervision, training or identified support for the staff involved. There was no documentary evidence to show what if any lessons were learnt from these complaints or the action taken as a result to improve the quality of care.

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 management team had a vision to deliver high quality care and promote good outcomes for patients, but this was not well documented or evidenced. Staff did not know what the vision was. The practice did not provide a business strategy.

Governance arrangements

The practice did not have an effective governance framework to deliver their vision of good quality care.

- Policies were generic and did not have up to date or relevant information. We were told that policies were accessible to all staff on the computer however; staff were not able to demonstrate how they would access the policies. For example, the child safeguarding policy was last updated in 2014 and did not contain up to date contact details of safeguarding leads. We found the other key policies, which were generic and had not been adapted to make them practice specific, including health and safety, information governance, recruitment, chaperone and Mental Capacity Act.
- Arrangements for identifying, recording and managing risks, issues and implementing mitigating actions were not in place. For example, there were no records of infection control audits carried out. We were also not provided with sufficient information to evidence the recording, analysis and learning from significant events.
- There were no systems in place to monitor or manage staff training. The management team had no oversight of the training requirements for individuals to carry out their roles. For example, we saw that the nurse had up to date training for cervical smears however, this had been facilitated by another practice they worked for and the nurse took ownership of her own development. Staff told us they did not have an appraisal in the last 12 months. One staff member said they had had an appraisal in the last 6 months, however they did not have a record of this and there was no record of it in the staff file.
- While we saw evidence of one set of data collection carried out by a GP, there was no programme in place for continuous clinical and internal auditing to be used to monitor quality and to make improvements.
- A comprehensive understanding of the performance of the practice was not always maintained across all staff groups.
- There was a staffing structure and staff were aware of their own roles and responsibilities although there was lack of clarity over who was the safeguarding and infection control lead.

Leadership and culture

The practice management team told us they prioritised safe, high quality and compassionate care. However, we found issues that threatened the delivery of safe, high quality care were not all identified or adequately managed. Staff told us the management team were approachable and always took the time to listen to all members of staff.

The management team told us that they were aware of the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment). The practice manager told us that when there was unexpected or unintended safety incidents the practice gave affected people reasonable support, truthful information and a verbal and written apology. However, there was no evidence to confirm this and they did not keep written records of verbal interactions. We did not see evidence of support training for staff on communicating with patients about notifiable safety incidents.

There was a leadership structure in place and staff told us that they felt supported by management.

- Staff told us the practice held monthly team meetings. However, these meetings were not recorded and there was no system to ensure staff who did not attend were updated with relevant information.
- Staff told us there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and felt confident and supported in doing so.
- Staff said they felt respected, valued and supported, particularly by the management team in the practice. However, we did not see evidence to suggest they were involved in discussions about how to run or develop the practice. For example, staff told us that they had suggested that the patient medical records be stored in a lockable cabinet. However, staff told us that the practice management team did not believe this was necessary and dismissed the suggestion.

Are services well-led?

Inadequate

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

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

The practice could not demonstrate how they encouraged feedback from patients, the public or staff.

- The practice did not have a patient participation group (PPG). The practice did not review the GP patient survey. The practice manager told us that they did review and address comments made by people on NHS Choices website and the NHS Friends and Family test (FFT). The FFT is a method of asking patients if they would recommend the service to friends and family.
- There were no recorded staff meetings and no evidence to show that the practice had gathered feedback from staff. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management; however staff could not give any examples of this.

Continuous improvement

We did not see evidence of a focus on continuous learning and improvement within the practice. Although, the lead GP told us that they had attended a three-day course on practice management. We did not see evidence of how the training had improved the management of the practice or aided in supporting the practice manager.

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 Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: The provider had not ensured that Patient Specific Directions (PSDs) were correctly authorised for clinical staff to administer vaccines and immunisations in line with national requirements. The provider had failed to risk assess not having a defibrillator. The provider had failed to assess the risk of, prevent, detect and control the spread of infections. The providers failed to keep patient records secure. This was in breach of regulation 12 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints **How the regulation was not being met:** The provider failed to investigate and take necessary and proportionate action in response to any failures identified through complaints. The provider failed to have systems for identifying, receiving, recording, handling and responding to complaints by people who use the services. This was in breach of regulation 16 (1) (2) (a) (b) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed How the regulation was not being met: The provider had failed to ensure that processes were in place to ensure staff have appropriate and current registration with a professional body, and had not ensured that information specific to schedule three was in place. The provider had failed to ensure that necessary pre-employment checks had been completed on staff. The provider had failed to risk assess staff needing a DBS check to carry out chaperoning duties. This was a breach of regulation 19 (3) 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	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: Effective systems and processes were not in place to enable the provider to identify and assess risks to health, safety and welfare of people who use the service. The provider did not demonstrate that good governance processes were in place and strong leadership. There provider failed to monitor significant events and complaints. The provider had not completed clinical audits to improve patient safety and outcomes. The provider did not ensure that all policies and procedures to govern activity were practice specific or always up to date. The provider did not have effective systems in place to securely monitor blank prescriptions. There was a lack of monitoring of emergency medicines. The provider had not ensured that their information security and governance systems were effective. Staff records were limited and lacked sufficient information. The provider failed to keep patient records secure. The provider had not sought feedback from patients or staff for the purpose of continually evaluating or improving the service. This was in breach of regulation 17(1) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.