Wainfleet 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	Inadequate
Are services safe?	Inadequate
Are services effective?	Inadequate
Are services caring?	Inadequate
Are services responsive to people's needs?	Inadequate
Are services well-led?	Inadequate

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Wainfleet Surgery on 20 and 31 October 2016. Overall the practice is rated as inadequate.

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

- Patients were at risk of harm because systems and processes were not in place to keep them safe. For example, those relating to Disclosure and Barring Service checks (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). This included some members of staff who acted as a chaperone. Both GP partners had not completed up to date basic life support training.
- Medication reviews were not being carried out appropriately to ensure the safe prescribing and monitoring of continued prescribing of medicines for patients. There was no evidence to show that some reviews had been carried out either face to face or by telephone consultation. Patient care records in relation to medication reviews were not found to be factually accurate and did not represent the actual care and treatment of patients.
- The practice prescribed methadone under a shared care agreement with Addaction. (a community-based treatment service for individuals experiencing the effects of problematic drug use). We were told that methadone was prescribed in two to four weekly instalments for patients on an FP10 prescription rather than an instalment (blue) prescription for controlled drugs and methadone. The GP was unsure if the correct prescriptions were being used and there was no policy or protocol in place for the prescribing of methadone.
- A GP partner carried out insertion of contraception implants. We requested the GP to provide evidence of this training immediately following inspection. The GP did provide evidence of training however, this GP was not a member of the Faculty of Sexual and

Summary of findings

Reproductive Healthcare as the GP had not completed up to date basic life support training and was therefore not accredited to carry out this procedure.

- Arrangements to safeguard children and vulnerable adults from abuse did not reflect relevant legislation and local requirements.Not all GPs had completed up to date safeguarding training.
- The practice did not hold regular, formal multi-disciplinary or team meetings, meetings that did take place were ad-hoc and were not minuted. There was no evidence of formal discussion or actions taken as a result of incidents and significant events being reported. There was no evidence of learning and communication with staff. Members of staff were not involved in significant event meetings.
- Not all risks to patients were assessed and well managed. The practice did not have an up to date fire risk assessment in place. The practice did not have other risk assessments in place to monitor the safety of the premises, staff and service users or for the control of substances hazardous to health (COSHH), legionella and infection control.
- The practice did not follow guidance in relation to cold chain management, the practice did not have a cold chain policy in place, there was no process in place to monitor temperatures at which vaccines were stored. Numerous recordings of temperatures were either above or below the minimum/maximum required temperatures.
- The practice did not maintain appropriate standards of cleanliness and hygiene. Annual infection control audits had not been undertaken and there were no action plans in place to address any improvements which may be required in relation to infection control.
- Staff had not received an annual appraisal since 2011 and there was no evidence of formal clinical supervision, mentorship and support in place for members of the clinical team.
- Patients were negative about their interactions with GPs during consultations and said they did not always feel listened to and were not always treated with compassion and dignity.
- Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day.
- The practice had limited formal governance arrangements in place. The practice did not have an effective, documented business plan in place.
- Although some clinical audits had been carried out, we saw no evidence that audits were driving improvement in performance to improve patient outcomes.
- The practice had a number of policies and procedures to govern activity, but some of these were either out of date, due a review or not relevant to this practice. The practice did not have a business continuity plan in place.

The areas where the provider must make improvements are:

- Introduce robust processes for reporting, recording, acting on and monitoring significant events, incidents and near misses.
- Ensure that the practice meets the requirements as detailed in the Health and Social Care Act 2008; Code of Practice for health and adult social care on the prevention and control of infections and related guidance.
- Review governance arrangements including systems for assessing and monitoring risks and the quality of the service provision such as implementing a system of effective clinical audits. Put systems in place to ensure all clinicians are kept up to date with national guidance and guidelines.
- Ensure all members of staff are suitably trained and qualified including safeguarding and basic life support training. Clinicians who carry out insertion of contraceptive implants must have completed accredited training and have membership of the Faculty of Sexual and Reproductive Healthcare.
- Ensure those staff who have direct patient contact have a DBS check in place including those who act as chaperones. Ensure a system of clinical supervision/mentorship for members of the clinical team.

Summary of findings

- Ensure patients receive appropriate care, treatment and monitoring ensuring all required reviews are carried out including medication reviews. Ensure that an accurate, complete and contemporaneous record is maintained for every patient.
- Ensure that patient safety alerts (including MHRA) are received by the practice, and then actioned if relevant.
- Ensure that there are appropriate systems in place to properly assess and mitigate against risks including risks associated with infection prevention and control, cold chain management, legionella and fire safety.
- Ensure the safe storage and security of patient records and blank prescriptions.

The areas where the provider should make improvement are:

- Address the issues highlighted in the national GP survey in order to improve patient satisfaction, including those in relation to consultations with GPs.
- Ensure a system of appraisals is in place to ensure all members of staff receive an appraisal at least annually.
- Ensure appropriate policies and procedures are implemented, relevant to the practice ensuring all staff are aware of and understand them.

Following our inspection on 20 and 31 October 2016 we took enforcement action against the provider on the 9 November 2016. We issued an urgent notice of decision to immediately suspend their registration as a service provider (in respect of all regulated activities for which they are registered) for a period of three months. We took this action because we believed that a person would or might be exposed to the risk of harm if we did not take this action.

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

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

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

Professor Steve Field (CBE FRCP FFPH FRCGP)

Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Inadequate

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

- Although the practice carried out some investigations when there were unintended or unexpected safety incidents, lessons learned were not communicated and so safety was not improved. There was no evidence of formal discussion or actions taken as a result of incidents and significant events being reported. Members of staff were not involved in significant event meetings.
- Patients were at risk of harm because systems and processes were not in place in a way to keep them safe. For example, those in relation to Disclosure and Barring Service checks (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). This included some members of staff who acted as a chaperone. Both GP partners had not completed up to date basic life support training.
- There was insufficient attention to safeguarding children and vulnerable adults. Staff did not recognise or respond appropriately if they suspected abuse had occurred. Not all GPs had completed up to date safeguarding training.
- Not all risks to patients were assessed and well managed. The practice did not have an up to date fire risk assessment in place. The practice did not have other risk assessments in place to monitor the safety of the premises, staff and service users or for the control of substances hazardous to health (COSHH), legionella and infection control.
- Medication reviews were not being carried out appropriately to ensure the safe prescribing and monitoring of continued prescribing of medicines for patients.
- The practice did not follow guidance in relation to cold chain management, the practice did not have a cold chain policy in place. There was no process in place to monitor temperatures at which vaccines were stored. Numerous recordings of temperatures were either above or below the minimum/ maximum required temperatures.

Summary of findings

- The practice did not maintain appropriate standards of cleanliness and hygiene. Annual infection control audits had not been undertaken and there was no action plans in place to address any improvements which may be required in relation to infection control.
- The practice did not ensure the safe storage and security of Lloyd George patient records or blank prescriptions.

Are services effective?

Inadequate

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

- Although some clinical audits had been carried out, we saw no evidence that audits were driving improvement in performance to improve patient outcomes. There was no evidence that the practice was comparing its performance to others; either locally or nationally.
- There was minimal engagement with other providers of health and social care. The practice did not hold regular, formal, minuted multi-disciplinary meetings to discuss and review the needs of patients.
- A GP partner carried out insertion of contraceptive implants. We requested the GP to provide evidence of this training immediately following inspection. The GP did provide evidence of training however, this GP was not a member of the Faculty of Sexual and Reproductive Healthcare as the GP had not completed up to date basic life support training.
- The practice held a computerised log of MHRA alerts received however, this log was incomplete and there was no evidence of actions taken as a result. There was no evidence that alerts were discussed in practice meetings as formal minuted meetings did not take place.

Are services caring?

Inadequate

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

- Data from the national GP patient survey showed patients rated the practice lower than others for some aspects of care. For example, 50% of patients said that the the last time they saw or spoke to a GP, the GP was good or very good at involving them in decisions about their care compared to the CCG average of 80% and the national average of 82%.
- 61% of patients said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 85% and the national average of 86%.

Summary of findings

- Not all patients said they were treated with compassion, dignity and respect. Not all felt cared for, supported and listened to. For example, 61% of patients said the GP was good at listening to them compared to the clinical commissioning group (CCG) average of 87% and the national average of 89%.
- The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 67 patients as carers (3% of the practice list). Written information was available to direct carers to the various avenues of support available to them.

Are services responsive to people's needs?

Inadequate

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

- The practice had reviewed the needs of its local population, however, it had not put in place a plan to secure improvements for all of the areas identified. The practice had suffered recruitment issues following the retirement of a practice nurse in recent months and did not have a practice nurse in post. They were not actively advertising externally for nursing staff and the practice were unable to provide effective chronic disease management services for patients.
- Patients could get information about how to complain in a format they could understand. However, there was no evidence that learning from complaints had been shared with staff.
- Results from the national GP patient survey showed that patient's satisfaction with how they could access care and treatment was comparable to local and national averages.

Are services well-led?

Inadequate

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

- The practice did not have a clear vision and strategy. Staff were not clear about their responsibilities in relation to the vision or strategy. Not all staff we spoke with knew and understood the values of the practice. The practice did not have a robust strategy or supporting business plans in place to reflect their vision. There was no business continuity plan in place.
- There was not an effective leadership structure in place and staff did not feel supported by the GP partners.
- The practice did not hold regular, formal governance, multi-disciplinary or team meetings, meetings that did take place were ad-hoc and were not minuted.

Summary of findings

- The practice had not proactively sought feedback from staff or patients and did not have a patient participation group.
- Staff had not received an annual appraisal since 2011 and there was no evidence of formal clinical supervision, mentorship and support in place for members of the clinical team.
- The practice had a number of policies and procedures to govern activity, but some of these were either out of date, due a review or not relevant to this practice.The practice did not have a business continuity plan in place.

Summary of findings

The six population groups and what we found

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

Older people

Inadequate

The provider was rated as inadequate for providing a safe, effective, caring, responsive and well led service. The issues identified as being inadequate overall affected all patients including this population group.

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

- The practice was responsive to the needs of older people, and offered home visits and urgent appointments for those with enhanced needs.
- Patients received personalised care plans from a named GP to support continuity of care.

People with long term conditions

Inadequate

The provider was rated as inadequate for providing a safe, effective, caring, responsive and well led service. The issues identified as being inadequate overall affected all patients including this population group.

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

- Performance for diabetes related indicators was 99% which was higher than the CCG average of 93% and the national average of 90%.(This included an exception reporting rate of 14%).
- The practice did not have nursing staff in place who were trained in chronic disease management, therefore the practice were unable to provide safe, effective management of these patients in-house. Future chronic disease management clinics such as asthma and chronic obstructive pulmonary disease (COPD) had been cancelled. This meant that structured annual reviews could not undertaken to check that patients' health and care needs were being met.

Families, children and young people

Inadequate

The provider was rated as inadequate for providing a safe, effective, caring, responsive and well led service. The issues identified as being inadequate overall affected all patients including this population group.

The practice is therefore rated as inadequate for the care of families, children and young people.

Summary of findings

- The practice's uptake for the cervical screening programme was 75% for the period 2015-16, which was comparable to the CCG average of 74% and the national average of 74%.
- Childhood immunisation rates for the vaccinations given were mixed, some vaccination rates were lower than CCG/national averages and some vaccination rates were higher. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 81% to 100% compared to the CCG average of 87% to 96% and five year olds from 86% to 100% compared to the CCG average of 85% to 94%.
- Appointments were available outside of school hours and the premises were suitable for children and babies.

Working age people (including those recently retired and students)

Inadequate

The provider was rated as inadequate for providing a safe, effective, caring, responsive and well led service. The issues identified as being inadequate overall affected all patients including this population group.

The practice is therefore rated as inadequate for the care of working age people (including those recently retired and students).

- The practice did not offer extended opening hours for patients who worked or students.
- 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.

People whose circumstances may make them vulnerable

Inadequate

The provider was rated as inadequate for providing a safe, effective, caring, responsive and well led service, requiring improvement for being caring. The issues identified as being inadequate overall affected all patients including this population group.

The practice is therefore rated as inadequate for the care of people whose circumstances may make them vulnerable.

- Some staff knew how to recognise signs of abuse in vulnerable adults and children, but they were not all 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. Not all GP partners had completed up to date safeguarding training.

Summary of findings

- The practice did not hold a register of patients living in vulnerable circumstances. The practice had not worked with multi-disciplinary teams in the case management of vulnerable people.
- The practice informed vulnerable patients about how to access various support groups and voluntary organisations.

People experiencing poor mental health (including people with dementia)

Inadequate

The provider was rated as inadequate for providing a safe, effective, caring, responsive and well led service. The issues identified as being inadequate overall affected all patients including this population group.

The practice is therefore rated as inadequate for the care of people experiencing poor mental health (including people with dementia).

- Performance for mental health related indicators was 87% which was worse than the CCG average of 89% and the national average of 93%. (This included an exception reporting rate of 33%).
- 71% of patients diagnosed with dementia had their care reviewed in a face to face meeting in the last 12 months, which is better than the CCG average of 76% and the national average of 78%.

Summary of findings

What people who use the service say

The national GP patient survey results were published in July 2016. The results showed the practice was performing significantly below local and national averages in some areas. 247 survey forms were distributed and 106 were returned which represented a response rate of 43%. This represented 5% of the practice's patient list.

- 95% of patients found it easy to get through to this practice by phone compared to the CCG average of 62% and the national average of 73%.
- 88% of patients were able to get an appointment to see or speak to someone the last time they tried compared to the CCG average of 73% and the national average of 76%.
- 77% of patients described the overall experience of this GP practice as good compared to the CCG average of 83% and the national average of 85%.
- 58% of patients said they would recommend this GP practice to someone who has just moved to the local area compared to the CCG average of 76% and the national average of 79%.
- 50% of patients said that the last time they saw or spoke to a GP, the GP was good or very good at involving them in decisions about their care compared to the CCG average of 80% and the national average of 82%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received nine comment cards which gave mixed views about the standard of care received. Some patients told us that they did not always feel listened to and that they felt they were being rushed during their appointment. Patients also told us they were not always treated with care and concern by GPs and that they were unhelpful. Other patients told us that practice staff were helpful and kind. We did not speak to patients during the inspection.

Friends and Family test results were not published on the NHS Choices website for this practice. The practice were unable to provide this information at the time of our inspection.

Areas for improvement

Action the service MUST take to improve

- Introduce robust processes for reporting, recording, acting on and monitoring significant events, incidents and near misses.
- Ensure that the practice meets the requirements as detailed in the Health and Social Care Act 2008; Code of Practice for health and adult social care on the prevention and control of infections and related guidance.
- Review governance arrangements including systems for assessing and monitoring risks and the quality of the service provision such as implementing a system of effective clinical audits. Put systems in place to ensure all clinicians are kept up to date with national guidance and guidelines.
- Ensure all members of staff are suitably trained and qualified including safeguarding and basic life support training. Clinicians who carry out insertion of contraceptive implants must have completed accredited training and have membership of the Faculty of Sexual and Reproductive Healthcare.
- Ensure those staff who have direct patient contact have a DBS check in place including those who act as chaperones. Ensure a system of clinical supervision/mentorship for members of the clinical team.
- Ensure patients receive appropriate care, treatment and monitoring ensuring all required reviews are carried out including medication reviews. Ensure that an accurate, complete and contemporaneous record is maintained for every patient.

Summary of findings

- Ensure that patient safety alerts (including MHRA) are received by the practice, and then actioned if relevant.
- Ensure that there are appropriate systems in place to properly assess and mitigate against risks including risks associated with infection prevention and control, cold chain management, legionella and fire safety.
- Ensure the safe storage and security of patient records and blank prescriptions.

Action the service SHOULD take to improve

- Address the issues highlighted in the national GP survey in order to improve patient satisfaction, including those in relation to consultations with GPs.
- Ensure a system of appraisals is in place to ensure all members of staff receive an appraisal at least annually.
- Ensure appropriate policies and procedures are implemented, relevant to the practice ensuring all staff are aware of and understand them.

Wainfleet 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.

A further visit carried out on 31 October 2016 included a CQC Lead Inspector, a second CQC inspector who were supported by a member of the Arden and Gem Commissioning Support Unit who specialised in information technology.

Background to Wainfleet Surgery

Wainfleet Surgery provides primary medical services to approximately 2,167 patients residing within in Wainfleet which is a small town in Skegness and also provides services to four surrounding villages. The practice also provides services to patients residing in one care home in Wainfleet.

It is located within the area covered by Lincolnshire East Clinical Commissioning Group (CCG). It is registered with the Care Quality Commission to provide the regulated activities of; the treatment of disease, disorder and injury; diagnostic and screening procedures; family planning; maternity and midwifery services and surgical procedures.

The practice is located within a purpose built property which opened in 1991. The building is single storey and all areas are accessible to people using wheelchairs and those with other disabilities.

At the time of our inspection the practice employed two GP partners, one locum GP, one health care assistant, one senior receptionist, a team of four reception staff and a domestic. They are supported by a practice manager. The practice is open from 8am until 6.30pm Monday to Friday. Appointments are available from 9.10am until 11.20am and from 4pm until 5.50pm Monday to Friday with the exception of a Thursday afternoon when no clinic is provided by a GP. A health care assistant (HCA) provides three morning sessions per week.

The practice has General Medical Services (GMS) contract which is a contract between the GP partners and the CCG under delegated responsibilities from NHS England.

The practice has a high number of older patients and 58% of patients have a long standing health condition compared to the national average of 54%.

The practice provides on-line services for patients such as to book routine appointments, ordering repeat prescriptions and ability to view patient summary care records.

During our inspection, the practice acknowledged that following the retirement of a practice nurse in early 2016, the practice had been unable to successfully recruit additional nursing staff. This had resulted in the practice being unable to provide nursing services including clinics for patients who require chronic disease management. The practice had recruited the services of a locum practice nurse who provided approximately three sessions per month however, this nurse was not trained in chronic disease management.

When the surgery is closed GP out-of-hours services are provided by provided by Lincolnshire Community Health Services NHS Trust which can be contacted via NHS111.

Detailed findings

Why we carried out this inspection

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

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 20 October 2016.

During our visit we:

- Spoke with a range of staff including two GP partners, a practice manager, a locum nurse, a health care assistant and a member of the reception team.
- Observed how patients were being cared for and talked with carers and/or family members
- Reviewed an anonymised sample of the personal care or treatment records of patients.
- Reviewed nine comment cards where patients and members of the public shared their views and experiences of the service.'
- Carried out a second visit on 31 October 2016 to gather further evidence.
- A visit was carried out on 24 October 2016 by the Head of Health Protection for Lincolnshire NHS Clinical Commissioning Groups to explore concerns raised following our first inspection visit carried out on 20 October 2016, in relation to infection control and cold chain.

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

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

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

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

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

Inadequate

Are services safe?

Our findings

Safe track record and learning

There was not an effective system in place for reporting and recording significant events.

- Staff told us they would inform the practice manager of any incidents and there was 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). We saw evidence of two significant events which had been reported and investigated in the past 12 months, both events were in relation to medication prescribing errors. We saw records which detailed actions taken as a result of these events however, there was no evidence that lessons learned following these incidents were shared with the practice team. Formal meetings did not take place, there was no evidence of formal discussion or actions taken as a result of incidents being reported.
- We found that a number of complaints merited further investigation as a significant event in order to promote shared learning and prevent reoccurrence. For example, two complaints we looked at were in relation to the outcome of patient consultations and a complaint about a medication review, another complaint was in relation to the overall care of a patient who had moved into a nursing home. The practice had not investigated these issues as significant events.

Overview of safety systems and processes

The practice did not have clearly defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from abuse, which included:

- Arrangements to safeguard children and vulnerable adults from abuse did not reflect relevant legislation and local requirements. Policies were accessible to all staff however, we saw three different safeguarding policies in place, it was unclear which was the correct policy in use. One policy we looked at, the 'safeguarding children and young persons policy' 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 children and also a named deputy lead. This policy had been reviewed in 2016 however, the safeguarding adults policy had last been reviewed in 2013 and this policy did not refer to a named lead and was not specific to the practice. The GPs attended safeguarding meetings when possible and provided reports where necessary for other agencies. Not all staff we spoke with demonstrated they understood their responsibilities in relation to safeguarding however, most staff had received training on safeguarding children and vulnerable adults relevant to their role. One GP partner was trained to child safeguarding level 3. During our inspection, we saw a notice of cancellation of child safeguarding level 3 training for a GP partner which was due to take place on 4 October 2016. This training had not yet been completed, there was no evidence of further training scheduled or previous training records for this GP. A member of the clinical team had completed level 1 training. All other non-clinical members of staff had completed on-line training in 2016.
- There was not an effective system in place to alert clinical staff via the electronic patient care record of any patients who were either vulnerable, had safeguarding concerns or suffered with a learning disability. The practice did not have a register in place of vulnerable adults and children and did not actively review these patients. There was no evidence of multi-disciplinary meetings taking place or formal discussions and reviews of these patients.
- There were notices on display in the waiting room to advise patients that chaperones were available if required. All staff who acted as chaperones were trained for the role however not all 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).
- The practice did not maintain appropriate standards of cleanliness and hygiene. A member of the clinical team was the infection control clinical lead who would normally liaise with the local infection prevention teams to keep up to date with best practice. However, this lead was new to this role and had not yet attended a local link practitioner meeting. We were informed that the

last two meetings had been cancelled but they would attend future meetings. There was an infection control protocol in place which stated that the practice manager was the infection control lead. We saw evidence that staff had received on-line training. Annual infection control audits had not been undertaken and there was no action plans in place to address any improvements which may be required in relation to infection control. We observed in one treatment room the bin used for the disposal of clinical waste was not a clinical, foot pedal operated bin.

- A visit from the Head of Health Protection took place on 24 October 2016 which highlighted further concerns such as evidence of staff re-using single use clinical items which included disposable swab forceps which were found to have been re-used in a treatment room cupboard. A used speculum was found next to a couch in a consulting room which indicated invasive procedures had been carried out which would normally be carried out in a treatment room to aid ease of cleaning and decontamination. Dirty equipment was found in a consulting room for example, otoscopes were found to be contaminated and stained in areas of the box fittings. There was evidence of used couch roll following patient examinations which was still in situ after a patient clinic which had not been removed. There was no evidence of safe management of COSHH products in line with COSHH regulations. There was no evidence of correct waste segregation procedures in place or being followed. For example, an orange waste sack normally used for infectious waste was used generically instead of yellow sacks for non-infectious offensive hygiene waste, for use in consulting rooms.
- The practice did not have general cleaning schedules in place. Cleaning schedules were not in place for specific clinical equipment. We observed that some sharps bins were not signed and dated upon assembly.
- The arrangements for managing medicines, including emergency medicines and vaccines, in the practice did not keep patients safe (including obtaining, prescribing, recording, handling, storing, security and disposal). Processes were in place for handling repeat prescriptions which included the review of high risk medicines.
- The practice prescribed methadone under a shared care agreement with Addaction. (a community-based treatment service for individuals experiencing the effects of problematic drug use). We saw evidence that a GP had undertaken two on-line training modules with the Royal College of General Practitioners (RCGP) and also accredited training to Level 1 with the RCGP to enable them to prescribe methadone. We were told that methadone was prescribed in two to four weekly instalments for patients on an FP10 prescription rather than an instalment (blue) prescription for controlled drugs and methadone. The GP was unsure if the correct prescriptions were being used and there was no policy or protocol in place for the prescribing of methadone.
- Medication reviews were not being carried out appropriately to ensure the safe prescribing and monitoring of continued prescribing of medicines for patients. Since August 2015, medication reviews had been recorded in some patient care records. Upon further investigation into a sample of patient care records, we noted a number of these patients had not physically attended for their medication review. There was no evidence to show that reviews had been carried out either face to face or by telephone consultation. Numerous medication reviews were added in a block of entries on patient care records. Records showed that patients had been logged as arriving on the computer system and the record then showed that the patients had immediately left the practice. However, patients had not physically attended the practice. Further audits showed that some patient records in relation to medication reviews had been amended or deleted. We were informed by a member of staff that some patient care records had been amended inappropriately at the request of the GP partners in relation to medication reviews. The practice had failed to ensure that an accurate, complete and contemporaneous record was maintained for every patient.
- The practice had not implemented an effective process to check and record internal temperatures of refrigerators that were used to store vaccines on a daily basis. A domestic fridge was in use which was not appropriate for the storage of vaccinations, immunisations and medicines and it did not have an in-built temperature gauge. An external temperature gauge was fitted to the top of the fridge and a data logger was inside the fridge which provided electronic temperature readings. During our inspection, we saw electronic fridge temperature records and some ad-hoc

hand written records within the last 12 months which showed numerous recordings of temperatures both above and below the maximum required temperatures. Some temperatures were recorded as 0 degrees Celsius. (temperatures must be maintained between 2-8 degrees at all times). Further investigation showed that some temperature recordings were out of the required range within the last five years. The fridge was not calibrated on a monthly basis. The practice did not have a cold chain policy in place to describe the actions to be taken in the event of a potential vaccination fridge failure or what to do in the event of temperatures found to be outside of the recommended range for storage of vaccinations.

- Blank prescription forms and pads were not always stored securely and there were no systems in place to monitor their use. We were informed that blank prescriptions were left in unlocked printers in consulting rooms when they were not in use. A member of the clinical team had recently been trained to administer vaccines and medicines against a patient specific prescription or direction from a prescriber.
- We were informed by the practice that they did not hold stocks of controlled drugs (medicines that require extra checks and special storage because of their potential misuse). However, we found three ampoules of diamorphine which had expired in 2010 which were secured in a locked controlled drugs cabinet. The practice did not have procedures in place to manage them safely and there were no arrangements in place for the destruction of controlled drugs. The practice was advised to arrange appropriate destruction of these drugs however staff did not know the correct process to follow at the time of our inspection. Following guidance given, the practice notified the accountable officer at NHS England to arrange removal of these drugs immediately following our inspection, we were provided with evidence that this had been arranged.
- We reviewed seven personnel files and found appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body. Appropriate checks through the Disclosure and Barring Service had not been carried out for all members of staff which included a member of the clinical team and those members of staff who acted as a chaperone. During our inspection, we saw evidence of DBS checks which had been carried out for two employees. We also saw evidence of DBS checks for both GP partners which had been carried out in 2012. We were informed that new applications had been made to renew these however we were not provided with evidence of these applications.
- The practice held a record of Hepatitis B status for clinical staff members who had direct contact with patients' blood for example through use of sharps.
- We observed Lloyd George, paper patient care records which were stored in a kitchen where the door was lockable with a key.These records were stored on open shelving facing a single pane glass window at the front of the building facing the patient car park. The blinds were open and there were no security measures in place to ensure the safe storage of patient identifiable information. Staff regularly entered this room for refreshments and lunch and the room was opposite GP consulting rooms. Notes were also stored in the reception office behind the main reception desk next to an unlocked door. These records were stored in cabinets with no doors, patient records were visible from the reception desk and accessible by others.

Monitoring risks to patients

Risks to patients were not assessed and well managed.

- There were limited procedures in place for monitoring and managing risks to patient and staff safety. There was a health and safety policy available with a poster in the reception office which identified local health and safety representatives. The practice did not have a fire risk assessment in place, there was no evidence of previous risk assessments being carried out. The practice was unable to provide evidence that regular fire drills were carried out and staff we spoke with were unaware of regular fire drills taking place. We were informed that regular testing of the fire alarm system did not take place and there were no records that this was carried out. There was adequate fire protection equipment in place.
- All electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly. The practice did not have any other risk assessments in place to monitor safety of the premises or for the control of

substances hazardous to health (COSHH) and infection control. We did not see evidence of COSHH data sheets on file for all substances used by the domestic. The practice did not have any procedures in place or a risk assessment for Legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings).

- We were told that annual electrical safety checks of the electrical heating system had not been carried out. We were also informed that the practice had not arranged five yearly fixed wire testing of the electrical hard wiring system in the premises.
- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw evidence of staff rotas during our inspection. However, the practice had suffered recent recruitment problems and no longer had any practice nurses in post. The practice had employed the services of a locum practice nurse who provided approximately three sessions per month.

Arrangements to deal with emergencies and major incidents

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

- There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency.
- Not all staff had undertaken physical basic life support training. We were informed that in-house training had been scheduled to take place in November 2016 by an external training company. All members of staff, had completed recent on-line training. There were emergency medicines available in the treatment room. At the time of our inspection, we were unable to find evidence of up to date basic life support training either face to face or on-line for the two GP partners. We asked for this evidence to be submitted immediately following our inspection however, this was not submitted.
- The practice had a defibrillator available on the premises and oxygen with adult 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 did not have a comprehensive business continuity plan in place for major incidents such as power failure or building damage.

Inadequate

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

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

- Staff had access to guidelines from NICE and used this information to deliver care and treatment that met patients' needs.
- The practice held a computerised log of MHRA alerts received however, this log was not up to date and there was no evidence of actions taken as a result of these alerts. There was no evidence that alerts were discussed in practice meetings as formal minuted meetings did not take place. For example, an alert dated August 2012 gave updated advice on drug interactions for patients prescribed both simvastatin and amlodipine and further changes to the prescribing of simvastatin which included changes to the maximum recommended dose of simvastatin. We identified 16 patients being prescribed both these medications following our recent inspection. Audit of patient care records showed that not all of these patients had a medication review carried out following the issue of this alert and some of these patients had not seen a GP since 2012. Those patients who did have a medication review carried out had not all had the relevant blood samples taken or other health screening required.

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent published results for 2015-16 were 99.2% of the total number of points available. Exception reporting rates for some clinical targets were significantly higher than CCG and national averages however, there had been some improvement compared to 2014-15 results. (Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend

- In 2014-15, exception reporting rate for depression was 54% compared to the CCG average of 29% and the national average of 25%. (43% in 2015-16)
- Exception reporting rate for mental health was 34% compared to the CCG average of 19% and the national average of 11%. (33% in 2015-16)
- Exception reporting rate for asthma was 17% compared to the CCG average of 11% and the national average of 7%. (15% in 2015-16)

The GP we spoke with during our inspection was unable to explain why exception reporting rates were higher than CCG and national averages.

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

- Performance for diabetes related indicators was 99% which was higher than the CCG average of 93% and the national average of 90%. (This included an exception reporting rate of 14%)
- Performance for mental health related indicators was 87% which was lower than the CCG average of 89% and the national average of 93%. (This included an exception reporting rate of 33%).
- Performance for depression related indicators was 92% which was higher than the CCG average of 84% and the national average of 83%. (This included an exception reporting rate of 43% which was higher than the CCG average of 25% and the national average of 22%).

There was evidence of some clinical audits carried out however there was no evidence that audits had led to quality improvement.

- There had been five clinical audits completed in the last two years, these included audits of medication reviews, NHS health checks and palliative care patients. One audit was a completed audit of patients diagnosed with chronic kidney disease (CKD) and had been carried out over two cycles. The aim of this audit was to identify all patients who required a diagnosis of CKD however, we did not see evidence that improvements were implemented and monitored as a result of this audit. An audit of medication reviews in May 2016 highlighted that 23% of the patient population who required a

medication review had not had a review completed. Following our inspection, we saw evidence of patients including those prescribed high risk medicines who had not had a review within the past 12 months.

Effective staffing

The provider did not ensure that staff had the skills, knowledge and experience to deliver effective care and treatment.

- The practice had an induction programme in place for all newly appointed staff. This covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality.
- A member of the clinical team had recently undertaken vaccination and immunisation training to enable them to administer influenza vaccinations. Training had included an assessment of competence. However, we were informed that this member of staff could not administer flu vaccinations unsupervised until basic life support training had been completed, we saw evidence that this had been scheduled to take place in November 2016.
- The practice did not have a system of appraisals in place to ensure the learning needs of staff were identified, the last appraisals has been carried out in 2011. There were no formal processes in place for clinical supervision of clinical staff.
- Staff received training that included: safeguarding, fire safety awareness, basic life support and information governance. Staff had access to and made use of e-learning training modules and in-house training. However, not all staff were up to date, for example one GP partner had not completed safeguarding children level 3 training. Both GP Partners had not completed basic life support training.
- A GP partner carried out insertion of contraceptive implants. We requested the GP to provide evidence of this training immediately following inspection. The GP did provide evidence of training however, this GP was not a member of the Faculty of Sexual and Reproductive Healthcare as the GP had not completed up to date basic life support training.

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.

We were told that staff worked together and with other health and social care professionals to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. This included when patients moved between services, including when they were referred, or after they were discharged from hospital. However, we were told that meetings were informal and not minuted. We were unable to see evidence of formal, minuted meetings with other health care professionals taking place on a regular basis to ensure care plans were routinely reviewed and updated for patients with complex needs.

Consent to care and treatment

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

- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005. When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance.
- Where a patient's mental capacity to consent to care or treatment was unclear the GP or practice nurse assessed the patient's capacity and, recorded the outcome of the assessment.
- The process for seeking consent was monitored through patient records audits.

Supporting patients to live healthier lives

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

Inadequate

Are services effective?

(for example, treatment is effective)

- Patients receiving end of life care, carers, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation. Patients were signposted to the relevant local service.

The practice's uptake for the cervical screening programme was 75% for the period 2015-16, which was comparable to the CCG average of 74% and the national average of 74%. This had shown improvement compared to an achievement of 68% in 2014-15. There was a policy to offer telephone reminders for patients who did not attend for their cervical screening test. The practice demonstrated how they encouraged uptake of the screening programme by using information in different languages and for those with a learning disability and they ensured a female sample taker was available. The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening. For example, 53% of patients aged between 60-69 years of age were screened for bowel cancer within six months of invitation compared to the CCG average of 59% and the national average of 55%. 76% of female patients aged between 50-70 years of age were screened for breast cancer in the last 36 months compared to the CCG average of 75% and the national average of 72%. There were failsafe systems in place to ensure results were received for all samples sent for the cervical screening programme and the practice followed up women who were referred as a result of abnormal results.

Childhood immunisation rates for the vaccinations given were mixed, some vaccination rates were lower than CCG/ national averages and some vaccination rates were higher. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 81% to 100% compared to the CCG average of 87% to 96% and five year olds from 86% to 100% compared to the CCG average of 85% to 94%.

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

Inadequate

Are services caring?

Our findings

Kindness, dignity, respect and compassion

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

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

We received nine patient Care Quality Commission comment cards which gave mixed views about the standard of care received. Some patients told us that they did not always feel listened to and that they felt they were being rushed during their appointment. Patients also told us they were not treated with care and concern by GPs and that they were unhelpful. Other patients told us that practice staff were helpful and kind. We did not speak to patients during the inspection.

When a GP partner was asked if they were aware of low patient satisfaction results in relation to experience of consultations with GPs, we were informed that they felt this was due to patients who may suffer from either dementia or hearing problems which may have affected their consultation experience. However, the practice did not provide a hearing loop to improve communication for patients with hearing difficulties.

We were informed prior to our inspection that the practice did not have a patient participation group (PPG) as it had been difficult to encourage patients to formulate a group and attend meetings.

Results from the national GP patient survey showed patients did not always feel they were treated with compassion, dignity and respect. The practice was below average for its satisfaction scores on consultations with GPs. For example:

- 61% of patients said the GP was good at listening to them compared to the clinical commissioning group (CCG) average of 87% and the national average of 89%.
- 75% of patients said the GP gave them enough time compared to the CCG average of 86% and the national average of 87%.
- 80% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 95% and the national average of 95%.
- 60% of patients said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 84% and the national average of 85%.
- 93% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 92% and the national average of 91%.
- 94% of patients said they found the receptionists at the practice helpful compared to the CCG average of 85% and the national average of 87%.

Care planning and involvement in decisions about care and treatment

Patients told us they did not always feel involved in decision making about the care and treatment they received. They also told us they did not always feel listened to and supported by staff or have sufficient time during consultations to make an informed decision about the choice of treatment available to them. Some patient feedback from the comment cards we received were negative in relation to care planning and involvement in decisions about their care and treatment. For example, some patients told us they felt rushed during their appointment, patients did not always feel listened to by the GPs and that GPs were often unhelpful and did not always show a caring attitude in the manner in which they spoke to patients during appointments.

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

- 61% of patients said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 85% and the national average of 86%.

Inadequate

Are services caring?

- 50% of patients said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 80% and the national average of 82%.
- 90% of patients said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average of 87% and the national average of 85%.

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

- Staff told us that translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patients this service was available.
- 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 67 patients as carers (3% of the practice list). Written information was available to direct carers to the various avenues of support available to them.

Staff told us that if families had suffered bereavement, their usual GP contacted them. 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.

Inadequate

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice had reviewed the needs of its local population, however, it had not put in place a plan to secure improvements for all of the areas identified.

At the time of our inspection, the practice did not employ practice nurses. The practice had suffered recruitment issues following the retirement of a practice nurse in early 2016 and did not have a practice nurse in post. The practice had successfully recruited a new practice nurse on a temporary basis to cover the period from July 2016 to October 2016. We were informed that the practice had hoped to recruit this nurse on a permanent basis however, this nurse resigned in October 2016. Following resignation of this nurse, the practice were not actively advertising externally for permanent nursing staff and were actively in contact with locum agencies to recruit nurses who were able to deliver chronic disease management services. At the time of our inspection, the practice were unable to provide effective chronic disease management services for patients. The practice employed the services of a locum practice nurse who provided approximately three sessions per month. We were informed that due to the lack of nursing staff, the practice were unable to provide services such as health checks and other reviews required for those patients who suffered with asthma or chronic obstructive pulmonary disease (COPD). The practice had cancelled future COPD clinics for patients in October and November 2016 and were hoping to recruit a nurse with the relevant skills to ensure these patients received appropriate care. At the time of our inspection, there were approximately 150 patients who were diagnosed with asthma and COPD.

The practice were unable to deliver wound care services for patients due to lack of nursing provision and training within the current clinical team. We were informed that all patients requiring wound care services were referred to local district nursing teams and were treated within the community.

- 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.
- Patients were able to receive travel vaccinations available on the NHS as well as those only available privately/were referred to other clinics for vaccines available privately.
- There were disabled facilities and translation services available.

Access to the service

The practice was open between 8am and 6.30pm Monday to Friday. Appointments were available from 9.10am until 11.20am and from 4pm until 5.50pm Monday to Friday with the exception of a Thursday afternoon when no clinic was provided by a GP. A HCA provided three morning sessions per week. In addition to pre-bookable appointments that could be booked up to four weeks in advance for a GP and eight weeks in advance for a HCA, urgent appointments were also available for people that needed them.

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

- 83% of patients were satisfied with the practice's opening hours compared to the CCG average of 77% and the national average of 78%.
- 95% of patients said they could get through easily to the practice by phone compared to the CCG average of 62% and the national average of 73%.
- 88% of patients said that the last time they wanted to see or speak to a GP or nurse, they were able to get an appointment compared to the CCG average of 73% and the national average of 76%.

The practice had a system in place to assess:

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

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

Listening and learning from concerns and complaints

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

Inadequate

Are services responsive to people's needs?

(for example, to feedback?)

- Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England.
- 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

We looked at four complaints received in the last 12 months and found that these were satisfactorily handled, and dealt with in a timely way, we saw evidence of a written acknowledgement sent to the patient and an apology given where necessary.

Some complaints we looked at constituted a significant event analysis however, we did not see evidence of an analysis carried out based on these complaints. We did not see evidence that lessons were learned from all individual concerns and complaints.

Are services well-led?

Inadequate

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

Our findings

Vision and strategy

The practice told us they had a vision to deliver high quality care and promote good outcomes for patients. However, we were unable to see evidence that the practice were taking positive steps to recruit additional clinical staff or to address gaps in care provision such as for patients suffering with long term conditions.

- Not all staff we spoke with knew and understood the values of the practice. The practice did not have a robust strategy or supporting business plans in place to reflect their vision. There was also no business continuity plan in place.
- During our inspection, the practice acknowledged that following the retirement of a practice nurse in early 2016, the practice had been unable to successfully recruit additional nursing staff. This had resulted in the practice being unable to provide nursing services which included clinics for patients who required asthma and chronic disease management. The practice had recruited the services of a locum practice nurse who provided approximately three sessions per month however, this nurse was not trained in chronic disease management. The practice had a high elderly population and did not have any clinical staff trained in wound care, we were informed that these patients were managed in the community by the local district nursing teams.

Governance arrangements

The practice did not have an effective, overarching governance framework in place to support the delivery of the strategy and good quality care. There was a lack of effective systems and processes in place for assessing and monitoring risks and the quality of the service provision. For example:

- There was not an effective leadership structure in place and staff did not feel supported by the GP partners.
- Practice specific policies were implemented and were available to all staff. We looked at eight policies during our inspection which included infection control, safe use of sharps, recruitment and safeguarding policies. Not all policies we looked at had been reviewed and updated and policies did not deliver consistency across the practice and were not always being implemented and followed, for example in relation to infection control and safeguarding.
- Although some clinical audits had been carried out, we saw no evidence that audits were driving improvement in performance to improve patient outcomes.
- The practice did not have robust arrangements in place for identifying, recording and managing risks, issues or implementing mitigating actions. The practice had not ensured environmental audits had been carried out in relation to infection control, the practice had not ensured legionella and fire risk assessments had been carried out to ensure the safety of staff, patients and visitors.
- The practice did not hold formal, structured, minuted meetings. Meetings were either held informally or were ad-hoc.
- The practice had not ensured that all members of staff received an appraisal within the last 12 months. Appraisals had last been carried out in 2011.
- We had been told that a member of the clinical team had received further training and developed additional skills following the retirement of a practice nurse and subsequent gaps in practice nursing provision. However, there was minimal evidence of formal clinical supervision, mentorship and support in place for this member of staff.

Leadership and culture

On the day of inspection, the partners told us they were aware of areas of concern which required addressing and discussed their plans to improve.

Not all members of staff we spoke with felt supported by the GP partners or that they were approachable and took the time to listen to all members of staff.

The practice did not hold regular, formal, minuted practice or team meetings for all practice staff to attend.

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

The practice told us that they encouraged and valued feedback from patients, the public and staff and had taken part in previous patient surveys. The last survey had been

Are services well-led?

Inadequate

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

carried out in 2015, a further survey had not been completed in 2016 prior to our inspection. We were told that the practice had been unable to encourage patients to formulate and attend a patient participation group to gather feedback from patients and to submit proposals for improvement to the management team.

Continuous improvement

The GP partners did not give any assurance that there was a focus on continuous learning and improvement at all levels within the practice.

Following our first visit on 20 October 2016, the practice did not take necessary actions to ensure immediate actions were taken in respect of legionella requirements, secure storage of patient records and five yearly fixed wire testing of the electrical hard wiring system in the premises. For example, we were informed during our second visit which took place on 31 October 2016, that the GP partners had refused to pay for a legionella risk assessment to be carried out by an external specialist following two quotations being obtained. The GP partners had also refused to authorise the purchase of new cabinets to ensure the safe and secure storage of Lloyd George patient records and there had been no action taken to ensure testing of the electrical hard wiring system of the premises was carried out. Following both inspections, we were informed that an electrician had been contacted to arrange testing of the electrical hard wiring system on the 7 and 8 November 2016 however, evidence was not provided to evidence that this has been carried out.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Transport services, triage and medical advice provided remotely	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **How the regulation was not being met:** The registered person did not do all that was reasonably practicable to assess, monitor, manage and mitigate risks to the health and safety of service users. For example: The practice did not have systems in place to properly assess and mitigate against risks including risks associated with infection prevention and control, legionella, fire, health and safety and cold chain. The practice did not ensure arrangements to safeguard children and vulnerable adults from abuse reflected relevant legislation and local requirements. Not all GPs had completed upto date safeguarding and basic life support training. The practice did not ensure a system of clinical supervision/mentorship for members of the clinical team. The practice did not ensure patient care records were factually accurate and represented the actual care and treatment of patients. The practice did not ensure patients received appropriate care, treatment and monitoring or ensured all required reviews were carried out including medication reviews, not all staff had received appropriate training to carry out clinical or surgical procedures. There was no process in place for acting on and monitoring significant events, incidents and near misses. The practice had not ensured those who had direct contact with patients including those who acted as a

Enforcement actions

chaperone had a DBS check in place. The practice had not documented or assessed their rationale for not ensuring a DBS check was in place for non-clinical members of staff.

This was in breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Transport services, triage and medical advice provided remotely	Regulation 17 HSCA (RA) Regulations 2014 Good governance **How the regulation was not being met:** The practice did not have a programme of regular audit or quality improvement methods to assess, monitor and improve the quality and safety of the services provided. Policies and procedures were not consistently implemented and followed across the practice. The practice did not ensure that an accurate, complete and contemporaneous record is maintained for every patient. Not all members of staff had received an appraisal within the last 12 months. There was no evidence of a system being in place for dissemination, reviewing and actioning NICE and MHRA alerts or evidence of any actions taken. There was no formal meeting structure in place for multi-disciplinary or practice meetings. The practice had not ensured the safe storage and security of patient records or blank prescriptions. These matters are in breach of regulation 17(1) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.