Dr Pal & Partners

Inspection report

Royton Health Wellbeing Centre
Park Street, Royton
Oldham
Lancashire
OL2 6QW
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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 location	Requires improvement
Are services safe?	**Inadequate**
Are services effective?	**Requires improvement**
Are services caring?	**Good**
Are services responsive?	**Good**
Are services well-led?	**Requires improvement**

Overall summary

This practice is rated as Requires improvement overall. (Previous inspection March 2015 – Good)

The key questions are rated as:

Are services safe? – Inadequate

Are services effective? – Requires improvement

Are services caring? – Good

Are services responsive? – Good

Are services well-led? - Requires improvement

We carried out an announced comprehensive inspection at Dr Pal & Partners on 14 June 2018. This was as part of our inspection programme.

There have been changes in the registration of this practice since the inspection in March 2015. That inspection report can be found by searching for Dr Pal & Partners in the archived services section in www.cqc.org.uk.

At this inspection we found:

- The practice reported on and discussed significant events but this was not consistent and their significant event policy was not followed.
- Training and supporting staff had not been a priority. Appraisals had not taken place and mandatory training was not up to date.
- There was insufficient emphasis placed on safety, with actions identified during fire risk assessments not being monitored.
- Although staff understood safeguarding, several staff had not received training.
- Evidence of medical indemnity insurance was not available for all appropriate staff.
- The practice was in the process of re-launching a patient participation group (PPG).
- Patients said they found the appointment system easy to use and reported that they were usually able to access care when they needed it.
- Staff involved and treated patients with compassion, kindness, dignity and respect.

The areas where the provider must make improvements as they are in breach of regulations are:

- Ensure care and treatment is provided in a safe way to patients.
- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.
- Ensure persons employed in the provision of the regulated activity receive the appropriate support, training, professional development, supervision and appraisal necessary to enable them to carry out the duties.
- Ensure recruitment procedures are established and operated effectively so only fit and proper persons are employed. The provider must ensure specified information is available regarding each person employed.

Professor Steve Field CBE FRCP FFPH FRCGPChief Inspector of General Practice

Population group ratings

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

Our inspection team

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

Background to Dr Pal & Partners

Dr Pal & Partners (also known as The Parks Medical Practice) has GP practice surgeries on two sites; they have a main surgery in Royton and a branch surgery in Shaw. The practice addresses are:

- Royton Health and Wellbeing Centre, Park Street, Royton, Oldham, OL2 6QW, and
- High Crompton Surgery, 164 Trent Road, Shaw, Oldham, OL2 7QR.

The practice is registered to carry out the regulated activities:

- Diagnostic and screening procedures.
- Family planning.
- Maternity and midwifery services.
- Treatment of disease, disorder or injury.

During the inspection of March 2015 it was identified that the practice was incorrectly registered with the CQC; both practices were individually registered when in fact the Shaw site was a branch surgery, with the main location being in Royton. The registration was amended and is now correct.

Royton Health and Wellbeing Centre is a large modern building where another GP practice and other health services are also located. High Crompton Surgery (the branch surgery) is located in a row of terraced shops.

There are three GP partners working between the two surgeries, two male and one female. One of the partners is not yet registered with the CQC. There are also two practice nurses, a healthcare assistant, a practice manager and administrative and reception staff.

There are 6044 patients registered with the practice, and patients can book appointments at the surgery of their choice. The practice has a Primary Medical Services (PMS) contract and is a member of Oldham NHS clinical commissioning group. The practice has a website that contains comprehensive information about what they do to support their patient population and the in house and online services offered.

The practice is situated in an area at number six on the deprivation scale (the lower the number, the higher the deprivation). People living in more deprived areas tend to have greater need for health services.

When the practice is closed out of hours services are provided by Go To Doc Limited, via NHS111.

Inadequate

Are services safe?

At our inspection in March 2015 we found that not all pre-employment checks had been completed, and chaperones did not always have a Disclosure and Barring Service (DBS) check in place. In addition, we identified that the provider should keep detailed records of significant events, have a spills kit available, return medicines to the pharmacy appropriately and carry out an infection control audit.

During this inspection we found that DBS checks were in place but not all pre-employment checks were carried out. There were still some gaps in the recording of significant events.

We rated the practice as inadequate for providing safe services.

The practice was rated as inadequate for providing safe services because:

- Not all staff training required to keep patients safe, including safeguarding, fire safety and infection prevention and control, had been carried out.
- Not all required safety checks were carried out adequately. For example, the fire risk assessment was not formally monitored and risks identified during health and safety risk assessments had not all been actioned.
- Medicines on the emergency trolley had not been assessed and an out of date syringe was found.
- Staff were recruited without the required pre-employment checks being carried out.

Safety systems and processes

The practice did not have clear systems to keep people safe and safeguarded from abuse.

- The practice had some systems to safeguard children and vulnerable adults from abuse. All the staff we spoke with knew who the lead GP for safeguarding was and how to access policies. However, seven administrative staff had received no training in safeguarding children and three had no training in safeguarding adults. The GPs told us they were trained to level three in safeguarding children. This evidence was not provided during the inspection, but evidence supplied afterwards showed they had been trained at the inspection date. The staff we spoke with had a good understanding of safeguarding procedures and knew how to access advice.
- 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.)
- Staff took steps, including working with other agencies, to protect patients from abuse, neglect, harassment, discrimination and breaches of their dignity and respect.
- The practice did not carry out appropriate staff checks at the time of recruitment and on an ongoing basis. There was no work history for either of the two practice nurses who had been recently recruited, and the practice manager confirmed one had been recruited by a GP without the usual checks taking place. No references were in place for one nurse, and a telephone reference was noted for the other nurse, although dates of employment were not recorded.
- There was no effective system to manage infection prevention and control. An infection control audit had been carried out by a practice nurse on 23 May 2018. This stated that all staff had received infection control training in the previous two years. We saw no evidence of this; of the 18 clinical and non-clinical staff at the practice there was no record of infection control training for 13 of them, including the practice nurse who carried out the risk assessment. Following the inspection the practice told us staff had been instructed to have on-line infection control training by 1 September 2018.
- The practice had arrangements to ensure that facilities and equipment were safe and in good working order. We saw that equipment had been calibrated at both sites in December 2017. Portable appliance testing (PAT testing) had been carried out at both sites.
- Arrangements for managing waste and clinical specimens kept people safe.

Risks to patients

There were systems to assess, monitor and manage risks to patient safety, but these were not always adequate.

- Arrangements were in place for planning and monitoring the number and mix of staff needed to meet

patients' needs, including planning for holidays, sickness, busy periods and epidemics. Staff told us they worked well together and covered absences for each other.

- The practice was equipped to deal with medical emergencies and although they had not been trained all the staff we spoke with were aware of the procedures in place.
- The practice had a resuscitation trolley and emergency medicines. Benzylpenicillin, an antibiotic used to treat infections including pneumococcal meningitis, was not held. GPs told us there had been no discussion or risk assessment regarding what emergency medicines were held. Following the inspection the practice told us they had decided to stock additional emergency medicines and they provided a risk assessment as evidence they had considered what medicines should be held.
- We found a syringe outside its expiry date in a drawer with in-date syringes in the practice nurse's room.
- Staff understood their responsibilities to manage emergencies on the premises and to recognise those in need of urgent medical attention. Clinicians knew how to identify and manage patients with severe infections including sepsis.
- We saw no examples of pre-employment health questionnaires being completed. During the inspection we saw no evidence of an employee immunisation programme being in place. Personnel files did not contain information about immunity for named diseases, immunisations given or offered, or a risk assessment relating to immunisations. However, the practice provided evidence of staff vaccinations following the inspection.
- We saw no evidence of the practice nurses being covered by medical indemnity insurance. In addition, the practice manager told us their medical defence union stopped covering healthcare assistants, so they had no medical indemnity insurance in place, but they said the partners would pay if there was an incident. Following the inspection the practice provided evidence that medical indemnity insurance was in place for the healthcare assistant from July 2018. They also provided evidence that the practice nurses had applied for medical indemnity insurance. The practice told us following the inspection that the nurses also had cover with the Nursing and Midwifery Council (NMC) and the Royal College of Nursing (RCN) but evidence of this was not provided. The NMC does not indemnify nurses.
- The healthcare assistant had a walk-in phlebotomy clinic at the branch surgery once a fortnight. There was no clinical supervision at the surgery during this clinic.

Information to deliver safe care and treatment

Staff had the information they needed to deliver safe care and treatment to patients.

- The care records we saw showed that information needed to deliver safe care and treatment was available to staff. There was a documented approach to managing test results.
- The practice had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.
- Clinicians made timely referrals in line with protocols.

Appropriate and safe use of medicines

The practice had systems for appropriate and safe handling of medicines.

- The systems for managing and storing medicines, including vaccines, medical gases, emergency medicines and equipment, minimised risks.
- Staff prescribed, administered or supplied medicines to patients and gave advice on medicines in line with current national guidance.
- Patients' health was monitored in relation to the use of medicines and followed up on appropriately. Patients were involved in regular reviews of their medicines.

Track record on safety

The practice did not have an adequate track record on safety.

- There had been a fire risk assessment for Royton Health and Wellbeing Centre (the building in which the main surgery was located) in October 2017. Some actions had been identified and there was an action plan in place. However, this had not been fully updated and there was no indication of who was responsible for each action. The risk assessment noted that all staff should be trained and training was the responsibility of each tenant of the building, and that tenants should have

their own fire safety risk assessment in place for the areas they occupied by December 2017. Of the clinical and non-clinical staff at the practice we saw no evidence of fire training for 10 of them.

- A fire risk assessment had been carried out at the Shaw site in March 2015 by an independent company. Several issues had been highlighted, including that there was no evidence of PAT testing, no evidence the heating system had been serviced, and no record of fire safety inspections. An action plan had been included in the company's report. There was no evidence of the action plan being updated and the practice manager was not aware that it was being monitored. Following the inspection the practice provided evidence that the heating system had been serviced in January 2018, weekly fire alarm checks were carried out, and PAT testing had taken place. However, the March 2015 risk assessment stated it should be reviewed annually. We saw no evidence of any review taking place.

Lessons learned and improvements made

The practice learned when things went wrong but processes were not clear.

- Staff told us they understood their duty to raise concerns and report incidents and near misses. However, we saw an example of a significant event not being reported by a staff member. This was dealt with when the patient reported it.
- The practice had a significant event audit policy, but this was not being followed. For example, the policy stated that when a significant event was raised it would be added to the agenda for the next practice meeting. We examined four significant events raised during 2017. We saw evidence and found these were not documented in any practice meeting minutes. The practice manager told us significant events were reviewed by relevant staff. Following the inspection the practice sent us a new meeting template that included an agenda item to discuss significant events.
- The policy also stated that documentation should include action points from significant events, the person responsible for actioning and a deadline. Forms included a 'what have you learned?' section but evidence of wider learning, and a designated person to make any improvements necessary within an agreed timescale, was not held.
- The practice manager told us that they received patient safety or medicine alerts, printed them, and gave to GPs to read. The GPs confirmed this and told us they were reviewed in meetings. We saw evidence of alerts being actioned.

Please refer to the Evidence Tables for further information.

Requires improvement

Are services effective?

At the inspection in March 2015 we found that the provider should implement a more comprehensive appraisal system. At this inspection we found this had not been put in place.

We rated the practice and all of the population groups as requires improvement for providing effective services.

The practice was rated as requires improvement for providing effective services because:

- Training was not well-monitored and several staff did not have up to date mandatory training.
- There was no appraisal system in place for staff and we did not see evidence of appraisals being carried out.

Effective needs assessment, care and treatment

The practice had systems to keep clinicians up to date with current evidence-based practice. We saw that clinicians assessed needs and delivered care and treatment in line with current legislation, standards and guidance supported by clear clinical pathways and protocols.

- Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.

We saw no evidence of discrimination when making care and treatment decisions.

- Staff advised patients what to do if their condition got worse and where to seek further help and support.

Older people:

- Older patients who are frail or may be vulnerable received a full assessment of their physical, mental and social needs. The practice used an appropriate tool to identify patients aged 65 and over who were living with moderate or severe frailty. Those identified as being frail had a clinical review including a review of medication.
- Patients aged over 75 were invited for a health check. If necessary they were referred to other services such as voluntary services and supported by an appropriate care plan.
- The practice followed up on older patients discharged from hospital. It ensured that their care plans and prescriptions were updated to reflect any extra or changed needs.
- The practice carried out a weekly ward round at a nearby nursing home, and implemented care plans for patients appropriately.

People with long-term conditions:

- The practice was significantly below average for their Quality and Outcome Framework (QOF) results for some monitoring of diabetes.
- Patients with long-term conditions had an annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.
- The practice had arrangements for adults with newly diagnosed cardiovascular disease.

Families, children and young people:

- Childhood immunisations were carried out in line with the national childhood vaccination programme. Uptake rates for the vaccines given were in line with the target percentage of 90% or above.
- The practice had arrangements to identify and review the treatment of newly pregnant women on long-term medicines. These patients were provided with advice and post-natal support in accordance with best practice guidance.
- The practice had arrangements for following up failed attendance of children's appointments following an appointment in secondary care or for immunisation.

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

- The practice's uptake for cervical screening was in line with the CCG and national average.
- The practices' uptake for breast and bowel cancer screening was in line the national average.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40-74. There was appropriate follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.

People whose circumstances make them vulnerable:

Requires improvement

Are services effective?

- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice held a register of patients living in vulnerable circumstances including those with a learning disability.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.

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

- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder by providing access to health checks, interventions for physical activity, obesity, diabetes, heart disease, cancer and access to 'stop smoking' services. There was a system for following up patients who failed to attend for administration of long term medication.
- The practice was below the CCG and national average for the number of patients diagnosed with dementia who had their care reviewed in a face to face meeting in the previous 12 months.
- Patients at risk of dementia were identified and offered an assessment to detect possible signs of dementia. When dementia was suspected there was an appropriate referral for diagnosis.
- The practice offered annual health checks to patients with a learning disability.

Monitoring care and treatment

The practice had a programme of quality improvement activity and reviewed the effectiveness and appropriateness of the care provided. Where appropriate, clinicians took part in local and national improvement initiatives.

- Some of the QOF results were in line with the CCG and national average, but others were consistently low.
- Exception rates were in line with the CCG and national average.
- The practice was involved in quality improvement activity.

Effective staffing

Staff could not demonstrate they had the skills, knowledge and experience to carry out their roles.

- Training was not well-monitored. The practice manager was aware of the updates one of the new practice nurses had attended. They held little training information for the other recently employed nurse, although they had a certificate for cervical screening update from January 2017. Following the inspection the practice provided further evidence of nurse training.
- The practice provided protected time for staff to complete training. This was usually on-line training, but the practice manager told us practice meetings were also used to update staff. The healthcare assistant gave us examples of how they had progressed in their role by attending training that had been agreed with the partners.
- The practice manager kept training information for all staff, but this indicated that there were gaps in training, for example in safeguarding, fire safety and infection prevention and control. Following the inspection the practice told us staff had been instructed to complete on-line mandatory training by 1 September 2018.
- The practice did not provide staff with ongoing support. The practice manager told us that a GP had intended to carry out appraisals for staff, but this had not started. We saw no evidence in personnel files of staff receiving previous appraisals, and the practice manager told us they last had an appraisal in 2008. Following the inspection the practice told us staff had now been appraised, and senior staff appraisals had been scheduled for September and October 2018.
- Staff induction was not consistent. We saw an induction checklist in some staff files but not others, including those recently employed.

Coordinating care and treatment

Staff worked together and with other health and social care professionals to deliver effective care and treatment.

- We saw records that showed that appropriate staff, including those in different teams and organisations, were involved in assessing, planning and delivering care and treatment.
- A counsellor from the drug misuse service attended the practice weekly.
- The practice shared clear and accurate information with relevant professionals when deciding care delivery for people with long term conditions and when coordinating healthcare for care home residents. They shared information and liaised with community

services, social services and carers for housebound patients and with health visitors and community services for children who have relocated into the local area.
- Patients received coordinated and person-centred care. This included when they moved between services, when they were referred, or after they were discharged from hospital. The practice worked with patients to develop personal care plans that were shared with relevant agencies.
- The practice ensured that end of life care was delivered in a coordinated way which took into account the needs of different patients, including those who may be vulnerable because of their circumstances.

Helping patients to live healthier lives

Staff were consistent in helping patients to live healthier lives.

- The practice identified patients who may be in need of extra support and directed them to relevant services.
- Staff encouraged and supported patients to be involved in monitoring and managing their own health, for example through social prescribing schemes. Staff discussed changes to care or treatment with patients and their carers as necessary.
- The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns, tackling obesity.

Consent to care and treatment

The practice obtained consent to care and treatment in line with legislation and guidance.

- Clinicians understood the requirements of legislation and guidance when considering consent and decision making.
- Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.

Please refer to the Evidence Tables for further information.

Good

Are services caring?

We rated the practice as good for caring.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- Feedback from patients was positive about the way staff treat people.
- Staff understood patients' personal, cultural, social and religious needs.
- The practice gave patients timely support and information.

Involvement in decisions about care and treatment

Staff helped patients to be involved in decisions about care and treatment.

- Staff communicated with people in a way that they could understand, for example, communication aids and easy read materials were available.
- Staff helped patients and their carers find further information and access community and advocacy services. They helped them ask questions about their care and treatment.
- The practice identified carers and supported them.

Privacy and dignity

The practice respected/did not respect patients' privacy and dignity.

- Reception staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.
- Staff recognised the importance of people's dignity and respect. They challenged behaviour that fell short of this.

Please refer to the Evidence Tables for further information.

Good

Are services responsive to people's needs?

We rated the practice, and all of the population groups, as good for providing responsive services.

Responding to and meeting people's needs

The practice organised and delivered services to meet patients' needs. It took account of patient needs and preferences.

- The practice understood the needs of its population and tailored services in response to those needs.
- Telephone consultations were available which supported patients who were unable to attend the practice during normal working hours.
- The facilities and premises were appropriate for the services delivered.
- The practice made reasonable adjustments when patients found it hard to access services.
- Care and treatment for patients with multiple long-term conditions and patients approaching the end of life was coordinated with other services.

Older people:

- All patients had a named GP who supported them in whatever setting they lived, whether it was at home or in a care home or supported living scheme.
- A GP carried out a weekly ward round at a nursing home in the area.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs. The GP and practice nurse also accommodated home visits for those who had difficulties getting to the practice due to limited local public transport availability.

People with long-term conditions:

- Patients with a long-term condition received an annual review to check their health and medicines needs were being appropriately met. Multiple conditions were reviewed at one appointment, and consultation times were flexible to meet each patient's specific needs.
- The practice held meetings, in person or by telephone, with the local district nursing team to discuss and manage the needs of patients with complex medical issues.

Families, children and young people:

- We found there were systems 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 accident and emergency (A&E) attendances. Records we looked at confirmed this.
- Parents or guardians calling with concerns about a child under the age of five were offered a same day appointment when necessary, and the practice gave same day appointments to older children where possible.

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

- The needs of this population group 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 open until 8pm three evenings a week, telephone appointments were available, and extended hours/weekend appointments were also available to patients at a nearby practice.

People whose circumstances make them vulnerable:

- The practice held a register of patients living in vulnerable circumstances including those with a learning disability.
- People in vulnerable circumstances were able to register with the practice, including those with no fixed abode.

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

- Staff interviewed had a good understanding of how to support patients with mental health needs and those patients living with dementia.
- These patients who failed to attend were proactively followed up by a phone call from a GP.

Timely access to care and treatment

Patients were able to access care and treatment from the practice within an acceptable timescale for their needs.

- Patients had timely access to initial assessment, test results, diagnosis and treatment.
- Waiting times, delays and cancellations were minimal and managed appropriately.
- Patients with the most urgent needs had their care and treatment prioritised.

Good

Are services responsive to people's needs?

- Patients reported that the appointment system was easy to use.

Listening and learning from concerns and complaints

The practice took complaints and concerns seriously and responded to them appropriately to improve the quality of care.

- Information about how to make a complaint or raise concerns was available. Staff treated patients who made complaints compassionately.
- The complaint policy and procedures were in line with recognised guidance. The practice learned lessons from individual concerns and complaints and also from analysis of trends. It acted as a result to improve the quality of care.

Please refer to the Evidence Tables for further information.

Requires improvement

Are services well-led?

We rated the practice and all of the population groups as requires improvement for providing a well-led service.

The practice was rated as requires improvement for providing well-led services because:

- Governance arrangements did not provide assurance that the practice functioned well. For example, training was missing and there was little evidence of support for staff.
- Systems and processes were not being followed. Although there was an in-depth significant event and recruitment policy these were not being followed.
- Arrangements were not in place to monitor safety. For example, the fire risk assessment had not been monitored to ensure premises were safe and risk assessments did not provide assurance that risks had been actioned.

Leadership capacity and capability

Leaders did not have the capacity and skills to deliver high-quality, sustainable care.

- Leaders were not knowledgeable about all the issues and priorities relating to the quality and future of services. They kept up to date with clinical aspects of practice, but we did not see a wider understanding of the service, such as having effective recruitment processes.
- Leaders were visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership.
- Succession planning to ascertain the future leadership of the practice had not been discussed.

Vision and strategy

The practice did not have a clear vision and credible strategy to deliver high quality, sustainable care.

- There was no clear vision and set of values.
- The practice had a mission statement displayed on their website, but staff were not aware of it.

Culture

The practice had a culture of high-quality sustainable care.

- Staff stated they felt respected, supported and valued. They were proud to work in the practice.
- The practice focused on the needs of patients.
- Leaders and managers acted on behaviour and performance issues.
- Openness, honesty and transparency were usually demonstrated when responding to incidents and complaints. The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour.
- Staff we spoke with told us they were able to raise concerns and were encouraged to do so. They had confidence that these would be addressed.
- Processes for providing staff with the development they needed were not consistent. Appraisals and career development conversations had been a low priority. The practice manager had not had an appraisal for 10 years and we did not see evidence of appraisal in the personnel files of administrative staff.
- There were positive relationships between staff and teams.

Governance arrangements

Clear responsibilities, roles and systems of accountability to support good governance and management were not in place.

- Structures, processes and systems to support good governance and management were not set out.
- The practice had failed to act on concerns raised during the previous CQC inspection.
- Staff were clear on their roles and accountabilities, although several staff did not have up to date training in safeguarding and infection prevention and control.
- Practice leaders had established policies, procedures and activities to ensure safety and assured themselves that they were operating as intended. However we saw these policies were not always followed. For example, the significant event policy stated that when a significant event was raised it would be added to the agenda for the next practice meeting. We did not see evidence of this. The recruitment policy also gave clear guidelines about the process to follow, but this did not happen.

Managing risks, issues and performance

Requires improvement

Are services well-led?

Processes for managing risks, issues and performance were not always clear.

- The process to identify, understand, monitor and address current and future risks including risks to patient safety was not effective. For example, safety checks for the Royton site were mainly carried out by the building managers. We saw no evidence of checks taking place at the Shaw site during the inspection. Following the inspection evidence of some safety checks was received but the fire risk assessment that should be updated annually had not been updated since 2015.
- The practice had processes to manage current and future clinical performance of GPs. Practice leaders had oversight of national and local safety alerts, incidents, and complaints.
- Clinical audit had a positive impact on quality of care and outcomes for patients. There was clear evidence of action to change practice to improve quality.
- The practice had plans in place for major incidents at the Royton site. However, there was no business continuity plan for the Shaw site. Following the inspection the practice told us that the business continuity plan for 'The Parks Medical Practice' related to both sites. However they said they would divide the plan into two sections for clarity.

Appropriate and accurate information

The practice acted on appropriate and accurate information.

- Quality and operational information was used to ensure and improve performance. Performance information was combined with the views of patients.
- Quality was discussed in relevant meetings.
- The practice used performance information which was reported and monitored and management and staff were held to account.
- The information used to monitor performance and the delivery of quality care was accurate and useful. There were plans to address any identified weaknesses.
- The practice used information technology systems to monitor and improve the quality of care.
- The practice submitted data or notifications to external organisations as required.
- There were robust arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

Engagement with patients, the public, staff and external partners

The practice tried to involve patients, the public, staff and external partners to support high-quality sustainable services.

- The practice was in the process of re-launching their patient participation group (PPG). The practice manager was liaising with another practice for advice on setting up a virtual PPG as they had struggled to encourage patients to attend meetings.
- The service was transparent, collaborative and open with stakeholders about performance.

Continuous improvement and innovation

There was some evidence of systems and processes for learning, continuous improvement and innovation.

- We did not see a focus on continuous learning and improvement. There were gaps in mandatory training for staff.
- The practice made use of internal and external reviews of incidents and complaints. Learning was shared during meetings.

Please refer to the Evidence Tables for further information.

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 the service provider was not meeting. The provider must send CQC a report that says what action it is 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 **The registered person had ineffective systems or processes in place in that they failed to enable the registered person to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk. In particular:** • The registered person did not have an adequate system to monitor and learn from significant events. • The practice did not follow their recruitment policy or process, or their significant event policy. **The registered person did not always assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity. In particular:** • There was insufficient emphasis on health and safety processes Fire risk assessments and other safety checks were not well-monitored. • Mandatory training required to assure health, safety and welfare was not always undertaken. This included safeguarding, fire, infection control and chaperoning training. • Some processes required to ensure the safety of service users were not effective. For example, an out of date syringe was found amongst syringes within their expiry date. **This was in breach of regulation 17 (1) 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 the service provider was not meeting. The provider must send CQC a report that says what action it is going to take to meet these. We took enforcement action because the quality of healthcare required significant improvement.

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 The registered person did not always assess the risks to the health and safety of service users of receiving the care or treatment. In particular: • Although some actions had been completed following a fire risk assessment at the Shaw site, these had not been formally monitored and the fire risk assessment had not been updated. • Some health and safety checks were carried out at the Shaw site but these did not provide assurance that safety was given sufficient priority. • There had been no discussion or risk assessment carried out to determine what emergency medicines should be available. • No antibiotic medicines were available on the emergency trolley and their need had not been assessed. 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 Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing The registered person had failed to ensure that persons employed in the provision of a regulated activity received such appropriate support, training, professional development, supervision and appraisal as was necessary to enable them to carry out the duties they were employed to perform. In particular:

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Enforcement actions

•The provider did not ensure all staff had appropriate training and did not monitor training.

•The provider did not ensure all staff had appropriate supervision and appraisals.

•Evidence of staff induction was not consistent.

This was in breach of regulation 18 (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 19 HSCA (RA) Regulations 2014 Fit and proper persons employed The registered person did not have systems and processes in place to ensure staff were of good character or had the required qualifications, skills or experience required for their role. In particular: •Not all relevant pre-employment checks were carried out. Not all information required under Schedule 3 was requested for staff. This was in breach of regulation 19 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.