# Forty Willows Surgery

## Quality Report

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

## Ratings

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

# Summary of findings

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## Overall summary

**Letter from the Chief Inspector of General Practice**

We carried out an announced comprehensive inspection at Forty Willows Surgery on 28 September 2017. Overall the practice is rated as requires improvement.

Forty Willows Surgery was previously inspected in October 2014 and was rated as good. The full comprehensive report on the October 2014 inspection can be found by selecting the 'all reports' link for Forty Willows Surgery on our website at www.cqc.org.uk.

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses.
- There were inconsistent arrangements in how risks were assessed and managed. For example we found risks relating to management of legionella, health and safety related risk assessments, safeguarding vulnerable adults and children training, basic life support training and management of blank prescription forms for use in printers which had not been monitored appropriately.
- The practice was unable to demonstrate that all appropriate recruitment checks had been undertaken prior to employment.
- The practice had a number of policies and procedures to govern activity, but most were not updated and reviewed regularly. Safeguarding policies did not include the correct name for lead staff.
- Data showed patient outcomes were low for cervical, breast and bowel cancer national screening programme uptake and medicines reviews for patients with long term conditions.
- The practice was unable to demonstrate that all staff had received up to date training relevant to their role. Staff appraisals had not always been completed in a timely manner.
- We found that completed clinical audits cycles were driving positive outcomes for patients in some cases.

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- Patients we spoke with on the day informed us they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Most of the patient's feedback we received on the day informed us they were able to get appointments when they needed them.
- There was a clear leadership structure and staff felt supported by management. However, there was limited evidence that the practice had proactively sought feedback from staff and patients.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- The provider was aware of the requirements of the duty of candour.

The areas where the provider must make improvements 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 recruitment procedures are established and operated effectively to ensure only fit and proper persons are employed.
- 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.

In addition the provider should:

- Review and improve the systems in place to effectively monitor face to face reviews of patients with dementia.
- Continue to monitor practice performance relating to exception reporting under the Quality Outcomes Framework.
- Provide patient information in languages and formats suitable to the patient population.
- Review the system in place to promote the benefits of cervical, breast and bowel cancer national screening in order to increase patient uptake.
- Review and monitor the system in place to assure that all confidential documents are disposed of in a safe manner.

**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.

- Although risks to patients who used services were assessed, the systems and processes to address these risks were not always implemented to ensure patients were kept safe. For example, we found gaps in safeguarding children and safeguarding vulnerable adults training, basic life support training, recruitment checks, management of legionella and management of blank prescription forms.
- There was a lead member of staff for safeguarding. However, safeguarding policies had not identified the correct lead name.
- The practice was unable to demonstrate that they had adequate health and safety related risk assessments and processes in place to ensure safety of the premises and patients.
- From the sample of documented examples we reviewed, we found there was an effective system for reporting and recording significant events; lessons were shared to make sure action was taken to improve safety in the practice.
- When things went wrong patients were informed as soon as practicable, received reasonable support, truthful information, and a written apology. They were told about any actions to improve processes to prevent the same thing happening again.
- The practice had adequate arrangements to respond to emergencies and major incidents.

**Are services effective?**

Requires improvement

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

- The practice was unable to demonstrate their monitoring of medicines reviews for patients with long term conditions was always effective.
- The practice could not demonstrate that all staff had received an annual appraisal in a timely manner and completed training relevant to their role.
- The practice could not demonstrate that their current system to promote the benefits of breast and bowel cancer screening was always effective.

# Summary of findings

- Data from the Quality and Outcomes Framework 2015-16 showed patient outcomes were at or above average compared to the national average. However, the level of exception reporting (12%) was above the CCG average (9%) and the national average (10%).
- Staff were aware of current evidence based guidance.
- Clinical audits demonstrated quality improvement.
- Staff worked with other health care professionals to understand and meet the range and complexity of patients' needs.
- End of life care was coordinated with other services involved.

**Are services caring?**

Good

The practice is rated as good for providing caring services.

- Data from the national GP patient survey showed patients rated the practice comparably to the local and national averages for several aspects of care.
- Patients we spoke with said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.
- Information for patients about the services was available. However, limited information was available in different languages and formats.
- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.

**Are services responsive to people's needs?**

Good

The practice is rated as good for providing responsive services.

- The practice understood its population profile and had used this understanding to meet the needs of its population. For example, the practice was offering an in-house phlebotomy service, resulting in patients who required this service not having to travel to local hospitals. Patients from other local practices were also able to book appointment for phlebotomy service at the practice.
- The practice took account of the needs and preferences of patients with life-limiting conditions, including patients with a condition other than cancer and patients living with dementia.
- Most of the patient's feedback we received on the day informed us they were able to get appointments when they needed them.
- The practice had good facilities and was well equipped to treat patients and meet their needs.

# Summary of findings

- Information about how to complain was available and evidence from eight examples reviewed showed the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.

**Are services well-led?**

**Requires improvement**

The practice is rated as requires improvement for being well-led.

- There was a governance framework. However, monitoring of specific areas required improvement, such as management of blank prescriptions, management of legionella, recruitment checks and medicines reviews for patients with long term conditions.
- The practice had a vision and a strategy but not all staff were aware of their lead role. There was a leadership structure and most staff felt supported by management.
- The practice had a number of policies and procedures to govern activity, but most of these were overdue a review.
- The practice was unable to demonstrate that they had proactively sought feedback from staff or patients and did not have an active patient participation group.
- The practice had not ensured that all relevant health and safety related risk assessments were carried out in a timely manner.
- Not all staff had received regular annual appraisals and we found significant gaps in staff training.
- The practice held regular governance and staff team meetings.
- The practice was aware of and complied with the requirements of the Duty of Candour.

# 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

Requires improvement

The practice is rated as requires improvement for the care of older people. The provider was rated as inadequate for safe and requires improvement for effective and well-led. The concerns which led to these ratings apply to everyone using the practice, including this population group.

- The practice offered proactive, personalised care to meet the needs of the older patients in its population.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs.
- The practice identified at an early stage older patients who may need palliative care as they were approaching the end of life. It involved older patients in planning and making decisions about their care, including their end of life care.
- The practice followed up on older patients discharged from hospital and ensured that their care plans were updated to reflect any extra needs.
- The premises was accessible to those with limited mobility. However, the practice did not provide a low level desk at the front reception.
- There were good working relationships with external services such as district nurses.
- Where older patients had complex needs, the practice shared summary care records with local care services.
- The practice was performing an electrocardiogram (ECG) and blood tests on-site.

### People with long term conditions

Requires improvement

The practice is rated as requires improvement for the care of people with long-term conditions. The provider was rated as inadequate for safe and requires improvement for effective and well-led. The concerns which led to these ratings apply to everyone using the practice, including this population group.

- There were clinical leads for long-term disease management and patients at risk of hospital admission were identified as a priority.
- Data from 2015/2016 QOF showed performance for diabetes related indicators was above the CCG and national averages. However, improvement was required in some areas. For example the percentage of patients with diabetes, on the

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register, in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less (01/04/2015 to 31/03/2016) was 70% compared to the CCG average of 80% and national average of 78%. Exception reporting for this indicator was 12% compared to the CCG average of 9% and national average of 9%.

- The practice followed up on patients with long-term conditions discharged from hospital and ensured that their care plans were updated to reflect any additional needs.
- There were emergency processes for patients with long-term conditions who experienced a sudden deterioration in health.
- All these patients had a named GP. For those patients with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care. However, a system to recall patients for a structured annual review had not been effective and the practice had not undertaken medicine reviews routinely for patients with long term conditions.

**Families, children and young people**

**Requires improvement**

The practice is rated as requires improvement for the care of families, children and young people. The provider was rated as inadequate for safe and requires improvement for effective and well-led. The concerns which led to these ratings apply to everyone using the practice, including this population group.

- From the sample of documented examples we reviewed 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.
- Immunisation rates were comparable for all standard childhood immunisations.
- The practice's uptake for the cervical screening programme was 75%, which was below the CCG average of 77% and the national average of 81%.
- Children and young people were treated in an age-appropriate way and were recognised as individuals.
- Appointments were available outside of school hours and the premises were suitable for children and babies.
- The practice worked with midwives, health visitors and school nurses to support this population group.
- The practice had emergency processes for acutely ill children and young people and for acute pregnancy complications.

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

Requires improvement

The practice is rated as requires improvement for the care of working age people (including those recently retired and students). The provider was rated as inadequate for safe and requires improvement for effective and well-led. The concerns which led to these ratings apply to everyone using the practice, including this population group.

- The needs of these populations had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care, for example, extended opening hours appointments.
- The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group. The practice informed us that 31% patients were registered for these services.
- Health promotion advice was offered but there was limited accessible health promotion material available through the practice.

**People whose circumstances may make them vulnerable**

Requires improvement

The practice is rated as requires improvement for the care of people whose circumstances may make them vulnerable. The provider was rated as inadequate for safe and requires improvement for effective and well-led. The concerns which led to these ratings apply to everyone using the practice, 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.
- Annual health checks and care plans were completed for patients on the learning disability register.
- 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 offered longer appointments for patients with a learning disability.
- The practice regularly worked with other health care professionals in the case management of vulnerable patients.
- The practice had information available for vulnerable patients about how to access various support groups and voluntary organisations.
- Staff interviewed knew how to recognise signs of abuse in children, young people and adults whose circumstances may

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make them vulnerable. They 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, we saw safeguarding policies had not included the correct name for a lead member of staff and there were gaps in safeguarding vulnerable adults training.

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

Requires improvement

The practice is rated as requires improvement for the care of people experiencing poor mental health (including people with dementia). The provider was rated as inadequate for safe and requires improvement for effective and well-led. The concerns which led to these ratings apply to everyone using the practice, including this population group.

- Data from 2015-16 showed, performance for dementia face to face reviews was below the CCG and national averages. The practice had achieved 79% of the total number of points available, compared to 86% locally and 84% nationally.
- Patients experiencing poor mental health were involved in developing their care plan and health checks.
- The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those living with dementia.
- Patients at risk of dementia were identified and offered an assessment.
- The practice had information available for patients experiencing poor mental health about how they could access various support groups and voluntary organisations.
- The practice had a system to follow up patients who had attended accident and emergency where they may have been experiencing poor mental health.
- Staff interviewed had a good understanding of how to support patients with mental health needs and dementia. However, not all staff had received training on how to care for patients with mental health needs.

# Summary of findings

## What people who use the service say

The national GP patient survey results published on 6 July 2017 showed the practice was performing in line with the local and the national averages for all of its satisfaction scores. Three hundred and eighty-seven survey forms were distributed and 129 were returned (a response rate of 33%). This represented about 1.9% of the practice's patient list.

- 86% of patients described the overall experience of this GP practice as good compared with a CCG average of 79% and a national average of 85%.
- 70% of patients described their experience of making an appointment as good compared with the CCG average of 67% and the national average of 73%.
- 77% of patients said they would recommend this practice to someone new to the area compared with the CCG average of 69% and the national average of 77%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. Sixteen of the twenty six patient CQC comment cards we received were positive about the service experienced. Five comment cards were negative and five were neutral which highlighted some concerns about the access to the service and delay in processing time of the repeat prescription requests. Patients providing positive feedback said they were satisfied with the standard of care received and thought staff were approachable, committed and caring.

We spoke with two patients during the inspection. Patients we spoke with were positive about the care and treatment offered by the GPs and nurses at the practice, which met their needs. They said staff treated them with dignity and their privacy was respected.

# Forty Willows Surgery

**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 advisor.

## Background to Forty Willows Surgery

Forty Willows Surgery is situated in in Wembley in North West London within converted premises with car parking for patients and staff. All patient services are offered on the ground and first floors. The premises comprises of seven consulting rooms, two treatment rooms, a patient waiting area, a reception area, administrative and management office.

The practice has core opening hours from 9am to 6.30pm Monday to Friday with the exception of every Wednesday (closed at 1pm). On the day of inspection the practice informed us they have decided to open on Wednesday afternoons from the first week of October 2017. Telephone calls are answered from 8.45am. The practice is closed from 1pm to 3pm on every Monday and from 1pm to 2pm on every Tuesday, Thursday and Friday. When the practice is closed in the mornings and on Wednesday afternoon, patients are directed to the out-of-hours service. The out-of-hours service is able to contact one of the practice oncall GPs. During the lunch time closure this out of hours service is managed internally by the practice by using their internal emergency on call protocol. The practice has published information about this at the practice website and on the practice leaflet.

The practice offers a range of scheduled appointments to patients every weekday from 9am to 5.50pm including open access appointments with a duty GP throughout the day. The practice offers extended hours appointments every Tuesday evening until 8pm.

The practice has a patient population of approximately 6,670 registered patients. The practice population of patients aged between 5 to 14 and 25 to 54 years old is higher than the national average and there is lower number of patients aged above 60 years old compared to national average.

Ethnicity based on demographics collected in the 2011 census shows the patient population is ethnically diverse and 68% of the population is composed of patients with an Asian, Black, mixed or other non-white background.

There are three GP partners, a salaried GP, two trainee GPs at the practice. Four GPs are female and two male, who work a total of 25 sessions. The practice employs a practice nurse and a health care assistant. The practice manager is supported by a team of administrative and reception staff. Services are provided via a General Medical Services (GMS) contract (GMS contracts are negotiated nationally between GP representatives and the NHS).

This is a training practice, where a doctor who is training to be qualified as a GP has access to a senior GP throughout the day for support. We received positive feedback from the trainee we spoke with.

Services are provided from the following location which we visited during this inspection:

46 Forty Lane

Wembley

London

HA9 9HA

# Detailed findings

The practice has opted out of providing out of hours services to their patients. There are arrangements in place for services to be provided when the practice is closed and these are displayed at the practice, in the practice information leaflet and on the patient website. Out of hours services are provided by Care UK or after 6:30pm, weekends and bank holidays by calling NHS 111.

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

## 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. This inspection took place on 28 September 2017 and 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.

We carried out a previous comprehensive inspection in October 2014. Overall the practice was rated as good during the previous inspection. The full comprehensive report on the October 2014 inspection can be found by selecting the 'all reports' link for Forty Willows Surgery on our website at www.cqc.org.uk.

## How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations, such as the local clinical commissioning group, NHS England area team and local Healthwatch to share what they knew. We also spent time reviewing information provided by the practice in advance of the inspection.

The inspection team carried out an announced visit on 28 September 2017. During our visit we:

- Spoke with a range of staff (GP partners, trainee GPs, practice nurse, practice manager, administrative and reception staff) and spoke with patients who used the service.
- Collected written feedback from six members of staff.
- Observed how patients were being cared for in the reception area and talked with carers and/or family members.
- Reviewed a 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.
- Looked at information the practice used to deliver care and treatment plans.

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 living with dementia).

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

Inadequate

# Are services safe?

## Our findings

**Safe track record and learning**

There was a system for reporting and recording significant events.

- Staff told us they would inform the practice manager of any incidents and there was a recording form available on the practice's computer system. The incident recording form supported 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).
- From the sample of seven documented examples we reviewed we found that when things went wrong with care and treatment, patients were informed of the incident as soon as reasonably practicable, received reasonable support, truthful information, a written apology and were told about any actions to improve processes to prevent the same thing happening again.
- We reviewed safety records, incident reports, patient safety alerts and minutes of meetings where significant events were discussed. The practice carried out a thorough analysis of the significant events.
- We saw evidence that lessons were shared and action was taken to improve safety in the practice. For example, we reviewed a significant event analysis following a prescribing incident caused due to an incorrect dosage entered into the practice's computer system when information was transferred from the hospital discharge summary. The practice had carried out an investigation, revised the protocol and advised all GPs to be extra vigilant when reading discharge summaries. The practice had implemented a change which included that a second GP must double check the prescription when new medicines were added following a hospital visit.
- The practice also monitored trends in significant events and evaluated any action taken.

**Overview of safety systems and processes**

The practice had some processes and practices in place to keep patients safe and safeguarded from abuse, however improvements were required.

- Arrangements for safeguarding reflected relevant legislation and local requirements. Policies were accessible to all staff. The policies had 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 but both safeguarding children and safeguarding vulnerable adults policies had not included the correct lead name for safeguarding. The GPs attended safeguarding meetings when possible and always provided reports where necessary for other agencies.
- Staff interviewed demonstrated they understood their responsibilities regarding safeguarding. We noted all staff had completed safeguarding children training relevant to their role. However, the practice was unable to demonstrate that a practice nurse and all non-clinical staff had completed training in safeguarding for vulnerable adults.
- A notice in the waiting room advised patients that chaperones were available if required. 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). However, the practice was unable to demonstrate that 10 out of 11 staff who could act as chaperones were trained for the role.

The practice maintained appropriate standards of cleanliness and hygiene.

- We observed the premises to be clean and tidy. There were cleaning schedules and monitoring systems in place.
- One of the GP partners and the practice nurse were the infection prevention and control (IPC) clinical leads who liaised with the local infection prevention teams to keep up to date with best practice. There was an IPC procedure in place but it was not dated and did not include name of the author. Names of lead members of staff were mentioned in an IPC procedure but the practice nurse (joint IPC lead) we spoke with was not aware about the lead role. The practice had undertaken a joint IPC audit on 19 September 2017 with Clinical Commissioning Group (CCG) IPC lead. The practice informed us they had already taken some actions and was in the process of developing an action plan to address the other issues identified during recent IPC

audit. The practice was unable to provide records to demonstrate that four GPs (a GP partner, a salaried GP and two trainee GPs) and a non-clinical staff member had received up to date IPC training.
- We found the fabric of chairs in the waiting area needed repairing and in the current state would be difficult to clean the surface properly.

The arrangements for managing medicines, including emergency medicines and vaccines, in the practice minimised risks to patient safety (including obtaining, prescribing, recording, handling, storing, security and disposal) with the exception of management of blank prescription forms.

- There were processes for handling repeat prescriptions which included the review of high risk medicines. Repeat prescriptions were signed before being dispensed to patients and there was a reliable process to ensure this occurred. However, we saw the notices were displayed in the premises and the practice was processing requests for repeat prescriptions within 72 hours instead of within 48 hours.
- Regular medicine audits were carried out to ensure the practice was prescribing in line with best practice guidelines for safe prescribing. Patient Group Directions had been adopted by the practice to allow nurses to administer medicines in line with legislation. Health care assistants were trained to administer vaccines and medicines and patient specific prescriptions or directions from a prescriber were produced appropriately.
- The practice did not have an effective system in place to monitor the use of blank prescription forms. Blank prescription forms for use in printers were not handled in accordance with national guidance as these were not tracked through the practice and kept securely at all times. On the day of inspection we found blank prescription printer forms were stored in unlocked printers in unlocked consulting rooms and these were not locked away at night from the printers. We saw handwritten pads were securely stored and tracked through the practice.
- We reviewed four personnel files and found appropriate recruitment checks had not always been undertaken prior to employment. For example, proof of identification, evidence of satisfactory conduct in previous employments in the form of references, health checks, interview records and contract of employment were not available for some staff. We found that the records of Disclosure and Barring Service (DBS) checks, qualifications and registration with the appropriate professional body were available on the day of inspection.

**Monitoring risks to patients**

There were some procedures in place for assessing, monitoring and managing risks to patient and staff safety, however improvements were required.

- A health and safety policy was not dated and did not carry any information that identified it as pertaining to the practice. There was a health and safety poster displayed in the communal area.
- The practice was unable to provide documentary evidence to demonstrate that a fire risk assessment had been carried out. The practice was not carrying out regular fire drills. However, we saw the practice had procedures in place to monitor fire safety at the premises. The practice had an electronic fire detection and alarm system installed in the premises which was serviced on 13 September 2017. We noted the practice had carried out the smoke alarm checks on 21 September 2017. Fire extinguishers were checked in July 2017.
- The practice was unable to provide documentary evidence to demonstrate that all staff were up to date with fire safety training.
- All electrical and clinical equipment was checked and calibrated to ensure it was safe to use and was in good working order.
- The practice had not carried out all risk assessments required to monitor safety of the premises such as control of substances hazardous to health (COSHH) risk assessment, electrical installation condition report and an asbestos survey.
- The practice Legionella (a bacterium which can contaminate water systems in buildings) risk assessment had expired on 31 August 2013. However, the practice informed us that a recent risk assessment had been carried out by an external contractor two days before the inspection. The practice was waiting to receive a formal written report but we saw a handwritten site report which had identified number of concerns during the recent risk assessment. We noted the practice was not carrying out regular water temperature checks.

Inadequate

# Are services safe?

- There were arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system to ensure enough staff were on duty to meet the needs of patients.

**Arrangements to deal with emergencies and major incidents**

The practice had most arrangements to respond to emergencies and major incidents, however improvements were required.

- There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency.
- The practice was unable to demonstrate that all staff had received annual basic life support training in the last 12 months. For example, a salaried GP had received training in August 2016, a health care assistant in February 2016 and most non-clinical staff in September 2015. The practice was unable to demonstrate that a trainee GP and a practice nurse had received annual basic life support training.
- There were emergency medicines available in the treatment room.
- The practice had a defibrillator available on the premises and oxygen with adult and children's masks. A first aid kit and accident book were available.
- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and stored securely.
- The practice had a comprehensive business continuity plan for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff.

Requires improvement

# Are services effective?

(for example, treatment is effective)

## Our findings

**Effective needs assessment**

Clinicians were aware of relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines.

- The practice had systems 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 risk assessments, audits and random sample checks of patient records.

**Management, monitoring and improving outcomes for people**

The practice used the information collected for the Quality 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). In 2015-16, the practice had achieved 99% of the total number of points available, compared to 96% locally and 95% nationally, with 12% exception reporting. The level of exception reporting was above the CCG average (9%) and the national average (10%). Exception reporting is the percentage of patients who would normally be monitored but had been exempted from the measures. These patients are excluded from the QOF percentages as they have either declined to participate in a review, or there are specific clinical reasons why they cannot be included.

We noted that the practice followed the national QOF protocol for inviting patients three times for the review of their long term conditions and all potential exceptions of the patient from the recall programme were reviewed by a GP. During this inspection in September 2017 we noted the practice had identified the high levels of exception reporting as an area for improvement and formulated action plan to reduce exception reporting.

Data from 2015-16 showed;

- Performance for mental health related indicators was above the CCG and national average. The practice had achieved 100% of the total number of points available, compared to 92% locally and 93% nationally.
- Performance for diabetes related indicators was above the CCG and national average. The practice had achieved 97% of the total number of points available, compared to 87% locally and 90% nationally.
- The percentage of patients with hypertension having regular blood pressure tests was lower than the CCG and national average. The practice had achieved 79% of the total number of points available, compared to 83% locally and 83% nationally.

The practice had not undertaken medicine reviews routinely for patients with long term conditions. For example, we found:

- On average 32% of structured annual medicines reviews had been undertaken for patients with long term conditions including diabetes, chronic heart disease and dementia; and 90% for patients with asthma and chronic obstructive pulmonary disease.
- The practice had undertaken 19% of repeat medicines reviews of patients on less than four repeat medicines.
- The practice had undertaken 54% of repeat medicines reviews of patients on four or more repeat medicines.

The practice was aware of shortfall in medicine reviews, understood the challenges in engaging with their practice population and recognised that they were required to improve the outcomes for patients with long term conditions. The practice informed us that they had recruited a new clinical pharmacist to take the lead role in carrying out medicine reviews for patients with long term conditions.

There was evidence of quality improvement including clinical audit:

- There had been five clinical audits commenced in the last two years, two of these were completed audits where the improvements made were implemented and monitored.
- Findings were used by the practice to improve services. For example, we saw evidence of repeated audit cycle of patients with atrial fibrillation (AF) (AF is a heart condition that caused an irregular and often abnormally fast heartbeat that could lead to blood clots, stroke, heart failure and other heart-related complications) not receiving anti-coagulation treatment (anticoagulants medicines were used to reduce the body's ability to form clots in the blood and prevent stroke).

Requires improvement

# Are services effective?

## (for example, treatment is effective)

- The aim of the audit was to identify and offer treatment to the patients with AF who required anti-coagulation treatment. The audit in 2013 demonstrated that 57% of patients with AF were receiving anti-coagulation treatment. The practice reviewed their protocol and invited patients for medicine reviews. We saw evidence that the practice had carried out a follow up audit in 2015 which demonstrated improvements in patient outcomes and found 69% AF patients were receiving anti-coagulation treatment. The practice had carried out the second follow up audit in 2017 which demonstrated continuous improvements in patient outcomes and found 76% AF patients were receiving anti-coagulation treatment.

**Effective staffing**

Most staff had the skills, knowledge and experience to deliver effective care and treatment. However not all staff had received training relevant to their role and some staff had not received regular support through annual appraisals.

- The practice had an induction programme for all newly appointed staff. This covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality. We spoke with a trainee GP who told us they had had an in-depth induction when they started and had continual supervision from in in-house clinical GP trainer.
- Staff administering vaccines and taking samples for the cervical screening programme had received specific training which had included an assessment of competence. Staff who administered vaccines could demonstrate how they stayed up to date with changes to the immunisation programmes, for example by access to on line resources and discussion at practice meetings.
- There was limited evidence that the learning needs of staff were identified through a system of appraisals and reviews of practice development needs. A health care assistant and all 11 non-clinical staff had not received an appraisal in the last 12 months. For example, we noted seven staff had not received appraisals since mid 2015 and two staff since mid 2016. In addition, the practice was unable to demonstrate that two staff had received an appraisal.
- Staff had limited access to appropriate training to meet their learning needs and to cover the scope of their work. The practice was unable to provide documentary evidence that all staff had received training relevant to their role. We identified gaps in the following training: safeguarding vulnerable adults (a practice nurse and all non-clinical staff), health and safety (a GP partner, a salaried GP, a practice nurse, a health care assistant and nine non-clinical staff), equality and diversity (a practice nurse, a health care assistant and six non-clinical staff), infection control (a GP partner, a salaried GP and a non-clinical staff), basic life support (a salaried GP, a health care assistant and nine non-clinical staff not completed in the last 12 months), Mental Capacity Act 2005 (a GP partner, a salaried GP, a practice nurse and nine non-clinical staff), chaperoning (a health care assistant and nine non-clinical staff) and fire safety (all clinical and non-clinical staff) had not completed training.
- The practice informed us they had provided ongoing support to trainee GPs and salaried GPs during one-to-one meetings, appraisals, coaching, mentoring, clinical supervision and facilitation and support for the revalidation of doctors.

**Coordinating patient care and information sharing**

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

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

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

Requires improvement

# Are services effective?

## (for example, treatment is effective)

Records showed the practice had systems that identified patients at high risk of admission to hospital and implemented care plans to reduce the risk and where possible avoid unplanned admissions to hospital.

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.

**Consent to care and treatment**

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

- Staff we spoke with understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act (MCA) 2005. However, the practice was unable to provide documentary evidence that all staff had received MCA training relevant to their role.
- When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance.
- Where a patient's mental capacity to consent to care or treatment was unclear the GP or practice nurse assessed the patient's capacity and, recorded the outcome of the assessment.
- The provider informed us that verbal consent was taken from patients for routine examinations and minor procedures and recorded in electronic records. The provider informed us that written consent forms were completed for more complex procedures.
- All clinical staff demonstrated a clear understanding of the Gillick competency test. (These are used to help assess whether a child under the age of 16 has the maturity to make their own decisions and to understand the implications of those decisions).

**Supporting patients to live healthier lives**

Patients who may be in need of extra support were identified by the practice.

- These included patients receiving end of life care, carers, those at risk of developing a long-term condition and those wishing to stop smoking. Patients were signposted to the relevant external services where necessary such as local carer support group.
- The practice was offering opportunistic smoking cessation advice and patients were signposted to a local support group. For example, information from Public Health England in 2015-16 showed 91% of patients (15+ years old) who were recorded as current smokers had been offered smoking cessation support and treatment in last 24 months. This was higher than the CCG average (86%) and to the national average (87%).

The practice's uptake for the cervical screening programme was 75%, which was below the CCG average of 77% and the national average of 81%. There was a policy to offer text message reminders for patients about appointments. The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening. However, the practice was unable to demonstrate how they encouraged uptake of the screening programme by using information in different languages. Data from 2015-16 showed, in total 46% of patients eligible had undertaken bowel cancer screening and 59% of patients eligible had been screened for breast cancer, compared to the national averages of 58% and 73% respectively.

The practice was aware of low cancer screening figures and had identified this as an area that required improvement and had put in place a range of measures to improve patient uptake and to catch up with patients that had previously been missed. The practice had invited an external consultant to train staff to adapt better tools to promote bowel cancer screening programme. The practice had developed a new patient information leaflet and sending letters in order to increase patient uptake.

Childhood immunisation rates for the vaccines given in 2015-16 were comparable or higher than the national averages. For children under two years of age, four immunisations were measured; each had a target of 90%. The practice achieved the target in two of the four areas; in other two areas the practice scored ranged from 86% to 88%. Childhood immunisation rates for vaccines given to five year olds ranged from 90% to 97%, these were higher than the national averages which ranged from 81% to 92%.

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.

Good

# Are services caring?

## Our findings

**Kindness, dignity, respect and compassion**

During our inspection we observed that 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.
- Consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- 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.
- Patients could be treated by a clinician of the same sex.

Sixteen of the twenty six patient CQC comment cards we received were positive about the service experienced. Five comment cards were negative and five were neutral which highlighted some concerns about the access to the service and delay in processing time of the repeat prescription requests. Patients providing positive feedback said they felt the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect.

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

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

- 84% of patients said the GP was good at listening to them compared to the clinical commissioning group (CCG) average of 86% and the national average of 89%.
- 84% of patients said the GP gave them enough time compared to the CCG average of 82% and the national average of 86%.
- 96% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 94% and the national average of 95%.
- 85% of patients said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 81% and the national average of 86%.
- 89% of patients said the nurse was good at listening to them compared to the CCG average of 84% and the national average of 91%.
- 87% of patients said the nurse gave them enough time compared to the CCG average of 85% and the national average of 92%.
- 95% of patients said they had confidence and trust in the last nurse they saw compared to the CCG average of 94% and the national average of 97%.
- 86% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 84% and the national average of 91%.
- 86% of patients said they found the receptionists at the practice helpful compared to the CCG average of 83% and the national average of 87%.

The practice informed us they were collecting the NHS friends and family test (FFT) results. However, the staff we spoke with were unable to provide the statistics.

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

Patients 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.

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

- 84% of patients said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 83% and national average of 86%.
- 79% of patients said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 78% and national average of 82%.
- 85% of patients said the last nurse they saw was good at explaining tests and treatments compared to the CCG average of 84% and national average of 90%.

Good

# Are services caring?

- 83% of patients said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average of 80% and national average of 85%.

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

- Staff told us that interpretation services were available for patients who did not have English as a first language. However, we did not see notices in the reception areas informing patients this service was available. Patients were also told about multi-lingual staff who might be able to support them.
- Information leaflets were available in easy read format.

**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.

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 158 patients as carers (2.4% of the practice patient list size) and they were being supported, for example, by offering health checks and referral for social services support. Written information was available for carers to ensure they understood the various avenues of support available to them. The practice website also offered additional services including counselling. Comment cards highlighted that staff responded compassionately when patients needed help and provided support when required.

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

Good

# Are services responsive to people's needs?

(for example, to feedback?)

## Our findings

**Responding to and meeting people's needs**

We found the practice was responsive to patient's needs and had systems in place to maintain the level of service provided. The demands of the practice population were understood and systems were in place to address identified needs in the way services were delivered. Many services were provided from the practice including diabetic clinics, mother and baby clinics, travel clinics, minor surgery and a family planning clinic. The practice worked closely with health visitors to ensure that patients with babies and young families had good access to care and support. Services were planned and delivered to take into account the needs of different patient groups and to help provide ensure flexibility, choice and continuity of care. For example;

- There were longer appointments available for patients with a learning disability.
- 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.
- The practice provided patients with the choice of seeing a male or a female GP.
- The practice took account of the needs and preferences of patients with life-limiting progressive conditions. There were early and ongoing conversations with these patients about their end of life care as part of their wider treatment and care planning.
- The practice maintained registers of patients with learning disabilities, dementia and those with mental health conditions. The registers assisted staff to identify these patients in order to help ensure they had access to relevant services.
- There was a system for flagging vulnerability in individual patient records.
- The practice had installed a multilingual touch screen check-in facility to reduce the queue at the reception desk.
- The practice sent text message reminders of appointments and test results.
- Patients were able to receive travel vaccines.
- There were accessible facilities, which included a hearing loop, and interpretation services available.
- Accessible toilet facilities were available for all patients attending the practice. There was a baby changing facility.
- An in-house phlebotomy service was offered onsite, resulting in patients who required this service not having to travel to local hospitals. Patients from other local practices were also able to book appointment for phlebotomy service at the practice.
- The practice installed an automatic floor mounted blood pressure monitor in the premises for patients to use independently.
- Female patients of child bearing age benefitted from a flexible and accessible contraceptive service. Appointments, where coils and implant devices could be fitted were available including outside of school hours.

**Access to the service**

The practice was open from 9am to 6.30pm Monday to Friday with the exception of every Wednesday (closed at 1pm). Telephone calls were answered from 8.45am. The practice was closed from 1pm to 3pm on every Monday and from 1pm to 2pm on every Tuesday, Thursday and Friday. When the practice was closed in the mornings and on Wednesday afternoon, patients were directed to the out-of-hours service. The out-of-hours service was able to contact one of the practice oncall GPs. During the lunch time closure this out of hours service was managed internally by the practice by using their internal emergency on call protocol. The practice published information about this at the practice website and on the practice leaflet. On the day of inspection the practice informed us they had decided to open on Wednesday afternoons from first week of October 2017 and was in the process of finalising the clinical staffing cover.

The practice offered a range of scheduled appointments to patients from 9am to 5.50pm including open access appointments with a duty GP throughout the day. In addition to pre-bookable appointments that could be booked up to two weeks in advance, urgent appointments were also available for patients that needed them. The practice offered extended hours on a Tuesday evening until 8pm for working patients who could not attend during normal opening hours.

Good

# Are services responsive to people's needs?

## (for example, to feedback?)

We checked the online appointment records of three GPs and noticed that the next pre-bookable appointments with named GPs were available within two to three weeks and any GP within one to two weeks. Urgent appointments with GPs or nurses were available the same day.

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

- 70% of patients were satisfied with the practice's opening hours compared with the clinical commissioning group (CCG) average of 73% and the national average of 76%.
- 65% of patients said they could get through easily to the practice by phone compared to the CCG average of 65% and national average of 71%.
- 77% of patients said that the last time they wanted to speak to a GP or nurse they were able to get an appointment compared with the CCG average of 77% and the national average of 84%.
- 71% of patients said their last appointment was convenient compared with the CCG average of 72% and the national average of 81%.
- 70% of patients described their experience of making an appointment as good compared with the CCG average of 67% and the national average of 73%.
- 45% of patients said they don't normally have to wait too long to be seen compared with the CCG average of 44% and the national average of 58%.
- 77% of patients said they would recommend this practice to someone new to the area compared with the CCG average of 69% and the national average of 77%.

Patients told us on the day of the inspection that they were able to get appointments when they needed them.

The practice had a system to assess:

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

The practice operated a triage system for urgent on the day appointments. Patients were offered an urgent appointment, telephone consultation or a home visit where appropriate. 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 for handling complaints and concerns.

- Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. However, we noted that the policy had not been reviewed since March 2014 and included details of previous practice manager.
- There was a designated responsible person who handled all complaints in the practice.
- We saw that information was available to help patients understand the complaints system. The complaints procedure was available from reception, detailed in the patient leaflet and on the patient website. Staff we spoke with were aware of their role in supporting patients to raise concerns. Patients we spoke with were aware of the process to follow if they wished to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice.

We looked at eight complaints received in the last 12 months and found that all written complaints had been addressed in a timely manner. When an apology was required this had been issued to the patient and the practice had been open in offering complainants the opportunity to meet with either the manager or one of the GPs. We saw the practice had included necessary information of the complainant's right to escalate the complaint to the Ombudsman if dissatisfied with the response. The Ombudsman details were included in complaints policy, on the practice website and a practice leaflet.

Lessons were learned from individual concerns and complaints and also from analysis of trends and action were taken to as a result to improve the quality of care. For example, the practice informed us they had organised a customer service skills training in October 2017 to improve staff skills.

# Are services well-led?

Requires improvement

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

## Our findings

**Vision and strategy**

The practice had a clear vision to deliver high quality care and promote good outcomes for patients.

- The practice had a mission statement which was displayed in the premises and on the practice website.
- The practice had a clear strategy and statement of purpose which reflected the vision and values and were regularly monitored. The practice statement of purpose included delivering a high quality and effective care tailored to the needs of local population. This included treating patients with dignity and respect. This also included training both medical students and GP trainees to a high standard.

**Governance arrangements**

The practice had a governance framework. However implementation of the governance framework was not robust enough to always provide assurance that safe good quality care was being provided.

- There was a clear staffing structure. However, not all staff were aware of their own lead roles and responsibilities.
- The practice was unable to demonstrate that all staff had received annual appraisal and training relevant to their role.
- Practice specific policies were available to all staff. However, these were not updated and reviewed regularly. Most policies were not dated so it was not clear when they were written or when they came into force. Some policies had not included correct name for a lead member of staff.
- There were some arrangements for identifying, recording and managing risks, issues and implementing mitigating actions. However, monitoring of specific areas required improvement such as management of blank prescriptions, management of legionella, recruitment checks and medicines reviews for patients with long term conditions.
- The practice had not carried out all related health and safety risk assessments required to monitor safety of the premises such as control of substances hazardous to health (COSHH), asbestos survey, fire safety and electrical installation condition report.
- We found the two recycling bins used to dispose of confidential documents were overflowing in the staff communal area.
- Practice meetings were held monthly which provided an opportunity for staff to learn about the performance of the practice.
- A programme of continuous clinical and internal audit was used to monitor quality and to make improvements.
- We saw evidence from minutes of a meetings structure that allowed for lessons to be learned and shared following significant events and complaints.

**Leadership and culture**

The partners and GPs in the practice aspired to provide safe, high quality and compassionate care. They were visible in the practice and staff told us that they were approachable and always took time to listen to all members of staff. Staff told us there was an open and relaxed atmosphere in the practice and there were opportunities for staff to meet for discussion or to seek support and advice from colleagues. Staff said they felt respected, valued and supported, particularly by the partners and management in the practice.

The provider was aware of and had systems 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). The partners encouraged a culture of openness and honesty. The practice had systems in place for knowing about notifiable safety incidents.

We found that the practice had systems to ensure that when things went wrong with care and treatment:

- The practice gave affected patients reasonable support, truthful information and a verbal and written apology.
- The practice kept written records of verbal interactions as well as written correspondence.

There was a clear leadership structure and staff felt supported by management.

- The practice held and minuted a range of multi-disciplinary meetings. GPs, where required, met with health visitors to monitor vulnerable families and safeguarding concerns.
- Staff told us the practice held regular team meetings.

# Are services well-led?

Requires improvement

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

- Staff told us there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and felt confident and supported in doing so. Minutes were comprehensive and were available for practice staff to view.
- Staff said they felt respected, valued and supported, particularly by the partners in the practice. Most staff we spoke with said they were involved in discussions about how to run and develop the practice, and the partners encouraged all members of staff to identify opportunities to improve the service delivered by the practice.

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

There was limited evidence that the practice encouraged feedback from patients and staff. For example:

- The patient participation group (PPG) was not active and last meeting was held in June 2016.
- The practice had not carried out internal patient or staff surveys. The practice was unable to demonstrate that they had made any improvement in response to the patient's feedback in the last 12 months.
- The practice had collected patient's feedback through the NHS Friends and Family test, complaints and compliments received.
- The practice had collected staff feedback through staff team meetings. Most staff told us they felt involved and engaged to improve how the practice was run.

**Continuous improvement**

There was evidence of learning and improvement within the practice. For example,

- Two of the GP partners were accredited GP trainers and the practice hosted GP trainee registrars from a recognised university postgraduate training programme. The GP trainees spoke highly of the quality of training and support they received which included protected time for discussion, presentation and reflection with established clinical staff members.
- Two of the GP partners and a practice nurse had recently completed a diabetes insulin initiation course, which would enable the practice to offer this service on-site.
- A health care assistant had completed a health care certificate.

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<br>Family planning services<br>Maternity and midwifery services<br>Surgical procedures<br>Treatment of disease, disorder or injury | Regulation 17 HSCA (RA) Regulations 2014 Good governance<br>**How the regulation was not being met:**<br>The registered person had systems or processes in place that operating ineffectively 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:<br>The practice had failed to demonstrate good governance in accordance with the fundamental standards of care.<br>The practice had not assured that all policies and procedures were up to date.<br>The practice was unable to demonstrate that they had proactively sought feedback from staff and patients.<br>**Regulation 17(1)** |

| Regulated activity | Regulation |
|---|---|
| Diagnostic and screening procedures<br>Family planning services<br>Maternity and midwifery services<br>Surgical procedures<br>Treatment of disease, disorder or injury | Regulation 18 HSCA (RA) Regulations 2014 Staffing<br>**How the regulation was not being met:**<br>The service provider 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:<br>The practice could not demonstrate that all staff had received an annual appraisal in a timely manner. |

This section is primarily information for the provider

# Requirement notices

Not all staff had completed training relevant to their role including safeguarding adults, safeguarding children, health and safety, equality and diversity, infection control, basic life support, mental capacity act and fire safety training.

**Regulation 18(2)**

| Regulated activity | Regulation |
| --- | --- |
| Diagnostic and screening procedures<br>Family planning services<br>Maternity and midwifery services<br>Surgical procedures<br>Treatment of disease, disorder or injury | Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed<br>**How the regulation was not being met:**<br>The registered person had not ensured that all the information specified in Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 was available for each person employed. In particular:<br>The practice was unable to demonstrate that they had undertaken appropriate recruitment checks prior to employment. Proof of identification, evidence of satisfactory conduct in previous employment in the form of references, health checks, interview records and contracts of employment were not available for some staff.<br>**Regulation 19(3)** |

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<br>Family planning services<br>Maternity and midwifery services<br>Surgical procedures<br>Treatment of disease, disorder or injury | Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment<br>**How the regulation was not being met:**<br>The registered persons had not done all that was reasonably practicable to mitigate risks to the health and safety of service users receiving care and treatment. In particular:<br>The practice was unable to demonstrate their monitoring of medicines reviews for patients with long term conditions was always effective.<br>The practice was unable to demonstrate that they always followed national guidance on management and security of blank prescription forms.<br>The practice was unable to demonstrate that they had adequate health and safety related risk assessments and processes were in place to ensure safety of the premises and patients.<br>**Regulation 12(1)** |