Dr Shada Parveen

Quality Report

The Maybury Surgery,
Woking,
Surrey
GU22 8HF
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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at The Maybury Surgery (Dr Shada Parveen) on 15 November 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 and infection control audits and activities were inconsistent.
- While there was evidence of some incident reporting, the recording, investigation, discussion and learning as a result was insufficient.
- Records relating to complaints were limited and it was unclear how complaints were reviewed, discussed and learning used to make improvements.
- Risk assessment and management processes were not embedded in the practice. For example there was no health and safety, security, fire safety, legionella or control of substances hazardous to health (COSHH) risk assessments in place within the practice. However, we were told that a legionella risk assessment was kept by the owner of the building. Risks had not been mitigated, for example staff had not attended fire training, there had been no routine test of the fire alarm system and no evacuation drill.
- Clinical equipment had not been tested to ensure it was working properly.
- There were out of date vaccines in the vaccination fridge and records of regular medicine and emergency equipment checks were not available.
- Printer prescriptions were not locked away when not in use and there was no tracking of prescriptions within the practice.
- The practice had not assessed the risk of not having a defibrillator on site.

Summary of findings

- There were no completed full cycle audits and it was unclear how audits were being used to improve patient outcomes.
- Induction plans for new staff did not cover areas of mandatory training and there was evidence of gaps in training for staff. Training records were often out of date or not in place so the practice could not demonstrate who had up to date training in place.
- Staff had not received appraisals in the last 12 months and not all staff had received training relevant to their role.
- There was inconsistent care planning and no record of multi-disciplinary meetings.
- The practice had an inconsistent approach to offering chaperones and the option of having a chaperone was not advertised within the practice.
- The uptake of health screening by the patient population was low and it was unclear how the practice was addressing this.
- The practice had limited formal governance arrangements and leadership was unclear in some areas.
- The content of practice policies had not been regularly reviewed with staff identified as having responsibilities in some areas no longer working for the practice.
- The practice did not have an active Pateint Participation Group and the use of proactive patient feedback approaches was limited although there was some evidence of the practice responding to feedback in relation to reinstating their walk in service.
- The practice had a flexible approach to providing appointments and patient feedback about access to the service was positive.
- We observed staff to be kind and caring and saw that patient's dignity was respected.
- Staff had a good understanding of how to support patients who were vulnerable and we observed the practice manager supporting one patient to make calls to address social care issues.
- Results from the GP patient survey showed the practice was below average in relation to the number of patients who would recommend the practice and in relation to GP consultations. However, recent results from the friends and family test showed that 100% of those responding would recommend the practice to their friends and family.
- The practice had a comprehensive business continuity plan in place and this had been effectively utilised during a recent incident that impacted the service.
- 90% of newly diagnosed patients with diabetes had been referred to a structured education programme within nine months of entry onto the register. This was 26% higher than the CCG average and 19% higher than the national average.

The areas where the provider must make improvements are:

- Introduce robust processes for reporting, recording, acting on and monitoring significant events, incidents, near misses and complaints.
- Take action to address identified concerns with infection prevention and control practice.
- Ensure recruitment arrangements include all necessary employment checks for all staff.
- Ensure there is a consistent and safe approach to the use of chaperones within the practice.
- Ensure that care plans are in place and that evidence of multi-disciplinary discussions and reviews are appropriately recorded.
- Carry out clinical audits including re-audits to ensure improvements have been achieved.
- Implement formal governance arrangements including systems for assessing, monitoring and managing risks and the quality of the service provision.
- Ensure that medicines management processes are in place for the effective storage, monitoring and review of all medicines management systems including vaccines and the security of prescriptions.
- Provide staff with appropriate policies and guidance to carry out their roles in a safe and effective manner which are reflective of the requirements of the practice.
- Ensure staff receive regular appraisals and training relevant to their role.
- Clarify the leadership structure and ensure there is leadership capacity to deliver all improvements.
- Ensure that there is an active Patient Participation Group put in place with effective feedback processes and evidence of on-going action to address issues identified.

In addition, areas where the provider should make improvements are;

Summary of findings

- Take action to improve the uptake of health screening by the patient population.
- Continue to improve patients overall experience relating to whether or not patients would recommend the practice and GP consultations.
- Review exception reporting within the practice and identify areas where this could be brought in line with CCG averages.
- Review childhood immunisation rates to ensure these are in line with CCG averages.

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.

- There was evidence of incident reporting, however investigations, discussions and learning were inconsistent and records were insufficient.
- Patients were at risk of harm because systems and processes were not in place in a way to keep them safe.
- Staff had not received safeguarding training.
- There was no policy or consistent approach to chaperoning within the practice.
- There was no infection control lead, completed audit or risk assessment in place.
- Clinical equipment including the vaccine fridge had not been calibrated.
- There were out of date vaccines and records of emergency medicine checks were not available.
- The practice did not have a defibrillator and had not undertaken a risk assessment for this.
- There was no system to monitor the use of blank prescriptions and prescriptions stored in printers were note stored securely.
- Recruitment checks were not consistently undertaken in line with the practice policy.
- Checks of locum staff were not carried out.
- DBS checks were not carried out and the practice was reliant on historical checks when taking on new staff.
- Environmental risks were not routinely assessed. For example there was no fire risk assessment, training, regular alarm checks and fire extinguishers did not have records of recent checks. There was no record of the assessment of risks associated with legionella, health and safety or security within the practice, although we were told this was held by owner of the building.
- Systems were in place for dealing with emergencies and we saw evidence of business continuity plans being used effectively.

Are services effective?

Inadequate

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

- Data showed patient outcomes were generally comparable to the national average. For example diabetes and asthma

Summary of findings

indicators were similar to the national average. Diabetes was the same as the national average at 90%, asthma at 100% was 3% higher than the national average. However, exception reporting was high in some areas including diabetes and asthma.

- There was no evidence that audit was driving improvement in patient outcomes.
- Multidisciplinary working was taking place but was generally informal and record keeping was limited or absent.
- There was no training log and learning needs were not consistently identified or addressed.
- There were inconsistencies in staff mandatory training attendance in a number of areas.
- Staff had not received appraisals in the last 12 months.
- The practice uptake of cervical, breast and bowel screening was low and it was unclear what action the practice was taking to address this.
- Care planning for patients at the end of life was not recorded.

Are services caring?

Inadequate

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

- Data from the national GP patient survey was mixed in relation to how patients rated the practice for several aspects of care. There were a number of areas where performance was significantly below average and the practice did not have an awareness of this and had not taken action to address it.
- Negative comments from patients on the NHS Choices website had not been responded to by the practice.
- Information for patients about the services was not always easy to understand, for example in terms of inconsistent information available on the practice website.
- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.
- Patients we spoke with said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.
- The practice identified carers and took action to support them.

Are services responsive to people's needs?

Requires improvement

The practice is rated as requires improvement for providing responsive services as there were areas where improvements should be made.

Summary of findings

- Practice staff reviewed the needs of its local population and engaged with the NHS England Area Team and clinical commissioning group to secure improvements to services where these were identified.
- The practice had responded to patient feedback about preferring the option of a walk in service by reinstating this two mornings a week.
- Patient feedback demonstrated satisfaction with how they could access services.
- Patients said they found it easy to make an appointment with a named GP and there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- Information about how to complain was available and easy to understand and evidence showed the practice responded to issues raised. However, records relating to complaints and evidence of learning and subsequent improvements were limited.

Are services well-led?

Inadequate

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

- The practice did not have a clear strategy and business plan in place.
- The practice had a number of policies and procedures to govern activity, but in some cases these were over five years old and had not been reviewed since.
- The practice did not hold regular governance meetings and issues were discussed at ad hoc meetings.
- There were no records of meetings kept.
- Risks were not consistently identified or managed.
- Learning from significant events and complaints was not evident.
- The practice had not proactively sought feedback from patients and did not have a patient participation group.
- Staff told us they had not received regular performance reviews and did not consistently 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 practice is rated as inadequate for providing safe, effective, caring and well-led services, and requires improvement for responsive services. The issues identified affects all patients including this population group.

- The practice offered personalised care to meet the needs of the older people in its population.
- The practice was responsive to the needs of older people, and offered home visits and urgent appointments for those with enhanced needs.
- Patients who were at risk of an unplanned hospital admission were offered care plans and there was a system in place to offer care plans to patients at the end of life. However the records of end of life care patients we viewed did not include documented care plans.

People with long term conditions

Inadequate

The practice is rated as inadequate for providing safe, effective, caring and well-led services, and requires improvement for responsive services. The issues identified affects all patients including this population group.

- The GP led on chronic disease management and patients at risk of hospital admission were identified as a priority.
- Performance for diabetes related indicators at 90% was similar to the local (92%) and national average (90%). However, exception reporting was high with 17.8% of patients not attending for diabetic reviews.
- Longer appointments and home visits were available when needed.
- These patients had a named GP and a structured annual review process was in place to check their health and medicines needs were being met.
- We were told that multi-disciplinary discussions were held for those patients with the most complex needs; however minutes of these meetings were not recorded or held within the practice.

Summary of findings

Families, children and young people

Inadequate

The practice is rated as inadequate for providing safe, effective, caring and well-led services, and requires improvement for responsive services. The issues identified affects all patients including this population group.

- There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. Immunisation rates were comparable with local averages for all standard childhood immunisations.
- Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this.
- The practice's uptake for the cervical screening programme was 56%, which was significantly lower than average when compared to the CCG average of 80% and the national average of 82%.
- Appointments were available outside of school hours and the premises were suitable for children and babies.
- We were told that the practice worked closely with midwives and health visitors within the practice, however no minutes of meetings were recorded and a communication book available to record communication with health visitors was empty.

Working age people (including those recently retired and students)

Inadequate

The practice is rated as inadequate for providing safe, effective, caring and well-led services, and requires improvement for responsive services. The issues identified affects all patients including this population group.

- The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care.
- The practice was offered online services as well as some health promotion services such as smoking cessation. However, uptake of cervical, breast and bowel cancer screening was all lower than average. The GP told us they believed this was due to some cultural differences within the patient population group

Summary of findings

People whose circumstances may make them vulnerable

Inadequate

The practice is rated as inadequate for providing safe, effective, caring and well-led services and requires improvement for responsive services. The issues identified affects all patients including this population group.

- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability.
- The practice offered longer appointments for patients with a learning disability and we observed administrative staff providing support to patients in accessing other services.
- We were told that the practice regularly worked with other health care professionals in the case management of vulnerable patients although recorded evidence of this was limited.
- The practice informed vulnerable patients about how to access various support groups and voluntary organisations.
- Staff 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. However, staff had not received safeguarding training.

People experiencing poor mental health (including people with dementia)

Inadequate

The practice is rated as inadequate for providing safe, effective, caring and well-led services, and requires improvement for responsive services. The issues identified affects all patients including this population group.

- 83% of patients diagnosed with dementia that had their care reviewed in a face to face meeting in the last 12 months, compared to the CCG average of 80% and the national average of 78%.
- 100% of patients with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive care plan documented in their record, compared to the CCG average of 81% and the national average of 78%.
- The practice told us they regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those with dementia, however there were no recorded minutes of these meetings.
- The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations.

Summary of findings

- Staff had a good understanding of how to support patients with mental health needs and dementia.

Summary of findings

What people who use the service say

The national GP patient survey results were published on 7 July 2016. The results showed the practice had mixed results in relation to local and national averages. 349 survey forms were distributed and 61 were returned. This represented 2.5% of the practice's patient list.

- 82% of patients found it easy to get through to this practice by phone compared to the national average of 73%.
- 74% 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%.
- 71% of patients described the overall experience of this GP practice as good compared to the national average of 85%.
- 58% 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 six comment cards which were all positive about the standard of care received. Comments included references to the welcoming and professional service, caring and patient staff and that patients were treated with respect.

We spoke with five patients during the inspection. All five patients said they were satisfied with the care they received and thought staff were approachable, committed and caring. Recent results from the friends and family test showed that 100% of those responding would recommend the practice to their friends and family.

Areas for improvement

Action the service MUST take to improve

- Introduce robust processes for reporting, recording, acting on and monitoring significant events, incidents, near misses and complaints.
- Take action to address identified concerns with infection prevention and control practice.
- Ensure recruitment arrangements include all necessary employment checks for all staff.
- Ensure there is a consistent and safe approach to the use of chaperones within the practice.
- Ensure that care plans are in place and that evidence of multi-disciplinary discussions and reviews are appropriately recorded.
- Carry out clinical audits including re-audits to ensure improvements have been achieved.
- Implement formal governance arrangements including systems for assessing, monitoring and managing risks and the quality of the service provision.
- Ensure that medicines management processes are in place for the effective storage, monitoring and review of all medicines management systems including vaccines and the security of prescriptions.
- Provide staff with appropriate policies and guidance to carry out their roles in a safe and effective manner which are reflective of the requirements of the practice.
- Ensure staff receive regular appraisals and training relevant to their role.
- Clarify the leadership structure and ensure there is leadership capacity to deliver all improvements.
- Ensure that there is an active Patient Participation Group put in place with effective feedback processes and evidence of on-going action to address issues identified.

Action the service SHOULD take to improve

- Take action to improve the uptake of health screening by the patient population.

Summary of findings

- Continue to improve patients overall experience relating to whether or not patients would recommend the practice and GP consultations.
- Review exception reporting within the practice and identify areas where this could be brought in line with CCG averages.
- Review childhood immunisation rates to ensure these are in line with CCG averages.

Dr Shada Parveen

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.

Background to Dr Shada Parveen

Dr Shada Parveen offers general medical services to people living and working in Woking. The practice population has a significantly higher than average proportion of working patients and also patients that are unemployed. There is a higher proportion of children under the age of 18 and a below average proportion of older patients. There is higher deprivation affecting older people and children. The practice population has a high proportion of Asian and Eastern European patients. The practice is placed in the sixth least deprived decile.

The practice holds a General Medical Service contract and is led by one female GP. The GP is supported by a locum GP (male), a locum practice nurse, a practice manager, and a team of two reception and administrative staff. A range of services are offered by the practice including asthma reviews, child immunisations, diabetes reviews, new patient checks, and smoking cessation.

9am and 6.30pm on a Tuesday and Friday. They were open between 9pm and 12.30pm on a Wednesday. Between 8am and 9am and from 12.30pm on a Wednesday access to the practice was through an out of hour's provider (Care UK). 9am and 12.30pm Monday to Friday and from 4pm to 6.30pm or 7pm on the other days. The practice runs a drop in service two mornings a week on a Tuesday and Thursday. The practice had made arrangements for patients requiring early morning blood tests to access these from a local community hospital. 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 practice has opted out of providing Out of Hours services to their patients. There are arrangements for patients to access care from an Out of Hours provider (111/Care UK).

Services are provided from:

The Maybury Surgery,

Woking,

Surrey

GU22 8HF

Why we carried out this inspection

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

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 15 November 2016.

Detailed findings

During our visit we:

- Spoke with a range of staff including a GP, practice nurse, practice manager and reception staff and spoke with patients who used the service.
- Observed how patients were being cared for when accessing the practice 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 not an effective system in place for reporting and recording significant events.

- Staff told us they would inform the practice manager of any incidents and there was an incident book where summaries of incidents were recorded. However, there was no recording form available on the practice's computer system. The process did not support the recording of notifiable incidents under the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).
- We did not see evidence that when things went wrong with care and treatment, patients were informed of the incident, received reasonable support, truthful information, a written apology and were told about any actions to improve processes to prevent the same thing happening again.
- The practice did not carry out a thorough analysis of the significant events. There were no records of action taken, lessons learned or the identification of themes or trends. Staff told us that significant events were discussed, however these were informal discussions and subsequently not minuted.

Overview of safety systems and processes

The practice had some systems, processes and practices in place to keep patients safe and safeguarded from abuse, which included:

- Arrangements were in place to safeguard children and vulnerable adults from abuse. These arrangements reflected relevant legislation and local requirements. Policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. There was a lead member of staff for safeguarding. The GPs attended safeguarding meetings when possible and always provided reports where necessary for other agencies. Staff demonstrated they understood their responsibilities however; they had not received training on safeguarding children and vulnerable adults relevant to their role. There was no record that GPs were trained to child protection or child safeguarding level three.
- There was no notice in the waiting room advising patients that chaperones were available if required and staff told us only one member of the reception team had received training to be a chaperone and was available to undertake the role. The practice did not have a process for ensuring that all staff who acted as chaperones 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). There was no risk assessment in place for staff relating to DBS checks and who should have them and the only staff that had DBS checks on record had received these some years prior to commencing in post.
- The practice maintained appropriate standards of cleanliness and hygiene. We observed the premises to be clean and tidy. Staff were unclear who the infection control lead was. The policy stated it was the GP but staff told us they believed that either the practice manager or the locum nurse took the lead. There was no record of any staff having undertaken training to lead on infection control. There was an infection control protocol in place although the information within the policy was out of date, for example in relation to the staff members in post. Not all staff had received up to date training. For example, only one member of the reception team had a record of infection control training. Reception staff did not know the process for cleaning spillages of body fluids and risks associated with reception staff receiving specimens had not been assessed or mitigated. An infection control audit had been undertaken although this was incomplete and there was no evidence that action was taken to address any improvements identified as a result. Staff told us that privacy curtains in treatment rooms were laundered every six months; however there was no record of this.
- The practice did not have the full range of sharps bins available. For example, they did not have orange (for disposal of sharps not containing or contaminated with medicines) or purple (for the disposal of sharps and medicines with cytotoxic or cytostatic contents) lidded bins. Cytotoxic and cytostatic medicines can be hazardous and such contaminated waste is required to be segregated and destroyed appropriately in line with waste management legislation.

Inadequate

Are services safe?

- The arrangements for managing medicines, including emergency medicines and vaccines, in the practice did not keep patients safe (including obtaining, prescribing, recording, handling, storing, security and disposal). For example, while we saw that temperatures of the vaccine fridge were monitored on a daily basis there was no evidence of calibration of the fridge and no clear policy in place on what staff should do if the fridge temperature was outside of the agreed range. During the inspection we found two doses of one vaccine (Revaxis) had expired in March 2016. Processes were in place for handling repeat prescriptions which included the review of high risk medicines. The practice 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 and we were told only accessible to the GP. There was no system in place to monitor their use. Blank prescriptions held in printers were not stored securely as they were stored in consulting rooms and printers that were not lockable. Patient Group Directions had been adopted by the practice to allow nurses to administer medicines in line with legislation.
- We reviewed four personnel files and found appropriate recruitment checks had not been undertaken prior to employment and in line with the practice policy. For example, references had not been obtained for three of the four staff. The fourth staff member had two references on file, however these had been received more than six months after they commenced in post. Two of four staff did not have proof of identity checks recorded. Two staff (the locum nurse and a receptionist acting as chaperone) had evidence of checks through the Disclosure and Barring Service (DBS) however these were dated more than three years before they commenced in post. There was no risk assessment within the practice to identify which staff should have a DBS check. There was no record held to evidence that the registration of the practice nurse was current, although this was checked and found to be current during the inspection. There were no records of relevant recruitment checks held for locum GPs. In addition, evidence of medical indemnity for the GPs and nurse were not held on site within the practice, although we did receive confirmation that these were in place following our inspection.

Monitoring risks to patients

Risks to patients were assessed and well managed.

- There were insufficient procedures in place for monitoring and managing risks to patient and staff safety. The practice did not have up to date fire risk assessments and had not carried out regular fire drills. The fire alarm system was serviced by a contractor as part of the lease for the building; however the practice did not carry out weekly checks that the alarm was working. The practice manager told us they had unsuccessfully attempted to obtain information from the owner of the building on how the system worked so that they could commence regular testing. There was no evidence of staff having attended fire safety training and no record of fire evacuation drills being carried out. There were three fire extinguishers in the practice, one had an up to date log of it being checked within the last 12 months, the other two did not have evidence of checks. Staff told us the extinguishers were new, however the practice was unable to verify this at the time of inspection. All electrical equipment was checked to ensure the equipment was safe to use however clinical equipment was not checked to ensure it was working properly. The practice did not have a variety of other risk assessments in place to monitor safety of the premises. For example, there was no health and safety risk assessment, no risk assessment of the control of substances hazardous to health (COSHH) and no legionella risk assessment (Legionella is a term for a particular bacterium which can contaminate water systems in buildings). However, we were told that the legionella risk assessment was held by the owner of the building.
- There were arrangements 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 reception staff to ensure enough staff were on duty and locum GPs were used regularly. Nursing appointments were available on two mornings a week and nursing roles such as immunisations and phlebotomy would be undertaken by the GPs outside of these times.

Arrangements to deal with emergencies and major incidents

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

Inadequate

Are services safe?

- There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency.
- All staff received annual basic life support training and there were emergency medicines available in the treatment room.
- A first aid kit and accident book were available and there was oxygen with adult and children's masks. However, the practice had no defibrillator available on the premises and there was no risk assessment relating to this.
- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the emergency medicines we checked were in date and stored securely. The nurse told us these were monitored regularly and a record kept, however the record was not available on the day of inspection.
- The practice had a comprehensive business continuity plan in place for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff. The plan had been implemented earlier in the year due to a flood. As a result the practice had relocated to temporary premises during the post incident refurbishment. Staff told us this had worked well and there had been minimal disruption in service during this time.

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.

- The practice had systems in place to keep all clinical staff up to date. Staff had access to guidelines from NICE and used this information to deliver care and treatment that met patients' needs.
- The practice monitored that these guidelines were followed through 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 95% of the total number of points available. Exception reporting was 6.6% higher than the local and national averages at 16.4%. (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). A specific example was in diabetes performance where exception reporting was higher than average in most areas of performance. For example 17.8% of patients with diabetes were excepted from having a diabetic foot examination and risk classification compared with CCG (8.7%) and national (8%) averages.

This practice was not an outlier for any QOF (or other national) clinical targets. Data from 2015/16 showed:

- Performance for diabetes related indicators at 90% was similar to the local (92%) and national average (90%).
- Performance for mental health related indicators at 86% was slightly lower when compared to the local and national average of 93%.
- Asthma related indicators at 100% were similar to the national average of 97%.
- Performance for secondary prevention of fragility fractures at 100% was 8% higher than the CCG average and 12% higher than the national average.

There was limited evidence of quality improvement including clinical audit.

- There had been two clinical audits completed in the last two years, neither of these were completed full cycle audits where the improvements made were implemented and monitored.
- The practice participated in local medicines management audits.
- There was limited evidence that findings were used by the practice to improve services. For example, a GP had identified that a number of patients had issues with poor diabetic control and had undertaken a diabetes audit to explore this. It was unclear how this audit was being used to improve outcomes for patients. However, we saw that 90% of newly diagnosed patients with diabetes had been referred to a structured education programme within nine months of entry onto the register. This was 26% higher than the CCG average and 19% higher than the national average.

Effective staffing

The practice could not demonstrate that staff had the skills, knowledge and experience to deliver effective care and treatment.

- The practice had an induction programme for all newly appointed reception staff. This covered areas relating to their role but did not cover such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality.
- The practice could not demonstrate how they ensured role-specific training and updating for relevant staff. For example, for those reviewing patients with long-term conditions. The practice did not maintain clear up to date records of clinical staff training, including for those undertaking the role as locums.
- Staff administering vaccines and taking samples for the cervical screening programme had received specific training which had included an assessment of competence. We were told that the locum nurse and GPs were responsible for their own training although there was evidence the nurse had attended some CCG updates through the practice. For example the nurse

had attended an immunisation update through the CCG in the weeks before our inspection. However, records held on file were inconsistent and did not include evidence of up to date training in all areas.

- There was some evidence that the learning needs of staff were identified through a system of appraisals and reviews of practice development needs however this was inconsistent. For example, one member of the reception team had received an appraisal in October 2015 and had been supported by the practice to undertake studies in business administration. However, there was no record of staff having received an appraisal in the last year and not all staff had received training appropriate to their role. For example, there was no record of the practice manager having attended training relevant to their role.
- Staff had not consistently received training. There was no training log held within the practice. Three of four staff files we looked at showed evidence of up to date basic life support training, two of four showed evidence of up to date information governance training and one demonstrated infection control training. There was no evidence of safeguarding training for any staff within the practice and no evidence of fire training or Mental Capacity Act 2005 training.

Coordinating patient care and information sharing

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

- This included medical records and investigation and test results. However, care plans were not always maintained. For example, we saw evidence of care plans in place for patients at risk of unplanned admissions; however two records of patients at the end of life did not have care plans in place.
- The practice shared relevant information with other services in a timely way, for example when referring patients to other services. There was appropriate safety netting in place to ensure that urgent referrals were followed up in a timely way.

We were told that 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. For example, the GP told us they regularly met with district nurses and attended meetings with the palliative care team, however there was no record of this and no minutes of meetings available.

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 in relation to obtaining consent prior to undertaking procedures. For example, the nurse recorded verbal consent within the patient record before undertaking procedures.
- There was no evidence of staff having attended training in the Mental Capacity Act 2005. However, the GP told us they had attended training through the CCG on the use of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS) and demonstrated an understanding of this.
- When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance.

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, carers, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation and general lifestyle issues. Patients were signposted to the relevant service.
- Smoking cessation advice was available from the practice nurse.

The practice's uptake for the cervical screening programme was 56%, which was significantly lower than average when compared to the CCG average of 80% and the national average of 82%. Staff told us that there were some cultural issues within the demographic of the practice population that impacted on the uptake of cervical screening. However, it was unclear what action was being taken to address this and encourage the uptake of the screening programme. The practice was also below average for its patients attending national screening programmes for bowel and breast cancer screening. For example, the percentage of eligible women attending breast screening

Inadequate

Are services effective?

(for example, treatment is effective)

was 44% compared with the CCG and national average of 72%. Eligible patients screened for bowel cancer was 25% compared with the CCG average if 56% and the national average of 58%. 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 vaccines given were mixed when compared to CCG. For example, childhood immunisation rates for the vaccines given to under two year olds ranged from 50% to 100% compared with the CCG average of 47% to 89% and five year olds from 55% to 88% compared with the CCG average of 74% to 90%.

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

Inadequate

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.

All of the six patient Care Quality Commission comment cards we received were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect.

We spoke with five patients. They also told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. Comment cards highlighted that staff responded compassionately when they needed help and provided support when required.

Results from the national GP patient survey showed patients generally felt they were treated with compassion, dignity and respect. However, the practice was below average for its satisfaction scores on consultations with GPs and nurses. For example:

- 64% of patients said the GP was good at listening to them compared to the clinical commissioning group (CCG) average of 89% and the national average of 89%.
- 64% of patients said the GP gave them enough time compared to the CCG average of 86% and the national average of 87%).
- 84% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 96% and the national average of 95%)
- 69% 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%.
- 77% 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%.
- 86% 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 practice did not have an awareness of these results.

Negative feedback from patients on the NHS Choices website had not been responded to by the practice.

Care planning and involvement in decisions about care and treatment

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

However, results from the national GP patient survey showed patients had not always responded positively to questions about their involvement in planning and making decisions about their care and treatment. Results were significantly below local and national averages in some areas. For example:

- 69% of patients said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 87% and the national average of 86%.
- 56% 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%.
- 80% 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%.

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. In addition, staff within the practice were fluent in a number of languages that reflected the needs of the local population. For example, both Asian and eastern European languages were spoken by staff.
- Information leaflets were available in easy read format.

Inadequate

Are services caring?

Patient and carer support to cope emotionally with care and treatment

Patient information leaflets and notices were available in the patient waiting area which told patients how to access a number of support groups and organisations. Information about support groups was also available on the practice website. We observed the practice manager taking time to spend with a patient who required additional support on the day of inspection.

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 50 patients as carers (2% of the practice list). Written information was available to direct carers to the various avenues of support available to them. The practice manager supported carers to access additional support including access to respite breaks and holidays.

Staff told us that if families had suffered bereavement, their usual GP contacted them; this call was either followed by a patient consultation at a flexible time 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

The practice reviewed the needs of its local population and engaged with the NHS England Area Team and clinical commissioning group (CCG) to secure improvements to services where these were identified.

- The practice offered extended hours appointments on a Monday and Thursday evening until 7pm for working patients who could not attend during normal opening hours.
- There were longer appointments available for patients with a learning disability.
- Staff told us that the GP was very flexible with appointment and would respond to the needs of patients as required. For example, patients could book double appointments if they had a number of issues to address.
- 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.
- There were disabled facilities and translation services available.
- Information for patients was available in different languages and staff within the practice spoke a range of languages.

Access to the service

The practice was open between 9am and 7pm on a Monday and Thursday and between 9am and 6.30pm on a Tuesday and Friday. They were open between 9pm and 12.30pm on a Wednesday. Between 8.00am and 9.00am and from 12.30pm on a Wednesday access to the practice was through an out of hour's provider (Care UK). 9.00am and 12.30pm Monday to Friday and from 4pm to 6.30pm or 7pm on the other days. The practice ran a drop in service two mornings a week on a Tuesday and Thursday. Patients requiring early morning blood tests could access these from a local community hospital. 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.

Information on the practice website was confusing. There was a patient notice stating that all surgeries were by appointment only until further notice, however a section on surgery hours stated that Tuesday and Thursday mornings were walk in clinics. In addition the surgery hours on the website appeared to be advertised as shorter than stated by the practice and there was no clarity of when the practice was open outside of surgery times for patients to call or visit.

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.

- 77% of patients were satisfied with the practice's opening hours compared to the national average of 78%.
- 82% 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.

The practice had a system in place to assess:

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

The GP would telephone the patient or carer to make a decision about prioritisation of visits. In cases where the urgency of need was so great that it would be inappropriate for the patient to wait for a GP home visit, alternative emergency care arrangements were made. Clinical and non-clinical staff were aware of their responsibilities when managing requests for home visits.

Listening and learning from concerns and complaints

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

- The practice had a complaints policy and procedures in place although this had not been updated in recent years.
- The practice manager was the designated responsible person who handled all complaints in the practice.
- We saw that information was available to help patients understand the complaints system through the use of an information leaflet available at reception.

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

We looked at four complaints received in the last 12 months and found that action was taken to address the concerns raised. However, records were limited and it was unclear how complaints were reviewed, discussed and learning used to make improvements.

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 to deliver high quality care.

- The practice did not have a mission statement and there was no evidence of documented values although staff demonstrated a patient focus and a shared understanding of the values of a caring practice.
- The GP had a goal to expand the practice so as to take on additional staff and increase the patient list size. However the practice did not have a strategy and supporting business plans and it was not clear how the goals would be achieved.

Governance arrangements

The practice did not have an overarching governance framework which supported the delivery of good quality care.

- There was a clear staffing structure although roles and responsibilities were not always clear.
- Practice specific policies were implemented and were available to all staff, however many of these appeared to be a number years out of date. For example, while some policies had a current date on them, the detail in the policy itself appeared to be out of date, such as individual staff named as having responsibilities who were no longer working at the practice. The practice manager told us they were working through each policy to update them, using online resources as guidance of up to date practice. However, there was limited capacity for them to undertake this role on top of their other duties.
- A comprehensive understanding of the performance of the practice was not maintained.
- While there was evidence of some clinical audit having taken place, this was not a programme of continuous clinical and internal audit used to monitor quality and to make improvements.
- There were limited arrangements for identifying, recording and managing risks, issues and implementing mitigating actions. For example, there was no fire risk assessment or evidence of mitigating action such as fire drills, alarm tests and training for staff. There was evidence of routine water testing having been carried out but the practice did not know if a legionella risk assessment had been undertaken and did not have records relating to this. However, staff believed that these were held by the owner of the building off site. Risks associated with the security of the building, control of substances hazardous to health (COSHH), infection control and inconsistent recruitment procedures had not been assessed or effectively managed.
- There were contracts in place for the maintenance of the building; however other areas such as the calibration of medical equipment had not been carried out.
- Processes for recording, investigating, discussing, taking action and learning from complaints and significant events were not in place.
- Meetings were not recorded in the practice. Staff told us they discussed issues as a matter of routine but there was no evidence of this.

Leadership and culture

Staff told us the GP and practice manager were approachable and always took the time to listen to all members of staff. There were some areas of leadership within the practice that were unclear. For example, infection control responsibilities were unclear.

The practice did not have systems in place to ensure compliance with the requirements of the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment). Records relating to significant events and complaints were limited and there was no evidence of patients receiving an apology if things went wrong. However, we were given an example where a patient was called and offered a verbal apology. The practice did not keep written records of verbal interactions as well as written correspondence.

There was a leadership structure in place and staff felt supported by management, although some areas of leadership such as infection control were unclear.

- Staff told us the practice held regular team meetings, however these were informal and there were no records available.
- Staff told us there was an open culture within the practice and they had the opportunity to raise any issues during discussions and felt confident and supported in doing so.

Are services well-led?

Inadequate

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

- Staff said they felt respected, valued and supported, particularly by the GP and practice manager in the practice.

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

The practice valued feedback from patients, the public and staff. However, it had not always proactively sought patients' feedback and engaged patients in the delivery of the service although there was some evidence of responding to feedback.

- The practice did not have an active patient participation group (PPG) in place.
- The practice had not undertaken specific patient surveys but had gathered feedback from patients through the Friends and Family Test (a feedback tool to help service providers understand where patients are happy with the service provided and where improvements may be required). Results we viewed on the day showed that 57% were extremely likely to recommend the service and 43% were likely to recommend.
- Staff told us an example where they had recently made changes as a result of feedback from patients was to re-introduce the walk in service on two mornings a week.
- The practice had gathered feedback from staff through informal discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged to improve how the practice was run.

Continuous improvement

There was limited evidence of a focus on continuous learning and improvement within the practice. The practice team was engaged with the local CCG and the GP attended meetings with other service providers within the locality.

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 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 had failed to ensure that there were clear records of complaints including how they were reviewed, discussed and learning used to make improvements. This was in breach of regulation 16 (1)(2) 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 Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing How the regulation was not being met: The provider had failed to ensure that staff received such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform. This was in breach of regulation 18 (2) 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 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: The registered person did not do all that was reasonably practicable to ensure that systems and processes to assess and monitor the service were effective. Risks were not adequately mitigated and records not always maintained. Policies and procedures were out of date, formal meetings were not held. The practice did not have an active PPG. This was in breach of regulation 17 (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 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 failed to ensure that risks were appropriately assessed and mitigated, that equipment was safe to use, that medicines were safely managed and that infection prevention and control processes were in place. 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	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed

This section is primarily information for the provider

Enforcement actions

Treatment of disease, disorder or injury

How the regulation was not being met:

The provider had failed to ensure that recruitment checks were carried out on all new employees. This included information set out in schedule 3 of the act.

This was a breach of Regulation 19 (1) (2) (3) (4) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.