East Park Medical Centre

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at East Park Medical Centre on 10 August 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 effective enough to keep them safe. We found areas of concerns in relation to policies, health and safety, fire risk, infection prevention and control and the recall and review of patients.
- Patients were signposted to other services for support as needed, such as alcohol misuse services, memory services and a health trainer who was attached to the practice.
- Staff understood their responsibilities to raise concerns and report incidents, however, not all non-clinical events or 'near misses' were reported and recorded as significant events.
- Although the practice cascaded national and regional safety alerts, they did not have a process in place to monitor what actions had been undertaken in respect of those alerts.
- There was little evidence to support whether checks of the medicines within the GPs' bags were kept. There was no evidence of a risk assessment being undertaken as to what emergency medicines were carried by the GPs.
- Annual appraisals for staff were overdue and it was not clear whether all staff had completed mandatory training, specifically regarding fire safety and safeguarding.
- We saw that due to workload demands, the opportunity to provide an effective and supportive induction and mentoring programme for new nursing staff members was limited.
- Although some audits had been carried out, not all had undergone two completed audit cycles to ensure that improvements made were implemented and monitored for quality improvement.

Summary of findings

- Patient survey responses rated the practice below the CCG and national averages for many questions relating to the care and service they received. However, patients' comments we received as part of the inspection, said they received a good service and were supported, listened to and cared for.
- The practice responded to patient feedback from the NHS Friends and Family Test and had improved access by increasing the number of same day appointments and telephone consultations.

The areas where the provider must make improvements are:

- Ensure there are effective systems in place for assessing and monitoring risks relating to good governance and the safety of staff and patients, which include addressing any identified concerns relating to fire risk and infection prevention and control.
- Ensure all clinical and non-clinical incidents and 'near misses' that may affect the health, safety and welfare of people using services are reported, recorded and investigated as significant events.
- Ensure there is a clear and consistent approach to managing policies and procedures and that these are practice specific.
- Ensure there is an effective repeat prescribing policy and a system and protocol in place for the recall and review of patients; particularly those who are on medicines which require close monitoring.
- Review the range of medicines available in GPs bags and undertake a risk assessment to evidence the rationale where some recommended medicines have been omitted.
- Ensure all staff receive appropriate support, including appraisal, training, induction and mentorship relevant to their role.
- Ensure patient outcomes are reviewed and recommendations made to contribute to a programme of continuous quality.
- Improve engagement with the patient participation group and take action where appropriate, based on patient feedback.

The areas where the provider should make improvements are:

- Undertake a risk assessment regarding the security of the reception desk at the Halton Medical Practice location.
- Establish a system to log the date that blank prescriptions are received into the practice.
- Provide practice and health information in appropriate languages and formats which reflect the patient population.

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.

- Staff understood their responsibilities to raise concerns. However, not all non-clinical incidents were reported and recorded as significant events. We saw evidence of investigation, actions and shared learning from those incidents which had been reported.
- There was a nominated clinical lead for safeguarding children and adults and processes in place to keep patients and staff safeguarded from abuse. However, one of the GP partners had not undergone the required level three safeguarding training.
- There was no repeat prescribing policy in place to support the recall and review of patients who were on regular medication.
- There was no protocol or effective process in place regarding the review and monitoring of patients who were on high risk medicines such as Amber drugs. (Amber drugs are prescribed medicines which require the patient to be closely monitored in line with specific guidelines.)
- Although the practice cascaded national and regional safety alerts, they did not have a process in place to monitor what actions had been undertaken in respect of those alerts.
- Patients were at risk of harm because systems and processes had areas of weakness. These included the absence of a fire risk assessment, a fire evacuation plan, or regular flushing of water in response to a legionella assessment.
- There was an infection prevention and control (IPC) lead and an up to date self-audit in place. There was an action plan, which was not dated, and many of the IPC issues identified related to the awaited refurbishment of the premises. However, there was no risk assessment in place to mitigate the impact of those issues. For example, there was carpeting throughout the consulting and treatment areas which had not been deep cleaned. In addition we saw that the vinyl covering on several of the bench seats in the waiting areas were torn and damaged.
- There was a business continuity plan in place. It contained staff contact details, however, it did not contain clear instructions of what should be done and who to contact in an emergency situation. For example, should there be a failure in electricity or telephone systems within the practice.

Summary of findings

Are services effective?

Requires improvement

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

- Data showed patient outcomes were low compared to the national average. For example, QOF achievement was 86% for 2015/16 (although this was yet to be verified or published). This had decreased from 95% the previous year (2014/15) and exception reporting had increased from 12% (2014/15) to 14% (2015/16).
- There was a system in place for the recall and review of patients, however, not all patients were recalled and reviewed in a timely manner.
- Although some audits had been carried out, not all had undergone two completed audit cycles to ensure that improvements required had been implemented and monitored.
- Clinical meetings were held every week, although due to work and capacity constraints the nursing staff told us they were unable to attend on a regular basis.
- There was evidence of working with other health and social care professionals, such as the community matron and district nursing team, to meet the range and complexity of patients' needs.
- Services were provided to support the needs of the practice population, such as screening and vaccination programmes, health promotion and preventative care.
- Annual appraisals for staff were overdue. We were unable to establish whether all staff were up to date with their mandatory training in relation to fire safety and safeguarding. We saw that one of the GP partners had not received safeguarding training to the appropriate level. Induction and mentoring processes for nursing staff did not provide sufficient support

Are services caring?

Requires improvement

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

- Data from the national GP patient survey responses rated the practice below the CCG and national averages for many questions relating to the care and service they received. For example, 50% of respondents said they would definitely or probably recommend their GP surgery to someone who has just moved to the local area (CCG 76%, national 79%). The NHS

Summary of findings

Friends and Family test also aligned with survey data. However, patients' comments we received as part of the inspection, said they received a good service and were supported, listened to and cared for.

- Information about the practice, services and how to complain were available both in the practice and on the website. However, these were not available in other languages, despite there being a large number of patients from mixed ethnic origins whose first language was not English.
- We observed that staff treated patients with kindness, dignity and respect.
- The practice had a carers' register and these patients were identified on their individual electronic records. They were supported and signposted to other services as needed.

Are services responsive to people's needs?

Requires improvement

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

- We were informed by the practice, and saw evidence, that the premises were in need of refurbishment. However, there were facilities suitable for patients, such as disabled access.
- National GP patient survey responses were variable in response to the practice and appointment system. For example, 67% of respondents were fairly or very satisfied with the practice opening hours (CCG 77%, national 78%) and 48% of respondents described their experience of making an appointment as good (CCG 71%, national 73%).
- The practice offered pre-bookable, same day and online appointments. They also provided extended hours appointments one day per week, telephone consultations and text message reminders.
- All patients requiring urgent care were seen on the same day as requested.
- Home visits and longer appointments were available for patients who were deemed to need them, for example housebound patients or those with complex conditions.
- Patients were signposted to other services for support as needed, such as alcohol misuse services, memory services and a health trainer who was attached to the practice.
- There was a designated lead for dealing with complaints and evidence showed they responded quickly to issues raised and learning was shared with staff. There was information for patients on how to complain, however this was not available in other languages.

Summary of findings

Are services well-led?

Inadequate

The practice is rated as inadequate for being well-led

- The practice had a number of policies and procedures to govern activity, however, some of the policies were generic and not practice specific. They operated two different electronic policy storage systems. We saw there were two versions of policies, which differed from one another. On the day of inspection it was not clear which set of policies staff were using or when the dates for review were.
- Risks and issues were not always identified which related to health and safety, infection prevention and control and recall and review of patients. There was a system in place for the recall and review of patients. We were informed it had recently been changed as it had not been consistent in ensuring all patients were reviewed in a timely manner.
- There was evidence of practice meetings being held, however, these had predominantly been held between the GP partners in isolation. The practice manager informed us they had not always been invited and nursing staff told us they had difficulty in attending the meetings due to work demands.
- The majority of staff said they felt supported by the GPs. However, staff informed us they did not have the capacity to fulfil the requirement of their role and there was low staff morale.
- New staff had received an induction but this was variable in length and not an effective process. Mentorship of new nursing staff was difficult due to capacity issues. We were informed a new clinical member of staff commenced full clinical sessions with patients on their first day of working.
- Staff were not up to date with their annual appraisals and it was not clear whether all staff had completed their mandatory training requirements.
- There was a patient participation group (PPG), however, the practice did not engage with them on a regular basis. The last meeting had been in December 2015, from which the PPG had not received any feedback or minutes.
- The provider was aware of and had a process in place to ensure compliance with 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.)

Summary of findings

The six population groups and what we found

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

Older people

Inadequate

The practice is rated as inadequate for the care of older people. The practice was rated as inadequate for being safe and well-led and requires improvement for being effective, caring and responsive. The concerns which led to these ratings apply to everyone using the practice, including this population group. However, there were examples of good practice:

- The practice provided proactive, responsive and personalised care to meet the needs of the older people in its population. Home visits, urgent appointments and health checks for the over 75s were available.
- The practice worked closely with other health and social care professionals, such as the district nursing team and community matron, to ensure housebound and elderly patients received the care and support they needed.
- Care plans were in place for those patients who were considered to have a high risk of an unplanned hospital admission.
- With their consent, elderly patients were referred to Age UK for additional support, particularly those who were isolated or lonely.

People with long term conditions

Inadequate

The practice is rated as inadequate for the care of people with long term conditions. The practice was rated as inadequate for being safe and well-led and requires improvement for being effective, caring and responsive. The concerns which led to these ratings apply to everyone using the practice, including this population group. However, there were examples of good practice:

- Nursing staff led on reviews of patients who had a long term condition. Care and support was delivered for some patients using an NHS approach called the Year of Care (YoC). YoC supports and enables patients to be involved in their own care, by providing a more personalised approach and supporting self-management. It was used with patients who had chronic obstructive pulmonary disease (COPD), ischaemic heart disease (IHD), diabetes and those who were at high risk of developing diabetes.
- Performance for QOF indicators relating to long term conditions was variable compared to the local CCG and national averages.

Summary of findings

For example, 82% of newly diagnosed diabetic patients had been referred to a structured education programme in the preceding 12 months (CCG average 87%, national average 90%); 76% of patients diagnosed with asthma had received an asthma review in the last 12 months (CCG and national averages of 75%); 41% of patients diagnosed with chronic obstructive pulmonary disease (COPD) had received a review in the last 12 months (CCG average 88%, national average 90%).

- There was a system in place for the recall and review of patients. However, this was not always effective in recalling patients in a timely manner.
- Longer appointments and home visits were available when needed.
- Patients who required palliative (end of life) care were provided with support and care as needed, in conjunction with other health care professionals.

Families, children and young people

Inadequate 

The practice is rated as inadequate for the care of families, children and young people. The practice was rated as inadequate for being safe and well-led and requires improvement for being effective, caring and responsive. The concerns which led to these ratings apply to everyone using the practice, including this population group. However, there were examples of good practice:

- Appointments were available outside of school hours and all children who required an urgent appointment were seen on the same day as requested.
- The practice worked with midwives and health visitors to support the needs of this population group. For example, the provision of ante-natal, post-natal and child health surveillance clinics.
- Childhood immunisations were offered in line with the public health programme. Uptake rates for all children aged eight weeks to 5 years were between 93% and 99%; which were comparable to the CCG averages of 84% to 100%.
- Cervical screening, sexual health and contraceptive services were provided at the practice. The latest data showed that 97% of eligible patients had received cervical screening, which was considerably higher than the CCG and national averages of 82%.
- There were appointments available with either a male or female GP.

Summary of findings

- There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances.

Working age people (including those recently retired and students)

Inadequate

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

- The needs of these patients had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. The practice provided extended hours appointments one day a week, telephone consultations, online booking of appointments and ordering of prescriptions.
- The practice offered a range of health promotion and screening that reflected the needs for this age group. This included screening for early detection of diabetes.
- NHS health checks were offered to patients aged between 40 and 74 who did not have a pre-existing condition.
- Travel health advice and vaccinations were available.

People whose circumstances may make them vulnerable

Inadequate

The practice is rated as inadequate for the care of people whose circumstances may make them vulnerable. The practice was rated as inadequate for being safe and well-led and requires improvement for being effective, caring and responsive. The concerns which led to these ratings apply to everyone using the practice, including this population group. However, there were examples of good practice:

- The practice held a register of patients living in vulnerable circumstances and regularly worked with multidisciplinary teams in the case management of this population group.
- Information was provided on how to access various local support groups and voluntary organisations.
- Longer appointments were available for patients as needed.
- Staff knew how to recognise signs of abuse in children, young people and adults whose circumstances may 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.
- The practice provided support for those patients who were HIV positive. Female patients in this group were encouraged and supported to attend for cervical screening. The practice could evidence 14 out of 17 patients were up to date with their smear.
- Those patients who had a learning disability were given a care plan booklet which they were encouraged to fill in prior to their appointment. This enabled staff to provide a more personalised service for these patients to aid understanding. Leaflets explaining about medicines and side effects, which had been designed specifically for someone with a learning disability, were used with these patients.

People experiencing poor mental health (including people with dementia)

Inadequate

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

- The practice regularly worked with multidisciplinary teams in the case management of people in this population group. Patients and/or their carer were given information on how to access various support groups and voluntary organisations.
- The numbers of patients who had received a review of their care was in line with CCG and national averages. For example, 89% of patients who had a complex mental health problem, such as schizophrenia, bipolar affective disorder and other psychoses (CCG and national averages of 88%); 97% of patients diagnosed with dementia (CCG average 88%, national average 84%).
- Staff had attended dementia friendly training and could demonstrate how to support patients with mental health needs or dementia.
- The practice operated a 'virtual green ticket' system with patients who had mental health needs, dementia or memory impairment. The GP gave the patient a 'ticket' to give a receptionist, to ensure a follow up appointment was booked at a time convenient for the patient.

Summary of findings

What people who use the service say

The latest national GP patient survey results were published in July 2016. A total of 321 survey forms were distributed, of which 116 were returned. This was a response rate of 36% which represented 1% of the practice patient list. Results showed the practice was performing below the local CCG and national averages in many areas. For example:

- 66% of respondents described their overall experience of the practice as fairly or very good (CCG 83%, national 85%)
- 50% of respondents said they would definitely or probably recommend their GP surgery to someone who has just moved to the local area (CCG 76%, national 79%)
- 48% of respondents described their experience of making an appointment as good (CCG 71%, national 73%)
- 78% of respondents said they found the receptionists at the practice helpful (CCG 85%, national 87%)
- 89% of respondents said they had confidence and trust in the last GP they saw or spoke to (CCG and national 95%)
- 95% of respondents said they had confidence and trust in the last nurse they saw or spoke to (CCG 96%, national 97%)

The results of the most recent Friends and Family Test (May to July 2016) showed that out of 67 respondents, 57% (38) said they would be extremely likely or likely to recommend the practice to friends and family if they needed care or treatment.

As part of the inspection process we asked for Care Quality Commission (CQC) comment cards to be completed by patients. On the day of inspection we had received 18 comment cards. All were positive about the care they received; some comments cited individual staff as being very caring and understanding. Five comment cards stated they found the environment to be safe, clean or hygienic. Only one comment stated it was difficult to get an appointment.

We spoke with three patients, who were also members of the patient participation group (PPG). We were given several examples where they had encountered issues, particularly with regard to repeat prescriptions. They also informed us they felt the practice did not engage with them regularly as a PPG, with the last meeting being in December 2015 of which they had not received any minutes. They had raised some issues but, as yet, had not received any feedback from the practice. Suggestions had included improving the patient notice boards, members of staff having name badges and keeping the website up to date. They had also requested a GP attend the PPG meetings, in addition to the practice manager.

We spoke with the practice regarding their low patient satisfaction scores. They had identified there had been issues regarding accessing clinical appointments due to the decreased number of clinicians being available and the increase in the numbers of patients registered.

Areas for improvement

Action the service MUST take to improve

- Ensure there are effective systems in place for assessing and monitoring risks relating to good governance and the safety of staff and patients, which include addressing any identified concerns relating to fire risk and infection prevention and control.
- Ensure all clinical and non-clinical incidents and 'near misses' that may affect the health, safety and welfare of people using services are reported, recorded and investigated as significant events.
- Ensure there is a clear and consistent approach to managing policies and procedures and that these are practice specific.

Summary of findings

- Ensure there is an effective repeat prescribing policy and a system and protocol in place for the recall and review of patients; particularly those who are on medicines which require close monitoring.
- Review the range of medicines available in GPs bags and undertake a risk assessment to evidence the rationale where some recommended medicines have been omitted.
- Ensure all staff receive appropriate support, including appraisal, training, induction and mentorship relevant to their role.
- Ensure patient outcomes are reviewed and recommendations made to contribute to a programme of continuous quality.
- Improve engagement with the patient participation group and take action where appropriate, based on patient feedback.

Action the service SHOULD take to improve

- Undertake a risk assessment regarding the security of the reception desk at the Halton Medical Practice location.
- Establish a system to log the date that blank prescriptions are received into the practice.
- Provide practice and health information in appropriate languages and formats which reflect the patient population.

East Park Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

a CQC inspector and included a GP specialist adviser and a practice manager specialist adviser.

Background to East Park Medical Centre

East Park Medical Centre is a member of the Leeds South and East Clinical Commissioning Group (CCG). General Medical Services (GMS) are provided under a contract with NHS England. They also offer a range of enhanced services, which include:

- delivering childhood, influenza and pneumococcal vaccinations
- facilitating timely diagnosis and support for people with dementia
- identification of patients who are at a high risk of an avoidable unplanned hospital admission
- extended hours access

The practice has two branches which are located in the more deprived areas of Leeds. Their main surgery is at 5-7 East Park Road, Leeds LS9 9JD with the branch surgery at Halton Medical Practice, 2a Primrose Lane, Leeds LS15 7HR. Both of these premises are purpose built. East Park is leased from a private landlord and Halton is leased from NHS Properties. The two locations share the same patient list, policies and procedures and Quality and Outcomes Framework data. Both clinical and administrative staff rotate between both sites and have access to the practice computer system.

The premises at East Park Road has consulting and treatment rooms over two floors, with the main reception on the ground floor and an additional patient waiting area on the first floor, which can be accessed by stairs or a lift. We were informed the patient waiting area on the first floor is not manned due to a lack of available manpower. The premises as a whole are in need of refurbishment, particularly in relation to the carpeted areas, decoration and patient seating. We were informed by the practice that they had raised issues regarding the maintenance and upkeep of the premises with the respective landlord. Also of the difficulties the current premises presented in developing further services for patients. The reception area at Halton Medical Practice does not afford any privacy. It has a low counter, which patients can easily sit on or lean/jump over to reach staff or equipment. Reception staff there informed us they had encountered situations where this had happened. A request had been made previously by the practice to the landlord to install a more secure reception area.

The practice currently has 8,539 patients split over both locations. They have a mixed ethnic patient population, with over 50 different languages being spoken. Their patient demographics deviate from local and national averages in some areas. For example:

- 26% of patients aged 18 years or younger (CCG 22%, national 21%)
- 62% of patients have a long standing health (CCG 56%, national 54%)

We were informed that the practice had seen an increase of approximately 1,000 patients over the preceding two years; with up to 800 being in a short period of time. This was due to the closure of two local practices in 2015 and the dispersal of patients. This influx of patients had also coincided with a number of staff, which included two GPs and two nurses, leaving due to retirement, ill health or

change in career. We were informed of the challenges and increased workload the practice as a whole had experienced, as many of the new patients needed longer appointments due to their complex or unmet needs.

There are two GP partners (one male, one female), a male salaried GP (three sessions per week) and a male locum GP (two sessions per week). Nursing staff consist of a recently appointed advanced nurse practitioner and two practice nurses; all of whom are full time and female. The clinicians are supported by a practice manager, an office manager and an experienced team of administration and reception staff. We were informed an additional experienced advanced nurse practitioner (male) and newly qualified nurse (female) were expected to commence employment at the practice in early September. The practice has the support of a member of the CCG pharmacy team one day per week. We were informed the GP partners worked eight sessions per week each but also did additional sessions to support patient demand.

East Park Medical Centre is open Monday to Friday 8am to 6pm, with extended hours from 7am on Monday. GP appointments are available:

Monday 7am to 11.40pm and 3pm to 5pm

Tuesday 2.40pm to 5pm

Wednesday 8.30am to 11.30am and 2.20pm to 4.30pm

Thursday 8.30am to 11.40am and 3pm to 5pm

Friday 8.30am to 11.30pm and 1.50pm to 4pm

Halton Medical Practice is open Monday to Friday 8am to 6pm. GP appointments are available:

Monday 8.45am to 11.15am and 3pm to 5pm

Tuesday 8.30am to 11.30am and 3pm to 5pm

Wednesday 8am to 11am and 2.20pm to 5.30pm

Thursday 8.30am to 11.30am and 3pm to 5pm

Friday 8am to 11am and 1.50pm to 4pm

In addition, there are extended hours from 6.30pm to 7.30pm on alternate Mondays at both locations and advanced nurse practitioner appointments outside those of the GP.

When the practice is closed out-of-hours services are provided by Local Care Direct, which can be accessed via the surgery telephone number or by calling the NHS 111 service.

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 that we hold about the practice and asked other organisations, such as NHS England and Leeds South and East CCG, to share what they knew about the practice. We reviewed the latest 2014/15 data from the Quality and Outcomes Framework (QOF) and the latest national GP patient survey results (July 2016). We also reviewed policies, procedures and other relevant information, including 2015/16 QOF data, which the practice provided before and during the day of inspection.

We carried out an announced inspection on 10 August 2016. During our visit we:

- Visited both locations at East Park Medical Centre, 5-7 East Park Road, Leeds, LS9 9JD and Halton Medical Practice, 2a Primrose Lane, Leeds LS15 7HR
- Spoke with a range of staff, which included both GP partners, the advanced nurse practitioner, the practice nurses, the practice manager, the office manager and reception staff.
- Reviewed questionnaire sheets which were given to four reception staff prior to inspection.
- Spoke with patients and reviewed CQC comment cards where patients and members of the public shared their views.

Detailed findings

- Observed in the reception areas at both locations how patients/carers/family members were treated.
- Looked at templates and information the practice used to deliver patient care and treatment plans, particularly in relation to the management of patients who were prescribed high risk medicines, such as lithium and methotrexate. These are also known as 'amber drugs' which require the patient to be closely monitored in line with specific guidelines.

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 are provided for specific groups of people and what good care looks like for them. The population groups are:

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

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

Inadequate

Are services safe?

Our findings

Safe track record and learning

There was a system in place for reporting and recording significant events.

- The practice was aware of their wider duty to report incidents to external bodies such as Leeds South and East CCG and NHS England. This included the recording and reporting of notifiable incidents under the duty of candour.
- When there were unintended or unexpected safety incidents, we were informed patients received reasonable support, truthful information, a verbal and written apology and were told about any actions to improve processes to prevent the same thing happening again. We saw evidence to support this.
- There was an incident reporting form available on the practice computer system, which supported the recording of notifiable incidents under the duty of candour. Staff told us they were aware of their responsibilities to report incidents to the practice manager or office manager. We saw evidence of investigation, actions and shared learning from those incidents which had been reported. However, we were informed that not all non-clinical incidents were reported and recorded as significant events. An example was given where issuing a prescription incorrectly would not have previously been recorded as an incident. However, it would have been acted upon.
- All recorded significant events relating to medicines were monitored by the local CCG medicines management team. Any concerns or issues were then fed back to the practice to act upon.
- Although the practice cascaded national and regional safety alerts, they did not have an effective process in place to monitor whether staff read them or what actions had been undertaken in respect of those alerts.

Overview of safety systems and processes

The practice had some systems and processes in place to keep people safe and safeguarded from abuse. However, we identified some areas of concern. We saw evidence of:

- Arrangements which reflected relevant legislation and local requirements were in place to safeguard children and vulnerable adults from abuse. Policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. There was a GP safeguarding lead for adults and children, who was up to date with the appropriate level three safeguarding training. We were told the children's safeguarding lead worked closely with health visitors, and although attendance at safeguarding case conferences was difficult, the practice ensured that reports where submitted when requested. One of the GP partners had not undergone the required level three safeguarding and it was unclear whether all staff were up to date with their safeguarding training.
- A notice was displayed in the waiting rooms at both locations, advising patients that a chaperone was available if required. A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure. All staff who acted as chaperones were trained for the role and had received a Disclosure and Barring Service check (DBS). (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable.) We saw evidence that the clinician recorded in the patient's records when a chaperone had been in attendance.
- Appropriate arrangements for managing infection prevention and control (IPC) were not in place. At the time of the inspection it was unclear whether all staff were up to date with IPC training. There was an IPC lead and a policy in place. We saw evidence that an IPC audit across both locations had taken place in March 2016 by the office manager. When we spoke with the IPC lead, they were unaware of the actions arising from this. There were some actions identified on the audit, however, there were no timescales or dates when these were to be completed. Several actions relating to the East Park location were identified as 'awaiting refurb'. For example, there was carpeting throughout the consulting and treatment areas which was stained and had not been deep cleaned. In addition, we saw that the vinyl covering on several of the bench seats in the patients waiting areas were torn and damaged. We saw that the interior walls were in need of repainting.
- The practice contracted the services of a private cleaning company for East Park and we saw evidence of

cleaning schedules and monthly audits undertaken by the cleaning supervisor from the company. We were informed the practice manager had a meeting with the cleaning supervisor every two months or earlier if needed. Cleaning of the Halton location was provided by NHS Property Services.

- There were some arrangements in place for managing medicines. Regular medicine audits, such as those relating to antibiotic prescribing, were carried out with the support of the local CCG pharmacy team to ensure the practice was prescribing in line with best practice guidelines. Blank prescriptions were transported from one site to another by a member of staff in their car. Although serial numbers were recorded, it was noted the practice did not keep a record of the date the boxes of prescriptions were received into the practice. At the time of inspection it was observed at the Halton location, that patients' prescriptions could easily be taken by reaching across the reception desk. Boxes of blank prescriptions were also transported from one site to another by members of staff in their own transport. There was no evidence to support whether a risk assessment had been undertaken regarding the transportation of both the prescriptions and Lloyd George notes (patients' written records) from one site to another.
- There was an out of date repeat prescribing policy, which was not effective enough to support the recall and review of patients who were on regular medication. There was no protocol or effective processes in place regarding the review and monitoring of patients who were on high risk medicines such as Amber drugs. (Amber drugs are prescribed medicines which require the patient to be closely monitored in line with specific guidelines.) We looked at reports for the recall of patients who were on methotrexate (used to treat rheumatoid arthritis and certain types of cancer of the breast, skin, head and neck, or lung) or lithium (used in the treatment of manic episodes in bipolar disorder). We found that five patients on methotrexate and two patients on lithium were overdue their reviews. This meant there was a risk to the health of these patients as they were not being closely monitored. At the time of inspection the GP we spoke with arranged for these patients to be contacted and an appointment made for their review as a matter of urgency.
- There was little evidence to support whether checks of the medicines within GPs' bags were kept. We saw the bags only contained one emergency medicine, benzylpenicillin, which is given to children in the case of meningitis. There was no evidence of a risk assessment being undertaken as to why no other recommended emergency medicines were carried by the GPs.
- There were patient group directives (PGDs) in place to enable the nurses to administer medicines or vaccines (PGDs are written instructions for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment.)
- We reviewed three personnel files and found appropriate recruitment checks had been undertaken prior to employment, in line with the practice recruitment policy, for example proof of identification, references and DBS checks.

Monitoring risks to patients

The systems and processes for assessing, monitoring and managing risks to patients and staff safety had areas of weakness.

- There was no assessment in place to monitor the risk of fire.
- A recent legionella inspection in May 2016 had identified the practice needed to undertake regular flushing of the water taps. We were informed a company had been contacted to oversee this, however, at the time of inspection this process had not yet commenced.
- Due to the low reception desk and open area at the Halton location, there was a potential risk to staff who were manning the desk. However, the low counter top provided easy access for those patients in wheelchairs.
- Arrangements were in place for planning and monitoring the number and mix of staff needed to meet patients' needs. Staff worked flexibly to cover any changes in demand, such as annual leave, sickness or seasonal absence.

Arrangements to deal with emergencies and major incidents

The practice had some arrangements in place to respond to emergencies and major incidents. We saw:

Inadequate

Are services safe?

- There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency.
- Emergency medicines were stored in a secure area which was easily accessible for staff. There was a defibrillator on the premises and pads suitable for adults. We saw the pads had expired at the end of April 2016. There was oxygen with adult and children's masks.
- In each consulting and treatment room there was a flowchart reminding staff what to do in the case of anaphylaxis. (Anaphylaxis is an extreme and severe allergic reaction, which can be life threatening.)
- At both locations there was a meningitis kit available which contained benzylpenicillin, should a child need urgent medical assistance.
- There was no evidence to support the practice had undertaken a fire risk assessment or had a fire evacuation plan in place. They did not carry out fire drills and staff were not up to date with their fire safety training. We have shared this information with the local fire service.
- There was a business continuity plan in place. It contained staff contact details, however, it did not contain clear instructions of what should be done and who to contact in an emergency situation. For example, should there be a failure in electricity or telephone systems within the practice.

Requires improvement

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice kept up to date 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 these and used the information to deliver care and treatment that met patients' needs.

Management, monitoring and improving outcomes for people

The practice participated in the Quality and Outcomes Framework (QOF). QOF is a system intended to improve the quality of general practice and reward good practice. The most recent published results (2014/15) showed the practice had achieved 95% (CCG 94%, nationally 95%) of the total number of points available, with 11% exception reporting (CCG 8%, 9% nationally. (Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects). However, QOF achievement had reduced to 86% and exception reporting had increased from 12% to 14%, for the period 2015/16 (this data was yet to be verified or published). It was discussed with the practice the rationale for the changes in QOF achievement. They felt that reductions in the number of clinicians, the increase in the patient list size and the ineffective recall and review system of patients could have contributed to this.

Data showed:

- Performance for some diabetes related indicators were variable, compared to CCG and national averages. For example, 81% of patients on the diabetes register had a recorded foot examination completed in the preceding 12 months (CCG and national averages of 88%).
- Performance for mental health related indicators were lower than CCG and national averages. For example, 78% of patients with schizophrenia, bipolar affective disorder and other psychoses had a record of blood pressure in the preceding 12 months (CCG average 88%, national average 90%).

The practice undertook quarterly medicine audits in line with local and national guidance and with the support of the local CCG medicines management team. These included Amber drugs monitoring. We reviewed the most recent audit which alerted us to the delayed recall and review of some of the patients.

We reviewed several other audits and found some needed to be completed by undergoing a second cycle or did not have a date recorded when the audit had been undertaken. A second cycle of an audit is necessary to ensure that any improvements required are implemented and monitored. This was raised with the GP we spoke with, who assured us they would complete the audit cycle. For example, an audit relating to patients who had a diagnosis of Barrett's oesophagus and whether they had undergone surveillance endoscopy and an audit of emergency admissions. There was no date to identify when these had been undertaken or when the reaudits would take place. There were clear actions arising from them, however, it was unclear whether these had been implemented. (Barrett's oesophagus relates to abnormal changes occurring in the cells of the lower portion of the oesophagus, often linked to a pre-malignant condition.)

Effective staffing

- The practice had an induction programme for all newly appointed staff, which covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality. However, the newest members of staff we spoke with told us they found it difficult finding the time to complete the programme due to workload demands. We were informed how providing mentorship to new nursing staff was challenging due to working across both sites, time and work constraints. On the first day of starting one of the newest clinical members of staff had been shown around the practice but had then commenced a full clinic seeing patients.
- Annual appraisals for all staff were overdue and it was not clear whether all staff had completed mandatory training, specifically regarding fire safety and safeguarding. We were informed that nursing staff had their own training files but information was not always updated on the practice training matrix.
- Staff informed us they could access role specific training, however, they found sometimes found it

Requires improvement

Are services effective?

(for example, treatment is effective)

difficult due to the workload demands. Nursing staff utilised e-learning, the CCG quarterly training sessions (TARGET) and peer support to keep up to date in their knowledge.

- 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 online resources and peer support.

Coordinating patient care and information sharing

The practice had timely access to information needed, such as medical records, investigation and test results, to plan and deliver care and treatment for patients. They could evidence how they followed up patients who had an unplanned hospital admission or had attended accident and emergency (A&E); particularly children or those who were deemed to be vulnerable.

Staff worked with other health and social care services to understand and meet the complexity of patients' needs and to assess and plan ongoing care and treatment. With the patient's consent, information was shared between services using a shared care record. We saw evidence that multidisciplinary team meetings, to discuss patients and clinical issues, took place on a bi-monthly basis.

Care plans were in place for those patients who had complex needs, were at a high risk of an unplanned hospital admission or had palliative care needs. These were reviewed and updated as needed. Information regarding end of life care was shared with out-of-hours services, to minimise any distress to the patient and/or family.

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.
- At the time of inspection there was no evidence to support consent was monitored through patient record audits.

Supporting patients to live healthier lives

The practice identified patients who may be in need of extra support and signposted those to relevant services. These included patients:

- who were in the last 12 months of their lives
- at risk of developing a long term condition
- required healthy lifestyle advice, such as dietary, smoking and alcohol cessation

We were informed (and saw evidence in some instances) that:

- There was a computer recall system in place to prompt staff when a patient's cervical smear test was due. The latest data showed that 97% of eligible patients had received cervical screening, which was considerably higher than the CCG and national averages of 82%. The practice demonstrated how they encouraged uptake of the screening programme and ensured a female sample taker was available. There were 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.

Patients were encouraged to attend national cancer screening programmes. However, the uptake rates for breast and bowel screening were below the local and national averages:

Breast screening of females aged 50 to 70 in the last 36 months was 60%, compared to 70% locally and 72% nationally.

Bowel screening of patients aged 60 to 69 years in the last 30 months was 51%, compared to 55% locally and 58% nationally.

- The practice provided support for those patients who were HIV positive. Female patients in this group were

Requires improvement

Are services effective?

(for example, treatment is effective)

encouraged and supported to attend for cervical screening. The practice could evidence 14 out of 17 patients were up to date with their smear. Women were offered an appointment or seen opportunistically.

- Immunisations were carried out in line with the childhood vaccination programme. Uptake rates for children aged eight weeks to five years ranged from 93% to 99%; which were comparable to the CCG averages of 84% to 100%.
- Patients had access to appropriate health assessments and checks. These included NHS health checks for people aged 40 to 75. Where abnormalities or risk factors were identified, appropriate follow-ups were undertaken.
- The practice had staff from specific support services attached to the practice, where patients could be signposted. For example, an alcohol worker, memory support workers for those patients with dementia and a health trainer to support self-care.
- With their consent, elderly patients were referred to Age UK for additional support, particularly those who were isolated or lonely.
- Those patients who had a learning disability were given a care plan booklet which they were encouraged to fill in prior to their appointment. This enabled staff to provide a more personalised service for these patients to aid understanding. Leaflets explaining about medicines and side effects, which had been designed specifically for someone with a learning disability, were used with these patients.

Requires improvement

Are services caring?

Our findings

Kindness, dignity, respect and compassion

During our inspection we observed that:

- Members of staff were courteous and helpful to patients and treated them with dignity and respect.
- Curtain screens were provided in consulting and treatment rooms to maintain the patient's dignity during examinations, investigations and treatment.
- Doors to consulting and treatment rooms were closed during patient consultations and that we could not hear any conversations that may have been taking place. However, due to the open area, conversations could be heard in the reception area at the Halton Medical Centre site. There was a private room at both sites, should patients in the reception area wish to discuss sensitive issues or appeared distressed.
- Chaperones were available for those patients who requested one and it was recorded in the patient's record by the clinician but not by the person who undertook the chaperone role.

Data from the July 2016 national GP patient survey showed respondents rated the practice lower than other practices, with regard to how they were treated. For example:

- 83% of respondents said the last GP they saw or spoke to was good at listening to them (CCG 87%, national 89%)
- 75% of respondents said the last GP they saw or spoke to was good at giving them enough time (CCG 85%, national 87%)
- 72% of respondents said the last GP they spoke to was good at treating them with care and concern (CCG 83%, national 85%)
- 75% of respondents said the last nurse they saw or spoke to was good at listening to them (CCG and national 91%)
- 80% of respondents said the last nurse they saw or spoke to was good at giving them enough time (CCG and national 92%)
- 79% of respondents said the last nurse they spoke to was good at treating them with care and concern (CCG 90%, national 91%)

We discussed these results with the practice, who informed us they felt that workload demands and a shortage of permanent clinicians may have contributed to the poor patient satisfaction. However, they had responded to patient feedback from the NHS Friends and Family Test to improve access by increasing the number of same day appointments and telephone consultations.

All of the 18 CQC patient comment cards we received were positive about the care they experienced. Patients stated they felt the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect. Several comments identified individual clinicians citing them as being 'very caring and understanding'.

Care planning and involvement in decisions about care and treatment

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

- The choose and book service was used with all patients as appropriate.
- Interpretation services were available for patients who did not have English as a first language.
- There were information leaflets and posters displayed in the reception area available for patients. There was also information available on the practice website. However, information both in the practice and on the website was not available in other languages, suitable for those patients whose first language was not English.
- The practice delivered care and support for some patients using an NHS approach called the Year of Care (YoC). YoC supports and enables patients to be involved in their own care, by providing a more personalised approach and supporting self-management. It was used with all patients who had chronic obstructive pulmonary disease (COPD), ischaemic heart disease (IHD), diabetes and those who were at high risk of developing diabetes.
- Patient comments we received said they felt involved in decisions about their care and treatment and were listened to.

Results from the national GP patient survey showed respondents rated the practice lower than other practices (CCG and nationally) regarding their involvement in planning and making decisions about their care and treatment. For example:

- 66% of respondents said the last GP they saw was good at involving them in decisions about their care (CCG 80%, national 82%)

Requires improvement

Are services caring?

- 74% of respondents said the last GP they saw was good at explaining tests and treatments (CCG 85%, national 86%)
- 76% of respondents said the last nurse they saw was good at involving them in decisions about their care (CCG 85%, national 85%)
- 80% of respondents said the last nurse they saw or spoke to was good at explaining tests and treatments (CCG 89%, national 90%)

Patient and carer support to cope emotionally with care and treatment

We saw there were notices and leaflets in the patient waiting area, informing patients how to access a number of support groups and organisations. There was also information available on the practice website. However, none of the information was available in other languages.

There was a carers' register in place and those patients had an alert on their electronic record to notify staff. The practice had identified 126 patients as being carers, this equated to just under 2% of the practice population. Carers were offered health checks, influenza vaccinations and signposted to local carers' support groups. We saw there were notices in the patient waiting area, informing patients how to access a number of support groups and organisations. They encouraged carers to participate in the Leeds yellow card scheme. The card informs health professionals that the individual is a carer for another person and to take this into consideration if the carer becomes ill, has an accident or is admitted to hospital.

The practice worked jointly with palliative (end of life) care and district nursing teams to ensure patients who required palliative care, and their families, were supported as needed. We saw minutes from meetings held with the palliative care team which evidenced care and treatment of patients. At the time of our inspection there were 29 patients on the palliative care register. We were informed that if a patient had experienced a recent bereavement, they would be contacted and support offered as needed.

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice reviewed the needs of its local population and engaged with the NHS England Area Team and CCG to secure improvement to services where these were identified. Services were provided to meet the needs of their patient population, which included:

- Home visits for patients who could not physically access the practice and were in need of medical attention
- Urgent access appointments for children and patients who were in need
- Telephone consultations
- Longer appointments as needed
- Extended hours access
- Travel vaccinations which were available on the NHS
- Interpretation services
- Facilities for disabled patients, such as access to the premises and toilets

Access to the service

East Park Medical Centre was open Monday to Friday 8am to 6pm, with extended hours from 7am on Monday. GP appointments were available:

Monday 7am to 12.30pm and 1pm to 3pm

Tuesday 8.30am to 12.30pm and 3.30pm to 5.30pm

Wednesday 9am to 12.30pm

Thursday 8.30am to 11.30am and 2.50pm to 5pm

Friday 8.30am to 12.30pm and 3pm to 5.30pm

Halton Medical Practice was open Monday to Friday 8am to 6pm. GP appointments were available:

Monday 3pm to 6pm

Tuesday 8.30am to 11.30am and 3pm to 5pm

Wednesday 8am to 11am and 2.20pm to 5.30pm

Thursday 8.30am to 11.30am and 3pm to 5pm

Friday 8am to 11am and 1.50pm to 4pm

In addition, there were extended hours from 6.30pm to 7.30pm on Mondays at either location. We were informed the GP partners also did additional sessions to support patient demand.

Appointments could be pre-booked up to two weeks in advance, with same day appointments also available. Nursing appointments could be pre-booked up to six weeks in advance. Telephone consultations were sometimes held by clinicians, dependent on the need of the patient.

When the practice was closed out-of-hours services were provided by Local Care Direct, which could be accessed via the surgery telephone number or by calling the NHS 111 service.

Data from the national GP patient survey showed that satisfaction rates regarding how respondents could access care and treatment from the practice were generally lower than local CCG and national averages. For example:

- 67% of respondents were fairly or very satisfied with the practice opening hours (CCG 77%, national 78%)
- 66% of respondents said they could get through easily to the surgery by phone (CCG 71%, national 73%)
- 48% of respondents described their experience of making an appointment as good (CCG 71%, national 73%)

We spoke with the practice regarding their low patient satisfaction scores. They had identified there had been issues regarding accessing clinical appointments due to the decreased number of clinicians being available and the increase in the numbers of patients registered.

Listening and learning from concerns and complaints

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

- The 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.
- The practice kept a record of all written and verbal complaints.
- All complaints and concerns were discussed at the practice meeting. Learning was cascaded to staff as appropriate.
- There was information displayed in the waiting area to help patients understand the complaints system, although this was not available in other languages.

We saw there had been 14 written and 18 verbal complaints received in the last 12 months. We found they

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

had been satisfactorily handled. Lessons had been learned and action taken to improve quality of care. For example, in relation to a trend of complaints with regard to customer care, reception staff had been given training on how to deal with patients appropriately.

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 had a vision and aim to deliver high quality care and promote good outcomes for patients and staff were aware of this. However, there was no evidence of a business plan or strategy to support delivery of this.

Governance arrangements

There were some governance arrangements in place, however not all were effective:

- There was a business continuity plan, however, it did not contain clear instructions of what should be done and who to contact in an emergency situation. For example, should there be a failure in electricity or telephone systems within the practice.
- The practice had a number of policies and procedures to govern activity, however, some of the policies were generic and not practice specific. They operated two different electronic policy storage systems. We saw there were two versions of policies, which differed from one another. At the time of inspection staff informed us they were unclear as to which policies they should be using.
- Risks and issues were not always identified which related to health and safety, infection prevention and control and the recall and review of patients. There was a system in place for the recall and review of patients, however, it was not effective in ensuring all patients were reviewed in a timely manner.

Leadership and culture

The GP partners told us they prioritised safe, high quality care. However, we found issues that threatened the delivery of this were not always responded to or managed adequately.

- We were informed that practice meetings took place, however, these had predominantly been held between the GP partners in isolation. We were informed the practice manager had not always been invited to attend these meetings. Nursing staff told us that although they were invited they experienced difficulty in attending the meetings due to work demands. The impact of this was that there was a risk the practice manager and nursing staff were not kept up to date with any concerns regarding patients or future developments within the practice.
- Staff we spoke with expressed their concern of not having the capacity to fulfil the requirements of their roles. We were informed that staff had previously been paid for working overtime, but this had now been stopped by the GP partners. However, staff told us they felt there were not enough people to cover the workload, that the 'work was building up' and they were feeling increasingly under pressure as a result. The managers told us of the low morale amongst the staff as a whole.
- New staff had received an induction but this was variable in length and not a robust process. Mentorship of new nursing staff was difficult due to capacity issues. We were informed a new clinical member of staff commenced full clinical sessions with patients on their first day of working.
- We were informed the practice manager did not always feel involved or supported regarding management of the practice. They were not routinely involved in the recruitment of nursing staff.
- Staff were not up to date with their annual appraisals and it was not clear whether all staff had completed their mandatory training requirements.

The provider was aware of and had a process in place to ensure compliance with the duty of candour. We were told there was a culture of openness and honesty. This was reflected in the issues and concerns staff raised with us on the day of inspection.

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

- There was limited evidence to demonstrate the practice encouraged feedback from patients. We did not see evidence of a practice initiated patient survey, however they used the information received from the NHS Friends and Family test and had made some changes as a result. For example, they had reviewed the number of 'on the day' appointments and appointments available for those patients who worked.
- We spoke with three patients, who were also members of the patient participation group (PPG). We were given several examples where they had encountered issues, particularly with regard to repeat prescriptions. They

Are services well-led?

Inadequate

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

also informed us they felt the practice did not engage with them regularly as a PPG, with the last meeting being in December 2015 of which they had not received any minutes. They had raised some issues but at the time of inspection had not received any feedback from the practice. Suggestions had included improving the patient notice boards, members of staff having name badges and keeping the website up to date. They had also requested a GP attend the PPG meetings, in addition to the practice manager.

- There were few staff meetings being held. Staff attended the TARGET afternoon training sessions once a month, where some issues may be discussed. It was difficult to assess whether staff feedback was encouraged or acted upon. The majority of staff said they could raise any issues with the GPs and had raised their concerns about not having enough capacity for the workload demand. At the time of inspection, there was little evidence to support how these concerns had been responded to by the provider.

Continuous improvement

At the time of inspection the practice themselves had identified many of the areas of concern to the inspection team. The practice informed us they found it a struggle at the present time to take on board new initiatives and resolve some of the issues, due to the challenges relating to staffing, patient demand and the premises.

The practice were engaging with NHS England and the local CCG to look at ways of improving. As a result of the inspection, they had also accepted an offer from the CCG of two half day facilitated time-out sessions. This was to support and enable the practice to concentrate on key areas of concern, develop an action plan and identify timescales for implementation and completion.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **How the regulation was not being met:** The registered provider did not always ensure that persons employed received appropriate support, training, mentoring and appraisal as was necessary to enable them to carry out the duties they were employed to do. This was in breach of regulation 18 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **How the regulation was not being met:** Care and treatment was not provided in a safe way for service users. Specifically: • The provider had not assessed the risks to the safety and welfare of service users relating to the risk of fire. There was little evidence to show the provider always did all that was reasonably practicable to mitigate any identified risks. • The provider was not assessing the risk of, and preventing, detecting and controlling the spread of, infections effectively. • The provider was not always assessing the risks to the health and safety of service users of receiving the care or treatment, or doing all that is reasonably practicable to mitigate any such risks. Not all significant events were reported by staff and acted on accordingly. • The management of medicines was not proper and safe. The process for repeat prescribing and the recall and review of patients was not always safe and effective. The provider had not undertaken a risk assessment relating to the emergency medicines kept in GPs' bags. This was in breach of regulation 12 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services	Regulation 17 HSCA (RA) Regulations 2014 Good governance **How the regulation was not being met:**

This section is primarily information for the provider

Enforcement actions

Surgical procedures

Treatment of disease, disorder or injury

The registered provider did not have effective systems and processes in place to demonstrate good governance. Specifically:

- There was a failure to assess and act on identified risks to the health and safety of staff and service users.
- There was a failure to maintain such records as are necessary to be kept in relation to the management of the regulated activities. Two different versions of policies were being used by staff.
- There was a failure to seek and act on feedback from relevant persons and other persons on the services provided, for the purposes of continually evaluating and improving such services. This included engaging with staff, with the patient participation group and in obtaining patient feedback.

This was in breach of regulation 17 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.