Dr Lalta Sachdeva

Quality Report

Abbey Court Medical Centre
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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?	Requires improvement
Are services responsive to people's needs?	Good
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 Dr Lalta Sachdeva on 5 May 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 there were no systems and processes in place to keep them safe. For example, appropriate recruitment checks on staff had not been undertaken prior to their employment, medicine management issues and actions identified to address concerns with infection control practice had not been taken.
- The practice did not have formal systems to underpin how significant events, incidents and concerns should be monitored, reported and recorded. Information about safety was not used to promote learning and improvement. There were no formal arrangements for monitoring safety, using information from audits, risk assessments and routine checks.
- Staffing levels were at a minimum level, which had a significant impact when staff were absent, due to sickness or holidays. There was a lack of evidence to demonstrate that actions were being taken to address this.
- National guidance and professional guidelines were not always being used to promote best practice in the care and treatment provided.
- Staff we spoke with told us they felt supported however; there was no documentary evidence to support this. For example, a newly appointed member of staff had not been supported by a formal induction program and existing staff had not received regular appraisals.

Summary of findings

- All staff had been trained in safeguarding procedures and a lead had been identified for both vulnerable adults and children.
- Data showed some patient outcomes were low compared to the locality and nationally.
- There was no evidence of two cycle clinical audits, in order to support quality improvement activity.
- Results from the National GP Patient Surveys in July 2015 and January 2016 indicated that patients scored the practice lower than average in relation to; GPs and nurses listening to them giving them enough time and treating them with care and concern. The practice scored higher than averagefor accessing the service and the manner in which reception staff treated them.
- Patients were positive about their interactions with staff and said they were treated with compassion and dignity.
- Appointment systems were effective and patients received timely care when they needed it.
- There was a lack of appropriate or suitable governance systems and processes. This meant that the practice was not providing safe, effective caring or well-led services for their patients, nor were they assessing and monitoring those services.
- The provider was aware of the requirements of the duty of candour. However, there were no systems to ensure compliance with the duty of candour, which included support training for all staff on communicating with patients about notifiable safety incidents.
- The practice did not have a Patient Participation Group (PPG). Whilst they were advertising for new volunteers to establish a new PPG, the practice had not reflected or learnt lessons from the last PPG, in order to ensure the effectiveness of such a group and to ensure improvements were made to the services offered.

The areas where the provider must make improvements are:

- Ensure that information about safety is used to promote learning and improvement by ensuring there are formal arrangements for monitoring safety, significant events, incidents and concerns; using information from audits, risk assessments and routine checks.
- Ensure that national guidance and professional guidelines are used to promote best practice in the care and treatment provided.
- Ensure recruitment arrangements include all necessary employment checks for all staff. Including appropriate risk assessments being completed for all staff where Disclosure and Barring Service (DBS) checks are deemed unnecessary.
- Ensure that new staff to the practice receive an induction that is recorded and they are signed off as competent for the role. As well as, ensuring staff are provided with up to date policies and guidance to carry out their roles in a safe and effective manner which are reflective of the requirements of the practice.
- Ensure that governance processes and procedures are implemented to establish an on-going programme of quality improvement activity, such as patient feedback, lessons learnt from the previous PPG and clinical audits, as well as audits of safety alerts which must be used to monitor quality and systems to identify where action should be taken.
- Ensure feedback is sought from patients in relation to the services provided at the practice and implement improvements where identified.
- Ensure that the structure of staff meetings inform staff about the safety and performance issues affecting the practice and enable staff to feedback about services to be provided in a timely manner. Ensure that minutes are recorded that reflect the discussion and any actions that follow, including an audit trail for completion.

In addition the provider should:

- Improve the system that identifies patients who are also carers to help ensure that all patients on the practice list who are carers are offered relevant support if required.

I am placing this service in special measures. Services placed in special measures will be inspected again within

Summary of findings

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.

- Staff did not formally report incidents, near misses and concerns. There was no evidence to show that the practice carried out investigations when there were unexpected safety incidents. Lessons learned were not formally communicated and so safety was not always improved. Patients did receive reasonable support but not a verbal and written apology.
- There were no formal processes to ensure that risks to patients' and staff safety were being monitored and managed. There were no formal processes to ensure that risks to patients' and staff safety were being monitored and managed. For example, there were no systems to routinely check that the landlord had carried out up to date fire risk assessments and fire drills, testing of electrical equipment to ensure the equipment was safe to use and working properly, as well as legionella testing. Recruitment checks were not conducted appropriately before staff were employed. Infection control procedures were carried out effectively. Medicine management was not always safe, in order to ensure that medicines held at the practice were safe to use, including the safety of prescriptions. Emergency equipment and medicine checks were routinely recorded.
- The practice had clearly defined and embedded systems, processes and practices to keep patients safeguarded from abuse.

Are services effective?

Inadequate

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

- Data showed that care and treatment was not delivered in line with recognised professional standards and guidelines. For example, p53% of patients with diabetes, on the register, in whom the last IFCCHbA1c (a blood test to check blood sugar levels) was 64 mmol/mol or less in the preceding 12 months (national average 79%).
- There was no evidence of two cycle clinical audits, in order to support quality improvement activity. Additionally, there was no evidence that the practice was comparing its performance to others; either locally or nationally.

Summary of findings

- The practice engaged with other providers of health and social care.
- There was limited recognition of the benefit of an appraisal process for staff.
- There was evidence of staff training. However, there were gaps identified. For example, records of training showed that the nurse had not been trained in infection control since 2013 and the healthcare assistant since 2011.
- The practice was below national and local averages for results in relation to its patients attending national screening programmes for bowel and breast cancer screening. For example, 47% of eligible patients had been screened for bowel cancer, which was below the CCG average of 61% and the national average of 58%.
- Childhood immunisation rates for the vaccinations given were lower than CCG/national averages. For example, childhood immunisation rates for the vaccinations given to five year olds ranged from 40% to 90% (CCG average 81% to 94%).

Are services caring?

Requires improvement

The practice is rated as requires improvement for providing caring services, as there are areas where improvements should be made.

- Data from the national GP patient survey showed patients rated the practice lower than others for some aspects of care. 77% of patients said the GP was good at listening to them compared to the clinical commissioning group (CCG) average of 84% and the national average of 81%. When asked the same question about nursing staff the results were 82% compared to the CCG average of 92% and national average of 91%.
- Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.
- Information for patients about the services available was easy to understand and accessible. The practices website had a translate button, which enabled the website to be read in several languages, in order to provide patients whose first language was not English with access to information.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services.

- Practice staff reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group to secure improvements to services where these were identified.

Summary of findings

- Patients said they found it easy to make an appointment with a named GP and there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- Information about how to complain was available and easy to understand.

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. There was a lack of team meetings to reflect that any vision had been discussed and shared with staff other than plans to recruit more GPs. Staff spoken with were not clear about the vision of the practice. The practice did not hold regular governance meetings and issues were discussed informally. Records of meetings that had taken place were lacking detail in relation to the issues discussed, action that had been taken and the person identified as being responsible for implementing improvements.
- There was a lack of leadership but staff told us they felt supported by management. There was also a lack of knowledge about the issues affecting the practice and insufficient action had been taken to improve them or formally share them with staff working at the practice.
- We found that the practice were aware of performance issues but there was no direction from the principal GP and the practice management to address these issues and no evidence to identify they had been addressed.
- The practice did not have an on-going programme of clinical audits to monitor quality and systems to identify where improvements could be made. Additionally, the practice did not have formal systems to underpin how significant events, incidents and concerns should be monitored, reported and recorded. Information about safety was not used to promote learning and improvement. There were no formal arrangements for monitoring safety, using information from audits, risk assessments and routine checks.
- Staff were encouraged to provide feedback but this was not being recorded. The staff meeting structure did not include issues such as significant events, safety alerts, complaints and updates to guidance.
- The practice did not have a patient participation group (PPG). Whilst they were advertising for new volunteers to establish a

new PPG, the practice had not reflected or learnt lessons from the last PPG, in order to ensure the effectiveness of such a group and to ensure improvements were made to the services offered.

- Staff told us they had not received regular practice performance updates in the form of formal supervision or regular appraisals.
- The provider had not ensured that the policy for recruitment and training was being followed.
- The practice did not provide any evidence to suggest that there was an ethos of continuous learning.

Summary of findings

The six population groups and what we found

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

Older people

Inadequate

The practice is rated as inadequate for providing safe, effective and well-led services, rated as requires improvement for providing caring services and rated good for providing responsive services. The concerns which led to these ratings apply to everyone using the practice, including this population group.

- The practice offered proactive, personalised care to meet the needs of the older people in its population.
- Patient satisfaction rates of the GPs at the practice were consistently low as compared with other practices locally and nationally.
- The practice performance in relation to the Quality and Outcomes Framework were below local and national averages.
- Care and treatment of older people did not always reflect current evidence-based practice.
- Staff at the practice had received training and understood the process to follow if they suspected any adult safeguarding concerns.
- Longer appointments and home visits were available for older people when needed.
- There was a system to follow up patients who had attended accident and emergency (A&E) to put steps in place to prevent a reoccurrence.

People with long term conditions

Inadequate

The practice is rated as inadequate for providing safe, effective and well-led services, rated as requires improvement for providing caring services and rated good for providing responsive services. The concerns which led to these ratings apply to everyone using the practice, including this population group.

- Data available to us reflected that the practice was below the local and national average in relation to the monitoring of diabetes and chronic obstructive pulmonary disease.
- Satisfaction rates about the GPs overall were low as measured by data from the National GP Patient Surveys of July 2015 and January 2016. This data also applied to this population group.
- Longer appointments and home visits were available when needed.
- Patients with complex needs had their care and treatment needs assessed with relevant health and care professionals to deliver a multidisciplinary package of care.

Summary of findings

- Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority.
- The practice performance in relation to the Quality and Outcomes Framework were below local and national averages.

Families, children and young people

Inadequate

The practice is rated as inadequate for providing safe, effective and well-led services, rated as requires improvement for providing caring services and rated good for providing responsive services. The concerns which led to these ratings apply to everyone using the practice, including this population group.

- There were systems to identify and follow up children living in disadvantaged circumstances and who were at risk. For example, children and young people who had a high number of A&E attendances.
- Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals.
- Appointments were available outside of school hours and the premises were suitable for children and babies.
- Immunisation rates were low for some of the standard childhood immunisations.
- The practice's uptake for the cervical screening programme was 75%, which was comparable to the CCG average of 83% and the national average of 81%.
- There was a collection point in the practice for obtaining Chlamydia testing kits.

Working age people (including those recently retired and students)

Inadequate

The practice is rated as inadequate for providing safe, effective and well-led services, rated as requires improvement for providing caring services and rated good for providing responsive services. The concerns which led to these ratings apply to everyone using the practice, including this population group.

- The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care.
- The practice offered online services as well as a full range of health promotion and screening that reflects the needs for this age group.

Summary of findings

- Satisfaction rates about the GPs overall were low as measured by data from the National GP Patient Surveys of July 2015 and January 2016. This data also applied to this population group.

People whose circumstances may make them vulnerable

Inadequate

The practice is rated as inadequate for providing safe, effective and well-led services, rated as requires improvement for providing caring services and rated good for providing responsive services. The concerns which led to these ratings apply to everyone using the practice, including this population group.

- The practice held a register of patients living in vulnerable circumstances including those with a learning disability.
- The practice offered longer appointments for patients with a learning disability.
- The practice regularly worked with other health care professionals in the case management of vulnerable patients.
- The practice informed vulnerable patients about how to access various support groups and voluntary organisations.
- Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.
- Satisfaction rates about the GPs overall were low as measured by data from the National GP Patient Surveys of July 2015 and January 2016. This data also applied to this population group.

People experiencing poor mental health (including people with dementia)

Inadequate

The practice is rated as inadequate for providing safe, effective and well-led services, rated as requires improvement for providing caring services and rated good for providing responsive services. The concerns which led to these ratings apply to everyone using the practice, including this population group.

- Performance for dementia related indicators were worse than the local and national average. For example, 57% of patients diagnosed with dementia whose care had been reviewed in a face-to-face review in the preceding 12 months (local average 85% and national average 84%).
- Performance for mental health related indicators were similar to the national average. For example, 86% of patients with

schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive, agreed care plan documented in the record, in the preceding 12 months (local and national average 88%).

- The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those with dementia.
- The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations.
- The practice had a system to follow up patients who had attended accident and emergency where they may have been experiencing poor mental health.
- Staff had a good understanding of how to support patients with mental health needs and dementia.

Summary of findings

What people who use the service say

The national GP patient survey results were published in January 2016. The results showed the practice was performing in line with local and national averages. Three hundred and seven survey forms were distributed and 106 were returned. This represented 2.4% of the practice's patient list.

- 99% of patients found it easy to get through to this practice by phone compared to the national average of 73%.
- 89% of patients were able to get an appointment to see or speak to someone the last time they tried compared to the national average of 76%.
- 85% of patients described the overall experience of this GP practice as good compared to the national average of 85%.
- 77% of patients said they would recommend this GP practice to someone who has just moved to the local area compared to the national average of 79%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received eight comment cards which were all positive about the standard of care received. General themes that ran through the comments included the caring attitude of all staff and the availability of appointments.

We spoke with three patients during the inspection. All patients said they were satisfied with the care they received and thought staff were approachable and caring. The practice took part in the NHS friends and family test and 80% of those taking part would recommend the practice.

Areas for improvement

Action the service MUST take to improve

- Ensure that information about safety is used to promote learning and improvement by ensuring there are formal arrangements for monitoring safety, significant events, incidents and concerns; using information from audits, risk assessments and routine checks.
- Ensure that national guidance and professional guidelines are used to promote best practice in the care and treatment provided.
- Ensure recruitment arrangements include all necessary employment checks for all staff. Including
- Ensure that new staff to the practice receive an induction that is recorded and they are signed off as competent for the role. As well as, ensuring staff are provided with up to date policies and guidance to carry out their roles in a safe and effective manner which are reflective of the requirements of the practice.
- Ensure that governance processes and procedures are implemented to establish an on-going programme of quality improvement activity, such as patient feedback, lessons learnt from the previous PPG and clinical audits, as well as audits of safety alerts which must be used to monitor quality and systems to identify where action should be taken.
- Ensure feedback is sought from patients in relation to the services provided at the practice and implement improvements where identified.
- Ensure that the structure of staff meetings inform staff about the safety and performance issues affecting the practice and enable staff to feedback about services to be provided in a timely manner. Ensure that minutes are recorded that reflect the discussion and any actions that follow, including an audit trail for completion.

Action the service SHOULD take to improve

- Improve the system that identifies patients who are also carers to help ensure that all patients on the practice list who are carers are offered relevant support if required.

Dr Lalta Sachdeva

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector**.** The team included a GP specialist adviser and a practice manager specialist adviser.

Background to Dr Lalta Sachdeva

Dr Lalta Sachdeva (also known as Abbey Court Medical Centre) delivers services from purpose built premises in Tunbridge Wells, Kent. There are approximately 4,388 patients on the practice list. The practice is similar across the board to the national averages for each population group. For example, 6.2% of patients are aged 0 -12 months compared to the CCG average of 6% and the national average of 5.9% and 20.4% are aged under 18 years compared to the CCG average of 21.8% and the national average of 20.7%. Scores were similar for patients aged 65, 75 and 85 years and over. The practice is in one of the least deprived areas of Kent.

The practice holds a Personal Medical Service contract is led by one GP (female). The GP is supported by two locum GPs (male), a practice nurse (female) and a healthcare assistant (female), a practice manager and a team of administration and reception staff. A range of services and clinics are offered by the practice including asthma and diabetes.

The practice is open from 8am to 6.30pm. Morning appointments are from 8.30am to 11.00am and afternoon appointments are from 3.30pm to 6.00pm. There is an early morning clinic every Tuesday from 7am to 8.30am and an early evening clinic every Wednesday from 6.00pm to 7.30pm.

An out of hour's service is provided by Integrated Care 24, outside of the practices open hours. There is information available to patients on how to access this at the practice, in the practice information leaflet and on the website.

Services are delivered from:

Abbey Court Medical Centre, 3rd Floor Abbey Court, 7-15 St Johns Road, Tunbridge Wells, Kent, TN4 9TF

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 5 May 2016.

During our visit we:

Detailed findings

- Spoke with a range of staff including the principal GP, the practice nurse, the healthcare assistant, the practice manager and members of the administration team.
- Spoke with three patients who used the service.
- Talked with carers and/or family members.
- Reviewed an anonymised sample of the personal care or treatment records of patients.
- Reviewed eight comment cards where patients and members of the public shared their views and experiences of the service.

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

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

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

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

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

Inadequate

Are services safe?

Our findings

Safe track record and learning

There was no formal system for reporting and recording significant events.

- Staff told us they would inform the practice manager of any incidents. However, there was no recording form available to staff to formally record incidents.
- There was no documented evidence to show that when things went wrong with care and treatment, patients were informed of the incident, received reasonable support, truthful information, a written apology and were told about any actions to improve processes to reduce the chance of the same thing happening again.
- The practice did not carry out a thorough analysis of the significant events.

Staff told us that lessons were shared and action was taken to improve safety in the practice. For example, following a medical emergency, the practice staff discussed what went well and areas that would need developing in future incidents of this kind. However, there were no safety records, incident reports or minutes of meetings to evidence this discussion.

Overview of safety systems and processes

The practice had clearly defined and embedded systems, processes and practices to keep patients safeguarded against abuse:

- Arrangements to safeguard children and vulnerable adults from abuse. These arrangements reflected relevant legislation and local requirements. Policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. There was a lead member of staff for safeguarding. The principal GP attended safeguarding meetings when possible and provided reports where necessary for other agencies. Staff demonstrated they understood their responsibilities and all had received training on safeguarding children and vulnerable adults relevant to their role. GPs and the practice nurse were trained to child protection or child safeguarding level three.
- A notice in the waiting room advised patients that chaperones were available if required. All staff who acted as chaperones were trained for the role and had received a Disclosure and Barring Service (DBS) check. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).

However, the practice did not always have clearly defined and embedded systems, processes and practices to keep patients safe, which included:

- The practice did not always maintain appropriate standards of cleanliness and hygiene. Whilst we observed the premises to be clean and tidy, we found that the sluice was being used for storing empty sharps boxes. These were placed on the floor, which was not completely clean and dust was evident. There was no procedure for cleaning the base of the sharps box before it was placed in a clinical area. The practice nurse was the infection prevention control clinical lead. However, training to support this role was out of date and files showed that clinical staff had not received any further infection control training or updates since 2013. Records showed that all other staff had received up to date training. There was an infection control protocol. However, this consisted of one document, which was basic in content and was not dated. There were no records to support that annual infection control audits were undertaken.
- The arrangements for managing medicines, including emergency medicines and vaccines, in the practice did not always keep patients safe. Processes for handling repeat prescriptions included the review of high risk medicines. The practice carried out regular medicines audits, with the support of the local CCG pharmacy teams, to ensure prescribing was in line with best practice guidelines for safe prescribing. For example, reviewing antibiotic items prescribed that are Cephalosporins or Quinolones. The fridge used for the safe storage of vaccines was not routinely checked. Records of fridge temperature checks showed that between January 2016 and the date of our visit, there were periods of between three and five days when the fridge temperatures had not been recorded. The recordings noted had been made by the practice nurse. However, there was no system to check the fridge temperatures on the days when the nurse was not at the practice. Patient Group Directions had been adopted by

the practice to allow the nurse to administer medicines in line with legislation. The health care assistant was trained to administer vaccines against a patient specific prescription or direction from a prescriber.

- We reviewed three personnel files and found Inductions for new staff were not being recorded.

Monitoring risks to patients

Risks to patients were not always assessed and managed.

- There were limited procedures for monitoring and managing risks to patient and staff safety. For example, there were no systems to check that there was an up to date fire risk assessment, records of regular fire drills, testing of electrical equipment to ensure the equipment was safe to use and working properly and legionella testing. (Legionella is a term for a particular bacterium which can contaminate water systems in buildings). We were told that the building was owned by a landlord, who was responsible for this.

  We saw that fire safety equipment was checked in 2013. There were no records to show that further checks had been conducted, in order to ensure the equipment was safe to use and was working properly.

- There was a health and safety policy available with a poster which identified local health and safety representatives. The practice had other risk assessments to monitor safety of the premises. For example, control of substances hazardous to health.

- There were arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. However, the practice manager told us that staffing levels were currently at a minimum level, which had a significant impact when staff were absent, due to sickness or holidays. There was a lack of evidence to demonstrate that actions were being taken to address this.

Arrangements to deal with emergencies and major incidents

The practice had adequate arrangements 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.

- All staff received annual basic life support training. Staff told us of an incident that had occurred at the practice and gave us examples of how the incident was managed to ensure patient safety.

- 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 nurse told us that these were routinely checked on a three month basis. However, there were no records to evidence that such checks had been made.

- The practice had a defibrillator available on the premises and oxygen with adult and children's masks. Staff told us that these were checked on an annual basis by external body, when the manufacturer checks were being conducted. There were no checks carried out by practice staff in between the annual checks. We raised this with the practice manager, who subsequently sent us documentary evidence to show that a new book for recording checks on a monthly basis had been obtained, with the first check having been conducted and recorded, the day after our inspection.

- A first aid kit and accident book were available.

- The practice had a business continuity plan for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff.

Inadequate

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice did not always assess needs and deliver 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 told us NICE guidance and alerts were routinely discussed and monitored. However, there was no evidence to show these were discussed with the staff team or to show that they were used to inform the delivery of care and treatment to meet patients' needs.
- The practice did not monitor these guidelines through risk assessments, audits and random sample checks of patient records.

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent published results were 71% of the total number of points available, with 5.6% exception reporting (compared to the CCG average of 9%). (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).

This practice was an outlier for some QOF (or other national) clinical targets. Data from 2014/15 showed:

- Performance for mental health related indicators were similar to the national average. For example, 86% of patients with schizophrenia, bipolar affective disorder and other psychoses who had a comprehensive, agreed care plan documented in the record, in the preceding 12 months (national average 88%).
- Performance for dementia related indicators were worse than the local and national average. For example, 57% of patients diagnosed with dementia whose care had been reviewed in a face-to-face review in the preceding 12 months (local average 85% and national average 84%). The practice provided us with QOF data from the 2015/16 (which has not yet been verified, published and made publically available) and these showed that a 1% improvement had been made. The practice informed us they had experienced issues with their IT system last year, which they say accounted for the error between the two results.

There was no evidence of quality improvement as to how outcomes for patients were monitored, as no reference was made to clinical audits beyond those set out by the Clinical Commissioning Group and medicines management.

- The practice participated in medicine management audits with the support of the local CCG pharmacy teams. Information about patients' outcomes was used to make improvements such as: reviewing patients on a certain medicine which had adverse cardiac (heart) side effects.
- However, there was no system to routinely conduct additional clinical audits and no two cycle audits had been carried out in the last two years.

Effective staffing

Staff did not always the skills, knowledge and experience to deliver effective care and treatment.

- There was evidence of staff training. However, there were gaps identified. For example, records of training showed that the infection control lead nurse had not been trained in infection control since 2013 and the healthcare assistant since 2011. Records showed that staff had received training that included: safeguarding, fire safety awareness and basic life support. Staff had access to and made use of e-learning training modules and in-house training.
- Staff told us they were supported by the management team. However, there was no formal system to ensure that staff received ongoing support, appraisals, mentoring, and clinical supervision There was facilitation and support for revalidating GPs and nurses. Staff told us that they had not received an appraisal for in the last two years.
- The practice had an induction programme for all newly appointed staff. It covered such areas as safeguarding, infection prevention and control, fire safety awareness, health and safety and confidentiality. One of the newer members of staff told us they had received induction

training. However, the practice was unable to produce documented evidence that confirmed that induction training had been completed or that staff had achieved the required competency.

- Staff administering vaccines and taking samples for the cervical screening programme had received specific training which had included an assessment of competence. Staff who administered vaccines could demonstrate how they stayed up to date with changes to the immunisation programmes. For example, by access to on line resources.

Coordinating patient care and information sharing

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

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

Staff worked together and with other health and social care professionals to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. This included when patients moved between services, including when they were referred, or after they were discharged from hospital. Meetings took place with other health care professionals on a monthly basis when care plans were routinely reviewed and updated for patients with complex needs. However, minutes of such meetings were not being recorded.

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 assessed the patient's capacity and, recorded the outcome of the assessment.
- The process for seeking consent was not routinely monitored through patient records audits, as these had not been carried out.

Supporting patients to live healthier lives

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

- Patients receiving end of life care, carers and those at risk of developing a long-term condition. As well as those requiring advice on their diet, smoking and alcohol cessation. Patients were signposted to the relevant service.
- Smoking cessation advice was available from a local support group.

The practice's uptake for the cervical screening programme was 75%, which was comparable to the CCG average of 83% and the national average of 81%.The practice provided us with QOF data from the 2015/16 (which has not yet been verified, published and made publically available) and these showed that a 1% improvement had been made. The practice informed us they had experienced issues with their IT system last year, which they say accounted for the error between the two results. The practice contacted patients who did not attend to remind them of the importance of the test. There were systems 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.

The practice achieved low results in relation to its patients attending national screening programmes for bowel and breast cancer screening. For example, 47% of eligible patients had been screened for bowel cancer, which was below the CCG average of 61% and the national average of 58%. Sixty one percent of eligible patients had been screened for breast cancer, compared to the CCG average of 74% and the national average of 72%.

Childhood immunisation rates for the vaccinations given were lower than CCG/national averages. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 43% to 92% (CCG average 68% to 92%). Rates for five year olds ranged from 40% to 90% (CCG average 81% to 94%).

Patients had access to appropriate health assessments and checks. These included health checks for new patients and

Inadequate

Are services effective?

(for example, treatment is effective)

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.

Requires improvement

Are services caring?

Our findings

Kindness, dignity, respect and compassion

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

- Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- We noted that consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- When patients wanted to discuss sensitive issues or appeared distressed, reception staff could offer them a private room, in order to discuss their needs.
- The facilities the practice had for the storage of patients confidential information was not being used appropriately. For example, we found that the room used to store records had a key code which, on the day of our visit, had been disabled and accessible to an unauthorised person. Additionally, we found completed repeat prescriptions ready for collection were not stored securely when the premises were closed overnight.

All of the eight patient Care Quality Commission comment cards we received were positive about the service experienced. Patients said they felt the practice offered a good service and staff were helpful, caring and treated them with dignity and respect. Comment cards also highlighted that staff responded compassionately when they needed help and provided support when required.

Results from the national GP patient survey showed patients felt they were treated with compassion, dignity and respect. The practice scored slightly lower than the CCG and national averages in some areas for its satisfaction scores on consultations with GPs and nurses. For example:

- 91% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 96% and the national average of 95%.

  When asked the same question about nursing staff the results were:

- 92% of patients said they had confidence and trust in the last nurse they saw compared to the CCG average of 98% and national average of 97%.

However, the practice scored lower than average in other areas. For example:

- 77% of patients said the GP was good at listening to them compared to the clinical commissioning group (CCG) average of 84% and the national average of 81%.
- 83% of patients said the GP gave them enough time compared to the CCG average of 89% and the national average of 86%.
- 80% of patients said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 87% and national average of 85%.

When asked the same question about nursing staff the results were:

- 82% of patients said the nurse they saw was good at listening to them compared to the CCG average of 92% and national average of 91%.
- 83% of patients said the nurse gave them enough time compared to the CCG average of 92% and national average of 91%.
- 84% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 87% and national average of 85%.

The practice scored better than average for the helpfulness of reception staff.

- 93% of patients said they found the receptionists at the practice helpful compared to the CCG average of 89% and the national average of 86%.

Care planning and involvement in decisions about care and treatment

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

Requires improvement

Are services caring?

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

- 86% of patients said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 88% and the national average of 86%.
- 85% of patients described the overall experience of their GP practice as fairly good or very good compared to the CCG average of 86% and the national average of 85%.

However, the practice scored lower than average in other areas. For example:

- 82% of patients said the last nurse they saw was good at explaining tests and treatments compared to the CCG average of 91% and the national average of 89%.
- 77% of patients said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 84% and the national average of 81%. When asked the same question about nursing staff the results were 72% compared to the CCG average of 87% and 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. The practices website had a translate button, which enabled the website to be read in several languages.
- 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 16 patients as carers (0.4% of the practice list). There was a section on the practices new patient registration forms where patients record whether they were or have a carer. Written information was available to direct carers to the various avenues of support available to them, in the form of a poster in the waiting room and forms to submit to the practice.

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

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

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

- The practice offered an early morning clinic every Tuesday from 7am to 8.30am and an early evening clinic every Wednesday from 6.00pm to 7.30pm.for working patients who could not attend during normal opening hours.
- 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.
- There were disabled facilities, a hearing loop and translation services available, as well as baby changing facilities. There was a lift to ensure that those with mobility impairments and wheelchair bound patients could access all clinical areas of the practice.

Access to the service

The practice was open from 8am to 6.30pm. Morning appointments were from 8.30am to 11.00am and afternoon appointments are from 3.30pm to 6.00pm. There was an early morning clinic every Tuesday from 7am to 8.30am and an early evening clinic every Wednesday from 6.00pm to 7.30pm. In addition patients could book appointments up to twelve weeks in advance; 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 better than local and national averages.

- 92% of patients were satisfied with the practice's opening hours compared to the CCG averages of 77% and the national average of 78%.
- 99% of patients said they could get through easily to the practice by phone compared to the CCG average of 74% and the national average of 73%.
- 89% of patients stated that the last time they wanted to see or speak to a GP or nurse from their GP practice said they were able to get an appointment compared to the CCG average of 80% and the national average of 76%.

People told us on the day of the inspection that they were able to get appointments when they needed them and that reception staff went the extra mile to ensure this.

Listening and learning from concerns and complaints

The practice had a system for handling complaints and concerns.

- Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England.
- 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. Information was available to help patients understand the complaints system in the form of leaflets, notices and material on the practices website.

The practice had not received any complaints in relation to care and treatment. We were told that all complaints received related to the changes in the car parking facilities. In response, the practice had taken action to inform patients of the new parking system. For example, posters in the waiting room and staff were observed informing patients verbally.

Are services well-led?

Inadequate

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

Our findings

Vision and strategy

The practice did not have a clear vision of the future of the practice. Staff had been made aware of the planned recruitment of an additional GP but were not aware of the vision, strategy or objectives of the practice. The practice had a mission statement which was displayed in the waiting areas and staff knew and understood the values. However, due to the absence of regular formal team meetings and the lack of meeting minutes, the practice was unable to evidence that the vision of the practice was being discussed with staff.

The practice was aware of the performance data both in relation to the Quality and Outcomes Framework and the patient satisfaction data. However, no action plan had been considered, in order to improve.

Governance arrangements

The areas in which we identified required improvement or inadequate practice had occurred because there was a lack of appropriate or suitable governance systems and processes. This meant that the practice were not providing safe, effective caring or well-led services for their patients, nor were they assessing and monitoring those that they provided.

The practice did not have an on-going programme of clinical audits to monitor quality and systems to identify where action should be taken.

The practice did not have formal systems to underpin how significant events, incidents and concerns should be monitored, reported and recorded. Information about safety was not used to promote learning and improvement. There were no formal arrangements for monitoring safety, using information from audits, risk assessments and routine checks.

We found that there was a lack of governance and written communication at the practice in some areas;

- A comprehensive understanding of the performance of the practice was not being provided to staff by the principal GP. Staff spoken with were aware of performance issues and patient satisfaction data. However these had not been acknowledged by the practice, nor was there an action plan being considered, in order to improve.
- The principal GP was not aware of issues affecting the practice and was not providing an oversight to ensure that improvements were made. For example, routinely monitoring poor QOF results and taking action to address these.
- There was no formal process, such as minuted staff meetings, to evidence that staff were informed about the risks in relation to significant incidents and safety alerts, in order to reduce the risk of reoccurrence. There was a lack of clinical audit being used to monitor quality and to make improvements.
- There was a lack of evidence that clinical assessments were being monitored to ensure that guidance from the National Institute for Clinical and Healthcare Excellence were being followed.
- Practice specific policies were implemented and were available to all staff on the practice computer system. However, not all of these had been routinely reviewed and did not include up to date guidance. These included clinical governance, infection control and risk management.

Although there was a lack of governance, there was a clear staffing structure and staff were aware of their own roles and responsibilities.

Leadership and culture

The principal GP was not providing a safe, effective, caring or well led oversight of the practice, in order to ensure high quality care.

There were defined leads in place for various aspects of the practice and these included infection control and safeguarding. However, lead staff were not up to date with training in infection control.

Staff told us that :

- Practice meetings were held informally. However, minutes of such meetings were not always recorded.

Are services well-led?

Inadequate

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

- They felt valued and supported and were being kept informed about developments within the practice. However, there was no documentary evidence to support this.
- They were aware of significant events, complaints and some safety issues and they were encouraged to raise concerns or identify areas for improvement to the services provided. However, we found that there was a lack of documentary evidence that reflected that significant events, safety alerts and updates to guidance, such as NICE guidelines were being acted upon and discussed with staff in a timely manner.

We saw minutes of a practice meeting held in September 2015. These minutes were available for staff to read at any time. However, they did not contain sufficient detail and there was a lack of evidence to demonstrate that significant events, safety alerts, updates to guidance, performance and survey data were being discussed at meetings.

The provider was aware of the requirements of the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment). However, there were no systems to ensure compliance with the Duty of Candour, which included support training for all staff on communicating with patients about notifiable safety incidents. The practice did not have a system to ensure that when things went wrong with care and treatment and gave affected people reasonable support, truthful information and a verbal and written apology.

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

The practice had gathered feedback from their patients via the use of the Friends and Family Test. However, with the exception of a comments and suggestions box in the reception area for patients to use, there were no other means of gathering patient feedback. For example, through a patient survey.

The practice did not have a patient participation group (PPG). A PPG had been organised previously however, due to a decline in numbers, it had ceased to be operational. We saw posters

in the waiting room promoting the importance of a PPG and the practice were trying to recruit new volunteers. However, the practice had not reflected or learnt lessons from the decline of the last PPG.

Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management and felt involved and engaged to improve how the practice was

run. However, there were no systems or formal processes in order to ensure these were monitored, recorded and responded to.

Continuous improvement

We found that there was a lack of focus on continuous learning and improvement at many levels within the practice. There was a lack of assessment, monitoring and clinical audit of the services provided at the practice. There were known performance issues and the practice had failed to address them.

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 Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control **How the regulation was not being met:** The registered provider did not always ensure the proper and safe management of medicines; In that: The arrangements for managing medicines, including emergency medicines and vaccines, in the practice did not always keep patients safe. • The fridge used for the safe storage of vaccines was not always checked on a routine basis. Records of fridge temperature checks showed that between January and the date of our visit, there were periods of between three and five days when the checks had not been recorded. The recordings noted had been made by the practice nurse. However, there was no system to check the fridge temperatures on the days when the nurse was not at the practice. **This was in breach of regulation 12(1)(2)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.** The registered person did not do all that was reasonably practicable to assess the risk of, and prevent, detect and control the spread of, infections, including those that are health care associated. In that: • The sluice was being used for storing sharps boxes. These were placed on the floor, which was not completely clean and dust was evident. There was no procedure for cleaning the base of the sharps boxes before they were placed in a clinical area. **This was in breach of regulation 12(1)(2)(h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment **How the regulation was not being met:** The registered provider did not ensure that sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed in order to meet the requirements of this Part. In that: • There were arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. However, the practice manager felt that staffing levels were currently at a minimum level, which was impacted significantly when staff were absent, due to sickness or holidays. There was a lack of evidence to demonstrate that actions were being taken to address this. **This was in breach of regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.** The registered person did not ensure that persons employed by the service provider in the provision of a regulated activity received appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform. In that: • The provider had not ensured that the policy for staff training was being followed. • The learning needs of staff were identified. However, there was no formal system of appraisals, meetings and reviews of practice development needs. • Staff did not always access appropriate training updates to meet their learning needs and to cover the scope of their work. For example, records of training showed that the nurse had not been trained in infection control since 2013 and the healthcare assistant since 2011.

This section is primarily information for the provider

Requirement notices

- Staff told us they were supported by the staff team. However, there was no formal system to ensure that staff received ongoing support, one-to-one meetings, mentoring, and clinical supervision.
- Staff had not received an appraisal within the last 12 months.
- Inductions for new staff were not being recorded.

This was in breach of regulation 18 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 19 HSCA 2008 (Regulated Activities) Regulations 2010 Complaints **How the regulation was not being met:** The registered person did not have an established and effective recruitment procedure. In that: • The provider had not ensured that the policy for recruitment was being followed. Personnel files showed that • There was no process for checking the recruitment of locum GPs, in particular their registration with the General Medical Council and whether they were registered on the performers list. • Appropriate checks through the Disclosure and Barring Service had been obtained for all staff who acted as chaperones. However, we found that where staff did not require these, there were no risk assessments to indicate why they had been deemed not necessary. • There was no process for routinely checking the registration with the appropriate professional body for nursing staff. **This was in breach of regulation 19(1)(2)(3)(4) 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 Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **How the regulation was not being met:** The registered person did not assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services). In that: • The practice did not have formal systems to underpin how significant events, incidents and concerns should be monitored, reported and recorded. Information about safety was not used to promote learning and improvement. • Staff told us they would inform the practice manager of any incidents. However, there was no recording form available to staff to formally record incidents. • The practice did not carry out a thorough analysis of the significant events. • There was no documented evidence to show that when things went wrong with care and treatment, patients were informed of the incident, received reasonable support, truthful information, a written apology and were told about any actions to improve processes to prevent the same thing happening again. • Staff told us that lessons were shared and action was taken to improve safety in the practice. For example, following a medical emergency, the practice staff discussed what went well and areas that would need developing in future incidents of this kind. However, there were no safety records, incident reports or minutes of meetings to evidence this discussion.

This section is primarily information for the provider

Enforcement actions

- There were no formal arrangements for monitoring safety, using information from audits, risk assessments and routine checks, as these had not formally been carried out.
- Fire safety equipment was checked in 2013. There were no records to show that further checks had been conducted, in order to ensure the equipment was safe to use and was working properly.
- The building was owned by a landlord who was responsible for premise safety; however, there were limited procedures for monitoring and managing risks to patient and staff safety. In that there were no systems to routinely check that there was an up to date fire risk assessments, records of regular fire drills, testing of electrical equipment to ensure the equipment was safe to use and working properly and legionella testing, had been conducted by the landlord.
- There was no system to check the fridge temperatures on the days when the nurse was not at the practice.
- The nurse told us were routinely checked on a three month basis. However, there were no records to evidence that such checks had been made.
- The practice had a defibrillator available on the premises and oxygen with adult and children's masks. Staff told us that these were checked on an annual basis by an external body, when the manufacturer checks were being conducted. There were no checks carried out by practice staff in between the annual checks.
- The practice did not hold regular governance meetings and issues were discussed informally. Records of meetings that had taken place were lacking detail in relation to the issues discussed, action that had been taken and the person identified as being responsible for implementing improvements.
- Practice specific policies had been implemented. However, not all of these were detailed in content, had been routinely reviewed and include up to date guidance.

This section is primarily information for the provider

Enforcement actions

This was in breach of regulation 17(1)(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered provider did not always maintain securely such other records as are necessary to be kept in relation to the management of the regulated activity.

In that:

- The facilities the practice had for the storage of patients confidential information was not being used appropriately. We found that the room used to store records had a key code which, on the day of our visit, had been disabled. Additionally, we found completed repeat prescriptions ready for collection were not stored securely when the premises were closed overnight.This meant the practice did not always ensure the confidentiality of patients' records.

This was in breach of regulation 17(1)(2)(d) (ii) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered provider did not always seek and act on feedback from relevant persons and other persons on the services provided in the carrying on of the regulated activity, for the purposes of continually evaluating and improving such services.

In that:

- There was a clear leadership structure and staff felt supported by management. However, there was a lack of knowledge about the issues affecting the practice (such as patient satisfaction and Quality and Outcome Framework data) and insufficient action had been taken to improve them or formally share them with staff working at the practice.
- Staff told us NICE guidance and alerts were routinely discussed and monitored. However, there was no evidence to show these were discussed with the staff team or to show that they were used to inform the delivery of care and treatment to meet patients' needs.
- The practice did not monitor these guidelines through risk assessments, audits and random sample checks of patient records.

This section is primarily information for the provider

Enforcement actions

- There was no system to routinely conduct clinical audits and no audits had been carried in the last two years.
- The process for seeking consent was not routinely monitored through patient records audits.
- There was no system to conduct clinical audits routinely as no reference was made to clinical audits beyond those set out by the Clinical Commissioning Group and medicines management or quality improvement. There was no evidence to demonstrate that such additional audits had been carried in the last two years, as you did not have an on-going programme of clinical audits which could be used to monitor quality and systems in order to identify where action should be taken.
- Staff were encouraged to provide feedback but this was not being recorded. The staff meeting structure did not include issues such as significant events, safety alerts, complaints and updates to guidance.
- The practice did not provide any evidence to suggest that there was an ethos of continuous learning.

This was in breach of regulation 17(1)(2)(e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.