Dosthill Surgery

Quality Report

45 Cadogan Road
Dosthill
Tamworth
B77 1PQ
Tel: 01827 283487
Website: www.wilnecoteanddosthillsurgeries.co.uk

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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?	Good
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 a short notice announced inspection on 28 September 2015. We inspected both locations Dosthill Surgery and Wilnecote Surgery. We found that the provider was incorrectly registered as they had registered two separate locations. We found that they operate as a main location with a branch surgery with the same patient list, and the governance arrangements managed from Dosthill Surgery. The opening hours of both surgeries were similar and patients were able to make appointments at either surgery to see a GP or a member of the nursing team.

We found both Dosthill and Wilnecote surgery locations to be inadequate in three of the five key domains inspected (safe, effective and well-led). They were good for providing a caring service and responsive service. There were aspects of practice which were inadequate that related to all population groups; it was also therefore inadequate for providing services for the all population groups.

Our key findings were as follows:

- Patients were at risk of harm because systems and processes were not in place to keep them safe. For example not all appropriate recruitment checks on staff had been undertaken prior to their employment. Staff who supported patients as a chaperone had not completed chaperone training and non-clinical staff had not had appropriate police checks completed.
- There was a lack of sufficient quality assurance and governance processes in place to support staff to deliver high quality evidence-based care to patients accessing the service.
- There was insufficient assurance to demonstrate people received effective care and treatment.
- There was a lack of appropriate policies or guidance in place to support staff and ensure that risks to patients were identified, monitored and reviewed.

Summary of findings

- Staff were clear about reporting incidents, near misses and concerns but the systems in place were not robust and there was no evidence of learning and communication with staff.
- There was a leadership structure with named members of staff in lead roles, but limited formal governance arrangements.
- Patients were positive about their interactions with staff and said they were treated with compassion and dignity. The Patient Involvement Group reported positively on their engagement and the responsiveness of the practice to their suggestions and surveys.
- Appointments with both the GP and the nurse were available at short notice, with the waiting time for non-urgent appointments generally around 24 hours. All urgent requests were usually addressed on the day either with a telephone consultation or a face-to-face appointment.
- We received positive comments from the patients we spoke to during the visit. They were complimentary about all their interactions with staff and felt they dealt with them with compassion, dignity and empathy.
- All areas of the practice were clean, tidy and well-maintained.

There were areas of practice where the provider needs to make improvements.

Importantly, the provider must:

- Ensure staff have appropriate and current policies and guidance readily available, in order to carry out their roles in a safe and effective manner, with a system to verify the staff's understanding and competency of policies and procedures.
- Ensure there are robust systems in place to review and monitor patients who may be at risk or vulnerable within the practice population.
- Take action to ensure patients on disease modifying medicines are monitored and managed by staff qualified and competent to do so.
- Take action to ensure that all blood results whether within normal ranges or otherwise are reviewed by a suitably qualified, skilled and competent staff member.
- Take action to ensure its recruitment arrangements are in line with Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and necessary employment checks are in place for all staff. Implement systems to be assured that all staff are appropriately registered with their professional bodies.
- Review its systems for assessing and monitoring the quality of service provision and take steps to ensure risks are managed appropriately.
- Put systems in place to ensure all clinicians are kept up to date with national guidance and guidelines.
- Ensure that staff training is effectively recorded and monitored.
- Accurately register their main and branch location with the Care Quality Commission.

In addition the provider should:

- Consider implementing a lone worker policy.
- Ensure policies have a review date and that this is actioned by the review or should change occur.
- Ensure that practice staff meeting minutes are distributed to all staff members and that staff have the opportunity to add to the meeting agenda.
- Ensure that staff are aware of the practice mission statement, vision and values.
- Ensure there is a policy for the management; testing and investigation of legionella (a bacterium found in the environment which can contaminate water systems in buildings).
- Ensure there is a clear strategy for the future of the practice.

On the basis of the ratings given to this practice at this inspection, I am placing the provider into special measures. This will be for a period of six months. We will inspect the practice again in six months to consider whether sufficient improvements have been made. If we find that the provider is still providing inadequate care we will take steps to cancel its registration with CQC.

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 safe services and improvements are required. There were safeguarding procedures in place and staff had received training in safeguarding children and vulnerable adults. However, there were no formalised systems in place to review and monitor patients who may be at risk or vulnerable within the practice population. Medicines management processes were ineffective and policies and procedures were not followed. There were policies available to staff detailing how to deal with foreseeable emergencies but staff were not familiar with these. There was no effective system in place to investigate and learn from incidents that occurred at the practice.

Are services effective?

Inadequate

The practice is rated as inadequate for effective services as there are areas where improvements should be made. There was no evidence that GPs used clinical audit to monitor patient outcomes of care and treatment, therefore the practice could not demonstrate which actions were taken to improve outcomes for patients. There was no evidence of completed clinical audit cycles or that audit was driving improvement in performance to improve patient outcomes. Knowledge of and reference to national guidelines were inconsistent. Multidisciplinary working was taking place but was generally informal and record keeping was limited or absent. We found that staff had not received chaperone training, some staff could not recall their adult safeguard training and not all staff could recall when they last attended a fire drill or fire safety awareness training. Staff training records had not been consistently maintained. Patients were involved in decision making. We were told by the nurse that assessments of care and treatment were in place, and support was provided to enable people to self-manage their conditions. We saw that referrals to secondary care were made in a timely manner. Care and treatments were provided in a clean and well-maintained environment. Equipment was in good condition and serviced as required. Staff did not raise any concerns in relation to availability of equipment.

Are services caring?

Good

The practice is rated as good for providing caring services. Patients told us they were treated with compassion, dignity and respect. They said staff were helpful, caring and treated them with dignity and respect. Information to help patients understand the services available was easy to understand. We saw that staff were respectful

Summary of findings

and polite when dealing with patients, and maintained confidentiality. The practice actively engaged with the Patient Involvement Group to gather patients' views and implement improvements where appropriate to do so.

Are services responsive to people's needs?

Good

The practice is rated as good for responsive services. Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day. The practice had good facilities and was well equipped to treat patients and meet their needs.There was one complaint recorded in the past 12 months and the actions and we saw that any learning from complaints were documented. However there was insufficient evidence to suggest that learning from complaints had driven improvement in practice.

Are services well-led?

Inadequate

The practice is rated as inadequate for well-led services and improvements are required.Although there was a business plan in place dated 2014 to 2015 which noted the practice mission statement and values. There was no clear strategy to assist staff to deliver high quality care. There were no formal governance arrangements and staff were not aware of what governance meant to the practice. There was no systematic programme of clinical audit to monitor quality and systems at the practice. There was no formal process for identifying, managing and reducing risk.

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.There were aspects of the practice which were inadequate and these related to all population groups.Care and treatment of older people did not reflect current evidence-based practice.The safety of care for older people was not a priority and there were limited attempts at measuring safe practice. Nationally reported data showed that outcomes for patients for conditions commonly found in older people were below the national average. For example: The percentage of patients aged 65 and older who have received a seasonal flu vaccination was 64.3% compared to 73.2%. There was no data available regarding the percentage of patients aged 75 or over with a fragility fracture who were currently being treated with an appropriate bone-sparing medicine. Home visits were available for older people when needed, some of these were carried out by the Home Visiting Service.

People with long term conditions

Inadequate

The practice is rated as inadequate for the care of people with long-term conditions. There were aspects of the practice which were inadequate and these related to all population groups. Nursing staff had lead roles in chronic disease management. Home visits were available for people with long-term conditions when needed, but the majority of these were carried out by the Home Visiting Service which the provider contracts and funds. Although patients were offered an annual review, the nationally reported data showed that outcomes for patients with long term conditions were below the national average. For example: The percentage of patients with diabetes who had a specific blood pressure reading in the previous 12 month period was 43.67% which was lower than the national average of 78.53%.

Families, children and young people

Inadequate

The practice is rated as inadequate for the care of families, children and young people. There were aspects of the practice which were inadequate and these related to all population groups. Although the electronic patient record identified patients who were living in disadvantaged circumstances and who were at risk, a system wasn't in place to follow up patients in this group. The practice did engage with health visitors and midwives, but this was on an ad hoc basis rather than regular meetings. Immunisation rates for the standard

Summary of findings

childhood immunisations were comparable with the Clinical Commissioning Group averages. Appointments were available outside of school hours and the premises were suitable for children and babies.

Working age people (including those recently retired and students)

Inadequate

The practice is rated as inadequate for the care of working-age people (including those recently retired and students). There were aspects of the practice which were inadequate and these related to all population groups. Appointments could be booked by telephone, in person and on line. Extended opening hours were available on evening a week for working people. Health promotion advice was offered but there was limited accessible health promotion material available through the practice.

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. There were aspects of the practice which were inadequate and these related to all population groups. The practice was able to identify the number of patients with a learning disability.

Staff told us they worked with multi-disciplinary teams in the case management of vulnerable people. Staff knew how to recognise signs of abuse in vulnerable adults and children, and were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies out of normal working hours.

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). There were aspects of the practice which were inadequate and these related to all population groups. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. It carried out advance care planning for patients with dementia. Patients and their families were supported by mental health nurses from the practice, and the consultant clinic was held at the practice every month.

Summary of findings

What people who use the service say

We spoke to fourteen patients during the inspection and their comments were all positive. Patients felt the listened to and they did not struggle to get appointments to see a GP or nurse. They told us their care was well-managed and coordinated, and that if they needed a referral elsewhere this was handled in a timely manner. Patients commented that the environment was clean and patient friendly.

Areas for improvement

Action the service MUST take to improve

- Ensure staff have appropriate and current policies and guidance readily available, in order to carry out their roles in a safe and effective manner, with a system to verify the staff's understanding and competency of policies and procedures.
- Ensure there are robust systems in place to review and monitor patients who may be at risk or vulnerable within the practice population.
- Take action to ensure patients on disease modifying medicines are monitored and managed by staff qualified and competent to do so.
- Take action to ensure that all blood results whether within normal ranges or otherwise are reviewed by a suitably qualified, skilled and competent staff member.
- Take action to ensure its recruitment arrangements are in line with Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and necessary employment checks are in place for all staff. Implement systems to be assured that all staff are appropriately registered with their professional bodies.
- Review its systems for assessing and monitoring the quality of service provision and take steps to ensure risks are managed appropriately.
- Put systems in place to ensure all clinicians are kept up to date with national guidance and guidelines.
- Ensure that staff training is effectively recorded and monitored.
- Accurately register their main and branch location with the Care Quality Commission.

Action the service SHOULD take to improve

- Consider implementing a lone worker policy.
- Ensure policies have a review date and that this is actioned by the review or should change occur.
- Ensure that practice staff meeting minutes are distributed to all staff members and that staff have the opportunity to add to the meeting agenda.
- Ensure that staff are aware of the practice mission statement, vision and values.
- Ensure there is a policy for the management; testing and investigation of legionella (a bacterium found in the environment which can contaminate water systems in buildings).
- Ensure there is a clear strategy for the future of the practice.

Dosthill Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team at Dosthill Surgery was led by a CQC Lead Inspector. The team included a second CQC inspector, a GP specialist adviser, a Practice Manager specialist advisor and an Expert by Experience.

Our inspection team at Wilnecote Surgery was led by a CQC Lead Inspector**.** The team included a GP specialist adviser, and a Practice Manager specialist advisor.

Background to Dosthill Surgery

Dosthill Surgery is located in Tamworth, Staffordshire. It is part of the NHS South East Staffordshire and Seisdon Peninsular Clinical Commissioning Group. We found that the provider is incorrectly registered as they had registered two separate locations. We found that they operate as a main location with a branch surgery with the same patient list, and the governance arrangements managed from Dosthill Surgery. The opening hours of both surgeries are similar and patients are able to make appointments at either surgery to see a GP or a member of the nursing team.

We inspected both Dosthill Surgery and Wilnecote Surgery. The Wilnecote and Dosthill Surgeries patient population totals 7,800. The practice is owned by a partnership of two GPs who are responsible for the maintenance of the building. The staff team comprises the two full time male GP partners, a female long term locum GP (since 2005) providing two, two hours sessions per week, a full time salaried male GP (since 2004) and a long term locum providing two sessions per week. The total GP service provision is equivalent to three full time GPs. The practice clinical team includes four practice nurses, two mental health nurses on a self-employed basis and a health care assistant, working various part time hours across both of the providers' surgery locations.

The clinical staff are supported by a newly appointed practice manager, working 30 hours per week (predominately at the Dosthill Surgery location). The practice team includes a self-employed human resource manager when required, reception and administration staff working a variety of part time hours and two apprentice/ trainee reception staff.

Dosthill opening hours are 8:30am to 6pm Monday to Friday with the exception of Thursday when they close at 1pm and Wednesdays when they offer extended hours to 8pm. The telephones are answered from 8am. The practice does not provide an out-of-hours service to its own patients but has alternative arrangements for patients which patient's access using the 111 service.

Patients can access appointments at either Dosthill or Wilnecote surgeries.

Why we carried out this inspection

We carried out a comprehensive inspection of the services underSection 60 of the Health and Social Care Act 2008 as part of our regulatory functions. We carried out a short notice announced inspection to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008 and to provide a rating for the service under the Care Act 2014. This was because we had received information of concern regarding one of the GP partner's compliance with the regulations in another care setting.

Detailed findings

How we carried out this inspection

Prior to our inspection we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. This included NHS South East Staffordshire and Seisdon Peninsular Clinical Commissioning Group and NHS England Area Team. Clinical

Commissioning Groups (CCG) are groups of General Practices that work together to plan and design local health services in England. They do this by 'commissioning' or buying health and care services.

We carried out a short notice announced inspection on 28 September 2015. During our inspection we spoke with a range of staff including the GPs partners, Practice Nurses, administrator/office managers, the Patient Involvement Group (PIG) and reception staff. We observed how patients were communicated with and how the practice supported patients with health promotion literature.

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)

Inadequate

Are services safe?

Our findings

Safe track record

The practice had some systems in place for reporting, recording and monitoring significant events and incidents. Staff at Dosthill Surgery reported directly to the practice manager, whilst staff working at Wilnecote Surgery reported to the office manager based at Wilnecote or directly to the practice manager, who was ordinarily based at Dosthill Surgery. The majority of records for both Wilnecote and Dosthill Surgeries were held at Dosthill Surgery. Documentation with regard to incidents and significant events were reviewed at the Dosthill Surgery. We found that there was one significant event reported over a 12 month period but that the learning from that event had not been implemented.

The practice staff had access to a range of information to identify risks. For example, the reported incidents, national patient safety alerts as well as comments and complaints received from patients.

Learning and improvement from safety incidents

Staff we spoke with were aware of their responsibilities to raise concerns and to whom they should report any incidents and near misses. However, when things went wrong, reviews and investigations were not sufficiently thorough and lessons learnt were not communicated widely enough to support improvement, or as in one case, implemented. For example, a serious event analysis (SEA) had been completed and the process to disseminate learning to all staff had not taken place. We found that the reporting and recording mechanisms were not robust. Staff did not take individual responsibility for recording first-hand incidents or significant events, other than the completion of the accident book. For example, we spoke with staff who were aware of the changes made to repeat prescribing on disease modifying medicines and that the policy stated that the GPs reviewed patient's blood test results in this regard. However, we found following discussions with the GPs and staff that this system was not appropriately followed.

Clinical staff at the practice said they had access to an electronic incident policy. However, during the inspection this file could not be opened. The clinical staff member reported they had slow electronic systems which had been reported to the partners and management team. Some clinical staff were aware of incident but could not recall how these had been managed or of any learning outcomes. There was no evidence seen at either Wilnecote Surgery or Dosthill Surgery that details of incidents were shared more widely, such as with the local Clinical Commissioning Group.

Reliable safety systems and processes including safeguarding

Staff had access to safeguarding procedures for both children and vulnerable adults. These provided staff with information about identifying, reporting and dealing with suspected abuse. We saw that staff had access to contact details for both child protection and adult local authority safeguarding teams. One of the GP partners took the lead for safeguarding and the other GP partner deputised according to staff. The GP said to be the safeguarding lead however cited the practice Human Resource Manager as the lead when asked. Staff put alerts onto the patient's electronic record when safeguarding concerns were raised. Nursing staff gave examples of prompt safeguard referrals made to the local authority and of the feedback they had received from the local authority.

The clinical staff we spoke with said they had received safeguarding adults and children training. They had attended a specific training event for GPs and nurses in the past 12 months. Staff, including the safeguarding lead, were unaware of the level of training they had achieved. Staff knew how to recognise signs of abuse in children. Staff were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding children concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details were easily accessible. Some non-clinical staff could not recall whether they had completed safeguard training.

Information was on display in the waiting room and consulting rooms on the availability of chaperones at Dosthill Surgery. (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). Staff had not received chaperone training. This is needed in order for staff to understand their responsibilities when acting as chaperones. Reception staff did on occasion provide a chaperone service. The non-clinical staff undertaking chaperone duties had not received Disclosure and Barring Service (DBS) checks. (DBS checks identify whether a person has a criminal record or is on an official

list of people barred from working in roles where they may have contact with children or adults who may be vulnerable). Staff personnel records were kept at Dosthill Surgery. Staff personnel records verified that non-clinical staff with chaperone duties had not been in receipt of DBS checks. Risk assessments had not been completed for reception staff who acted as chaperones.

Medicines management

We checked medicines stored in the treatment room and medicine refrigerators and found they were stored securely and were accessible to authorised staff. There were processes in place to ensure that medicines were kept at the required temperatures. Records showed that fridge temperature checks were carried out which ensured medication was stored at the appropriate temperature. Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

We found that safe systems were not followed in relation to prescribing medicines. We asked staff about how any changes to medicines requested by the hospital were managed. They told us they would make the medicine changes and print the prescription ready to be signed by the GP. The letter would then be scanned onto the system. We asked if the letter from the hospital was reviewed by the GPs before the changes were made and told that it was not. There was a protocol for repeat prescribing, dated January 2014. We asked staff if this protocol was followed. They told us that if the number of repeat prescriptions had been reached they could prescribe a further month, and if they had any doubts, they could discuss this with the GP. This contradicted the comments made by one of the GP partners, who told us staff were not allowed to prescribe repeats and should always arrange a review appointment.

The practice did not have a robust system in place for the management of disease modifying medicines. These medicines require regular monitoring such as blood tests. A significant event relating to the prescribing of this type of medicine had been reported and recorded. There was no evidence to support that the action required and learning from this significant event had taken place. The nursing staff demonstrated that they had made contact with specialist nurses in respect of a specific disease modifying medicine and obtained guidelines, dated 2007, on amongst other details, blood test thresholds.

An anti-coagulation service for patients who were prescribed blood thinning medication was delivered at both of the provider's surgery locations. There were approximately 15 patients seen each week in total across both sites. The GPs supported the nurses completing these checks however the nurses at the practice were not prescribers. Staff used an electronic software program to analyse patients' blood results. The GP prescribed according to the result. However, on discussion with one of the GP partners at the Dosthill Surgery location it was clear the GP was unaware of the name of the computer software system they used to calculate the correct dosage of blood thinning medication, whether it had been updated or whether the nurses had been in receipt of update training.

We asked whether the GPs carried medicines in their doctor's bag. One of the GPs told us they carried stocks of controlled medicines in their bag. We were unable to verify whether the medicines were stored securely at all times, or a register maintained, as the GP did not have their doctor's bag with them. They informed us they were personally responsible for the medicines and the medicines expiry date checks.

We were not assured that all clinicians had access to a copy of the local prescribing guidelines or could evidence change in prescribing habits in line with the guidelines.

Blank prescription forms for use in printers were handled in accordance with national guidance and kept securely. Medicines were dispensed according to the patients' choice of pharmacy.

Clinical staff told us there were signed Patient Group Directions (PGD) in place to support the nursing staff in the administration of vaccines and other medicines. A PGD is a written instruction from a qualified and registered prescriber, such as a doctor, enabling a nurse to administer a medicine to groups of patients without individual prescriptions.

A review of records showed that a number of the PGDs were not signed by all of the nursing staff. Staff told us that the health care assistant also administered influenza vaccines. This should be done via a Patient Specific Direction. A Patient Specific Direction (PSD) is a written instruction,

signed by a doctor, for medicines to be supplied and/or administered to a named patient after the prescriber has assessed the patient on an individual basis. Staff told us this had been completed for the influenza vaccines the previous year, although there was no evidence seen to support this.

Cleanliness and infection control

We observed the premises to be clean and tidy. The practice employed staff to clean the premises. We did not see any evidence to support that cleaning schedules were in place. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control. The practice had a lead for infection control across both of the providers' surgery locations. Training records indicated that infection control training had taken place although there were no details as to when this took place or what the training included. It was not possible to determine whether the infection control lead had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement control of infection measures. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these in order to comply with the practice's infection control policy.

Hand hygiene techniques signs were on display in staff toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms. We asked to see information relating to legionella. The practice was unable to provide a policy for the management; testing and investigation of legionella (a bacterium found in the environment which can contaminate water systems in buildings), or records to confirm that regular checks were completed in order to reduce the risk of infection to staff and patients were being carried out.

The practice nurses had completed a self-assessment infection and prevention control audit in September 2015 for both Dosthill and Wilnecote Surgeries. Action plans had not been developed to address any issues identified, for example, examination couch in a poor state of repair at Dosthill Surgery. Procedures for the safe storage and disposal of needles and waste products were evident in order to protect the staff and patients from harm.

Equipment

Staff we spoke with told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and equipment maintenance logs held at Dosthill Surgery confirmed this. All portable electrical equipment had been tested in November 2014. We saw evidence of calibration of relevant equipment had taken place in November 2014. All portable electrical equipment had been tested in November 2014. We saw evidence of calibration of relevant equipment had taken place in November 2014.

Staffing and recruitment

Staff personnel files were held at Dosthill Surgery. The practice staff we spoke with were unaware of where the practice recruitment policy would be held. They informed us they would speak with their Human Resources Manager who worked across both of the provider's surgery locations if they had any questions. A recruitment policy sets out the standards the practice should follow when recruiting clinical and non-clinical staff. There was no evidence of an effective systematic process to support the recruitment of new staff. The practice's most recent employees were two apprentice/trainee receptionists and the practice manager.

Non-clinical staff who provided chaperone duties during consultations had not had a Disclosure

and Barring Service (DBS) check carried out. These 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.

At the Dosthill Surgery location we reviewed 10 staff recruitment records. Five of these members of staff were employed by the practice, three worked on a self-employed basis and two were locum GPs. We found inconsistencies in the level of record keeping in the files. In three files there was no evidence to show that appropriate recruitment checks had been undertaken prior to employment. The practice had no systems in place to ensure staff maintained their registration with their appropriate professional body. The files did not always contain evidence that the practice

had verified that clinical staff had maintained their own indemnity insurance. There was not always a record kept of this at the practice and this system relied on the staff member providing this information.

The GP partners were providing locum type cover arrangement for a local GP practice with local CCG awareness. The Practice Manager was not aware of the extent of the cover the GP partners were providing or the arrangements in place to cover the GP partners work load should it be required. The GP partners told us they may occasionally cover a session at the other GP practice.

Clinical staff spoken with said there were sufficient staff on duty to ensure patients were kept safe but found it challenging at times. There was an arrangement in place for members of administrative and reception staff to cover each other's annual leave. The practice had on occasion employed a locum practice nurse to provide nursing cover. If locum GP cover was required the GP discussed the necessary arrangements with the practice manager.

Monitoring safety and responding to risk

The practice had limited systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. A health and safety policy was in place dated January 2014 but was out of date as it made reference to the responsibilities of the previous practice manager. There was no evidence to support regular checks of the practice environment, medicines management or staffing took place. The building was owned by one of the GP partners. It was not clear what arrangements were in place regarding the maintenance of the building.

There were a number of risk assessments in place, which had been completed in January 2014 but had not been reviewed since.

We saw that staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies. Staff we spoke with told us that children were always provided with an on the day appointment if required.

Arrangements to deal with emergencies and major incidents

The practice had some arrangements in place to manage emergencies. Staff told us they had received training in basic life support. Emergency equipment was available including an automated external defibrillator (used in cardiac emergencies).

Emergency medicines were available for use by staff. These included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. Processes were in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

There were no records seen to evidence that a fire risk assessment had been completed. There were no staff records showing that staff were up to date with fire safety awareness training. Staff could not recall the last fire drill they had attended but thought it was more than two years ago. There was no regular testing of the fire alarm system or emergency lighting or records held at Wilnecote Surgery or of whether they had been serviced or checked on a regular basis. The fire extinguishers had been serviced in July 2015. At Dosthill Surgery we found there were no staff records showing that that staff were up to date with fire training or that they practised regular fire drills. There was no evidence to support that the fire alarm and emergency lighting had been serviced or checked on a regular basis.

There was a business continuity plan in place, which contained contact details including names and telephone numbers. It was not clear when the plan was due for review. Staff were unaware of the plan or where to relocate to in the event of a disaster. We asked staff if they could locate the disaster recovery plan, or business continuity plan and were informed there was no copy of the plan at Wilnecote Surgery.

Inadequate

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice nurses told us they were familiar with current best practice guidance. They accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from meetings with other practitioners through forums such as the local protected learning time events with the local Clinical Commissioning Groups. They said they would refer to NICE guidelines if they required any assistance but could not recall a time recently when they had needed to do this. They said that all clinical staff held their own responsibility for ensuring they remained up to date with best practice.

Informal discussions were said to take place between the GPs and the long term locum GP but minutes of these meetings were not available. There was no evidence seen that during these meetings implications for the practice's performance and patients were identified and required actions agreed. For example, complex cases and palliative care patients.

Through discussion we found that one of the GP partners did not know whether they had a practice system in which clinical staff received updates from NICE. They presumed staff would access these guidelines via the practice's electronic system. The GP said they maintained their clinical professional development through external courses and carried a guideline book which they referred to.

There was no comprehensive or cohesive process for dealing with alerts from the National Reporting and Learning System (NRLS) and notices from the Medicines and Healthcare Products Regulatory Agency (MHRA) at the practice.

The practice nurses described how care and treatment was planned to meet identified needs and how patients were reviewed at required intervals to ensure their treatment remained effective. For example, patients with diabetes had regular health checks and were referred to other services when required. Feedback from patients confirmed they were referred to other services or hospital when required. One of the practice nurses gave an example of how they had worked closely with the diabetic nurse specialist and the hospital in the management and monitoring of a patient who had not attended the practice due to their family commitments. When the patient attended they had abnormally high blood sugar results and required immediate intervention. The nurse was able to demonstrate positive individual patient's results. The patient had made significant improvements to their health and wellbeing as a consequence and the practice nurse said that the learning from this event had been that earlier detection would have improved the patients' health and well-being. We found that all of the six indicators for diabetes within the Quality and Outcomes Framework data between 2013 and 2014 were lower than the national average and three showed a large or very large variation. For example:

- The practice clinical exception rate of 8.1% was comparable to the CCG average national average. Clinical exception rates tell us how many patients GPs have excluded from the statistics.
- The percentage of patients with diabetes at the practice whose last specific blood test result was less than a specific level in the preceding 12 months was 67.33%. This was lower than the national average of 85.94%.
- The percentage of patients with diabetes who had a specific blood pressure reading in the previous 12 month period was 43.67% which was lower than the national average of 78.53%.
- The percentage of patients with diabetes, on the register, whose last measured total cholesterol is 5 mmol/l or less, was 65.93% which was lower than the national average of 81.6%.
- There was no data available regarding the percentage of patients aged 75 or over with a fragility fracture who were currently being treated with an appropriate bone-sparing medicine.
- The percentage of patients with high blood pressure in whom the last blood pressure reading measured in the preceding 9 months was within a specific range was 65.96% which was lower than the national average of 83.11%.

We found that the practice child immunisation and vaccination in the age ranges between 0 to five years were comparable to the local CCG average.

Management, monitoring and improving outcomes for people

Staff told us that clinical audits had been completed. However, when asked, they were unable to show us any evidence of monitoring by clinical audit of patient outcomes of care and treatment with improvement in

Inadequate

Are services effective?

(for example, treatment is effective)

patient care and treatment as a result of audits completed. The nurse had monitored inadequate cervical smear results and informed that where nurses had a greater number of inadequate smears refresher training had taken place. However the training records we saw only indicated what training had been completed. The records did not contain details of the course content, length of the course or the date the member of staff attended. Consequently the records were not an adequate record of staff training.

Patients told us they were very satisfied with their care. Patients with long-term conditions told us their conditions were well managed and that they had regular reviews. Staff told us that patients with multiple health conditions had all their health reviews completed on the same visit to minimise the number of visits for the patient's convenience.

Effective staffing

Staff spoken with assured us their registration with professional awarding bodies was up to date. We looked at the records of staff training and recruitment checks at Dosthill Surgery. We found that the practice did not have a system in place to be assured that all staff were appropriately registered with their professional bodies. We checked the registrations of the nursing staff during our visit to assure ourselves that these were up to date.

Staff told us they were up to date with attending courses such as annual basic life support and defibrillator training. Staff said they attended the practice learning time events held with the local CCG and in-house training events. The training records seen recorded only indicated that basic life support training had been completed. The records did not contain details of the course content, length of the course or in some instances, the date the member of staff attended. Consequently the records were not an adequate record of staff training.

The GP told us they were up to date with their yearly continuing professional development requirements and had been revalidated in 2014. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England). One GP said that they felt that more could be done to be up to date clinically.

Staff told us they had received regular appraisals. The staff files seen at Dosthill surgery did not clearly demonstrate that staff had received an appraisal or that individual development plans were in place.

Staff told us that should they require or request training, this was agreed by the GP, for example the practice had agreed nurse prescribers training. However, we found for example that staff had not received chaperone training; some staff could not recall their safeguard training, or recall when they last attended fire safety awareness training or attended a fire drill. Staff informed us that it could be as long as two years since they attended a fire drill. When asked about training nurses and the healthcare assistant, one of the GP partners told us they sometimes showed staff how to do things, but admitted they did not then check on their competency, or sign a statement of competency for that training.

There was no management oversight of staff training to ensure that staff worked within their scope of practice or that they were suitably skilled and qualified to undertake specific delegated roles or responsibilities. For example, nursing staff were found to be interpreting all the blood results electronically sent to the practice. We found no evidence to suggest that staff were suitably skilled or qualified to undertake this role. There was a specific process in place in respect of blood results and the filing of the results. The nurses were tasked with filing results that had been reported as within a normal range. The nurses tasked with ensuring that patients with abnormal results had a follow up appointment with the GP and filed the results into the patients' electronic record on their system. Any result that required a GP intervention was also printed off and passed to the GP. It was then the GP's responsibility to document in the patients' record any actions required. There were no safeguards in place to ensure that staff understood the relevant clinical context. For example the consideration of the age of patient, their clinical condition and any prescribed medicines that may impact on the decision.

Working with colleagues and other services

The practice nurses and GPs engaged with other health professionals such as health visitors and midwives and the local authority safeguarding team when required. These in general were described as ad hoc and arranged to discuss a particular patient, rather than to establish an effective working relationship.

Inadequate

Are services effective?

(for example, treatment is effective)

Correspondence from other services such as test results and letters from hospitals were received either electronically or via the post. All correspondence was scanned and passed to the GP. We saw the practice did not employ a failsafe method to ensure that letters received were actioned, such as maintaining a record of incoming mail.

The practice had a system for referral to, and handling of discharge letters from, other healthcare environments. We had concerns about the monitoring of letters into the practice and the handling of any changes to a patient's medicine by the practice. There was a lack of appropriate policies or guidance in place to support staff and ensure that risks to patients were identified, monitored and reviewed. For example, the GP wrote in the patient's electronic consultation record the reason for a referral. It was left for the practice secretary to add from the patient record their past medical history, allergies and medicines. We saw no evidence of GP note summaries.

Information sharing

Details of out-of-hours consultations that patients had attended were shared with the practice by the out-of-hours provider each morning. These were reviewed and where follow-up action was required this was allocated to the GP. The practice shared with the out-of-hours provider information relating to any complex patients or patients receiving end of life care.

Information on test results was available electronically to the GP and nurses to ensure care and treatment was current. Patients requiring a follow up appointment to discuss any test results were made at the patient's earliest convenience.

GPs informed us that they attended multi-disciplinary meetings such as the palliative care meetings which were said to be monthly and staff attended the protected learning events held by the local CCG in where staff communicated with and listened to members of staff within their locality. We asked to see minutes of these meetings but the practice was unable to provide them. We were shown minutes of a review of patients on the vulnerable patient register. However these minutes were not dated and did not record the attendees at the meeting.

Consent to care and treatment

The practice nurse was aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. The nurse spoken with understood the key parts of the legislation and was able to describe how they implemented it. For some specific scenarios where capacity to make decisions was an issue for a patient, the practice had awareness of how patients should be supported to make their own decisions and how these should be documented in the medical notes.

Health promotion and prevention

We had only limited time available with the partner GPs and discussed health promotion and prevention in the form of QOF and clinical audits. The nurses were able to tell us how the practice managed the care of patients with long-term conditions and what these were. They also outlined the actions taken to try to regularly review their needs. Patients were encouraged by the practice nurses to take an interest in their health and to take action to improve and maintain it. This included advising patients on the effects of their life choices on their health and wellbeing. There was a range of health promotion and prevention literature and brochures available for patients in the waiting room.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We observed throughout the inspection that members of staff were courteous and helpful to patients attending at the reception desk and that people were treated with dignity and respect.

We spoke with fourteen patients from both Wilnecote and Dosthill surgeries during the inspection. Patients were positive about the service they experienced. Patients said they felt the practice offered a good service and staff were helpful, caring and treated them with dignity and respect. They said the nurses and GPs listened and responded to their needs and they were involved in decisions about their care.

Consultations and treatments were carried out in the privacy of a consulting room. Curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. Consultation and treatment room doors were closed during consultations.

Data from the National GP Patient Survey July 2015 reflected the views of both Wilnecote and Dosthill surgeries. The survey showed from 109 responses that performance in some areas was slightly lower than local and national averages for example:

• 84% said they found the receptionists at this surgery helpful compared to the CCG average of 88% and national average of 87%.

• 67% said they would recommend this surgery to someone new to the area compared to the CCG average of 80% and national average of 78%.

• 80% said their overall experience of the surgery was good compared to the CCG average of 88% and national average of 85%.

However the percentage of patients who said they had confidence and trust in the last nurse they spoke to was 100% compared to the CCG average of 98% and national average of 97%.

Care planning and involvement in decisions about care and treatment

Patients we spoke with on the day of our inspection told us that they felt fully informed and involved in the decisions about their care and treatment. They 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.

Data from the National GP Patient Survey July 2015 showed that performance in some areas was slightly lower than local and national averages for example:

• 78% said the GP was good at giving them enough time compared to the CCG average of 89% and national average of 87%.

• 62% said the last GP they spoke to was good at involving them in decisions about their care compared to the CCG average of 83% and national average of 82%

• 73% 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%.

However the percentage of patients who said that the last time they saw or spoke to a nurse; the nurse was good at explaining tests and treatments was 93%, above both the CCG (91%) and national average (90%).

Staff told us that translation services were available for patients who did not have English as a first language. We saw a notice in the waiting room informing patients about communication support for people who were hard of hearing, visually impaired and translation services.

Patient/carer support to cope emotionally with care and treatment

Notices in the waiting room and information on the practice website told patients how to access a number of support groups and organisations. Information about bereavement services and mental health support groups was on display.

Patients spoke very highly of one of the mental health nurses, in terms of support following bereavement and when caring for a person with dementia. They told us they were given contact details for the nurse, and felt able to ring for advice and support as required. They told us the nurse had discussed the care and medication, so they understood what was being provided for their relative..

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

Patients who were aged over 75 had a named GP. The practice had a palliative care register and engaged in multidisciplinary discussions to discuss patients and their families' care and support needs. We found that the practice was accessible to patients with mobility difficulties. Car parking was available outside the practice. Staff said they had access to translation services for

patients who needed them. The practice nurses held regular clinics for a variety of complex and long-term conditions such as respiratory disease and diabetes. Patients with multiple health conditions had their reviews undertaken during one visit, where possible, to reduce the burden of additional visits.

The practice had an active patient involvement group (PIG) which had been established for approximately eight years. A PIG is a group of patients registered with a practice who work with the practice to improve services and the quality of care. The practice PIG had eight active core members, both male and female across the age ranges between 30 and 80 years. We met and spoke with four members of the PIG. They told us they were in the process of considering how to recruit younger members and ideas had included targeting information about the PIG towards patients who attended for the childhood immunisation clinics.

Tackling inequity and promoting equality

We spoke with the nurses about the management of patients with mental health and patients living with dementia or those with a learning disability, who could be at their most vulnerable when attending the practice. We were informed that the GP dealt with all patients who had a chronic mental health need and the nurse would only be called upon to carry out routine monitoring, for example blood tests, height or weight checks, if required. The practice contracted two community mental health nurses on a self-employed basis to support their patients.

One of the nurses we spoke said they were able to access their electronic systems to establish the numbers of learning disability patients registered at the practice.

We were not able to establish whether clinical staff had awareness of the current NHS clinical commissioning group's (CCG's) equality and diversity strategy. This had been designed to tackle current health inequalities, promote equality and fairness, and establish a culture of inclusiveness using the Equality Delivery System (EDS) to drive improvement. We were not able to establish how the practice took account of the diversity of patients' needs derived from factors such as age, disability, cultural beliefs or religious beliefs.

Dosthill Surgery had access to a hearing loop for patients who were hard of hearing and this was advertised in the waiting room.

Access to the service

Patients told us they felt the practice staff responded well to their needs well and were always accommodating if they needed appointments at specific times. Comprehensive information

was available to patients about appointments in the practice literature and website. Dosthill opening hours were 8.30am to 6pm Monday to Friday with the exception of Thursday when they closed at 1pm and Wednesdays when they offered extended hours to 8pm. Patients could access appointments at either Dosthill or Wilnecote surgeries. Appointments with the nurses at were arranged between 9am and 6am Monday to Friday and they offered extended hours on a Wednesday evening until 8pm at the Dosthill Surgery location.

Non-urgent appointments were available with the GPs for two days in advance, with urgent appointments still available for the evening of the inspection day. Appointments with the nurse were available the next working day.

The GPs carried out home visits to patients who could not access the surgery and they also accessed the home visiting service provided locally. At the time of the inspection the provider partnership was supporting another local practice with some additional GP cover, this included where necessary providing home visits to this other practices patients. The impact on the GPs availability at the Wilnecote and Dosthill Surgeries for their patients had not been assessed.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. The complaints policy was in line with recognised guidance and contractual obligations for GPs in England and there was a designated responsible person who managed all complaints in the practice. However the

Good

Are services responsive to people's needs?

(for example, to feedback?)

policy required updating with the new practice manager's details. Staff said they did not get many complaints. Staff told us they were not aware of any recent complaints. We did not receive any comments regarding complaints from the patients we spoke with. Complaints records were held at Dosthill Surgery. There was one recorded complaint received in the last 12 months, this was investigated and the complainant was informed of the outcome. We noted that the letter to the patient on the outcome of the investigation did not contain contact details or information on what the patient could do in the event they were not satisfied with the investigation, however the practice's complaints leaflet did. It was not clear in the final letter to the patient that the practice leaflet had or had not been enclosed.

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

There was a lack of clarity regarding the purpose of the aims and objectives of the practice and how these would be achieved. There was a business plan in place dated 2014 to 2015 which noted the practice mission statement and values. However, there was no clear strategy to assist staff to deliver high quality care. The practice staff had no awareness of the practice vision or strategy for the future. There was no involvement in the business development plan or business development meetings. There was a lack of evidence of a documented long term strategic review and the practice was working on a day to day basis. We saw no evidence of clear succession planning in place and practice priorities were not cascaded to all staff. One of the GP partners felt that the lack of a regular practice manager in the previous year had impacted on their awareness of any areas in which they needed to improve such as those within the Quality and Outcomes Framework (QOF). QOF is a voluntary annual reward and incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions e.g. diabetes and implementing preventative measures.

Governance arrangements

There was a lack of effective governance arrangements. There were some policies and procedures in place but these were not always up dated. There was no additional monitoring of clinical performance at the practice other than the voluntary completion of the Quality and Outcomes Framework (QOF) system. Staff spoken with were unaware of the disaster recovery plan. There were risks to the health and safety of patients and staff which had not been assessed.

There was no evidence to support that two cycle clinical audits had taken place and were used to monitor quality or systems to identify where action should be taken. One GP said they had completed an audit for example on skin lesions such as moles and in exacerbation of asthma for revalidation. There was no evidence seen on whether the findings of these audits had influenced the care and treatment provided to patients at the practice. Staff could not produce any completed audits that we could review.

Nursing staff had taken on a number of extended roles. Policies and procedures were not in place to support and safeguard them when carrying out these roles. They told us they had received training from the GPs and been assessed as competent. However, records to support this were not available. In addition there was no continual assessment of nursing competency throughout the year. Staff told us they tried to do their best for their patients and felt they achieved this as patients were very complementary of staff involvement in their care.

Systems for monitoring the fitness of clinicians to practice were not evident and we could not find evidence to demonstrate routine checks on professional registrations had been carried out.

There was no effective arrangement available for identifying, recording, managing and mitigating risk. The practice had an incident policy which was held electronically. Staff working at the Wilnecote Surgery had difficulty accessing this policy via the IT system.

Leadership, openness and transparency

We found a lack of leadership and governance relating to the overall management of the service. There was no clear lead for the various aspects of practice management, and the practice was unable to demonstrate strong leadership to improve safety, outcome for patients or learning from significant events. There was a lack of clarity regarding the responsibilities between the partners with regard to management of the practice; in particular the arrangements in place for providing locum type cover for a local GP practice. The Practice Manager and one of the GP partners were not aware of the extent of the cover the practice was providing or the arrangements in place to cover the GP partners work load should it be required.

Staff we spoke with told us the GPs were approachable and they could discuss issues with the new practice manager if needed. Staff who had been at the practice for a number of years said they felt supported in their roles at the practice. Clinical staff told us they felt able to raise issues and concerns and where required also emailed any issues such as equipment requirements to the practice management.

We were informed that whole staff meetings were held following the monthly protected learning events and that these meetings were minuted. However, when asked the practice was unable to provide minutes of the clinical

Are services well-led?

Inadequate

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

meetings or meetings following the protected learning events. Staff did not receive their own copy of any minutes. This meant that staff who were not in attendance were not able to update themselves.

Practice seeks and acts on feedback from its patients, the public and staff

The last in-house patient survey was carried out according to the Patient Involvement Group (PIG) was in 2013 to 2014. The three action points from this questionnaire included an improvement in the length of time waiting to see a GP, and the practice reported there was greater availability for same day appointments. Repeat prescribing and patients' overall satisfaction with the practice, which also noted an improvement.

The latest national GP survey results July 2015 were unknown to the staff we spoke with on the day of the inspection. There was a suggestions box in the practice which the PIG also had access to. Staff told us they did not receive many suggestions from patients but admitted they did not actively promote the use of the suggestions box.

The PIG found that patients' views were taken into account when planning or making changes at the practice. For example the practice had invested in electronic entrance doors at Dosthill Surgery. One of the GP partners regularly attended the PIG meetings and the PIG found the GP to be approachable and open to constructive feedback.

There had been one complaint recorded within the last 12 months. There had been no staff surveys completed for the practice. Staff told us they had no concerns but they would speak to the GP or administrator if they did.

Management lead through learning and improvement

Staff supported each other at the practice. Nurses we were told were able to gain peer support with other nurses at the practice or at their nurses' meetings. GPs met weekly with no fixed agenda to discuss clinical issues. All staff met following the monthly protected learning events. It was said that these meetings were minuted. However, when asked the practice was unable to provide minutes of the clinical meetings or meetings following the protected learning events.

The practice promoted attendance at the monthly protected learning events and provided in-house training sessions on various topics.

We did not see evidence of staff appraisal, personal objectives or the training plans for any member of staff.

There was little innovation or service development. There was some evidence of learning and reflective practice, as discussed with nursing staff for example, audits on infection rates in wound care following minor surgery, but no evidence to date that the findings had influenced changes or improvement.

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 19 HSCA (RA) Regulations 2014 Fit and proper persons employed **People using the service were not protected against the risks of inappropriate or unsafe care and treatment because the required information as outlined Regulation 19 and Schedule 3 (Information Required in Respect of Persons Seeking to Carry On, Manage Or Work For The Purposes of Carrying On, A Regulated Activity) was not recorded.** Regulation 19(3)(a)

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 **The provider therefore had not assessed the risks to the health and safety of service users; done all that is reasonably practicable to mitigate any such risks, or ensure that persons providing care or treatment to service users have the qualifications, competence, skills and experience to do so safely.** **The provider had not questioned whether staff were suitably qualified, experienced, or skilled to interpret blood results.** **They delegated responsibility without appropriate assurances of staff competency or training.** **Regulation 12 (1) (2) (a) (b) (c)**

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **17 (1) Systems or processes must be established and operated effectively to ensure compliance with the requirements in this Part.** • (2) Without limiting paragraph (1), such systems or processes must enable the registered person, in particular, to – • assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity; • maintain securely such other records as are necessary to be kept in relation to— i. persons employed in the carrying on of the regulated activity, and ii. the management of the regulated activity;

This section is primarily information for the provider

Enforcement actions

- 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;
- evaluate and improve their practice in respect of the processing of the information referred to in sub-paragraphs (a) to (e).

Staff did not have all the appropriate policies and guidance in place, which were reflective of the requirements of the practice, in order to carry out their roles in a safe and effective manner.

Policy guidance was not always current or readily available to staff and there was no system in place to verify the staff's understanding of policies and procedures.

There was a lack of robust systems in place to review and monitor patients who may be at risk or vulnerable within the practice population.

Patients on disease modifying medicines were not always monitored and managed by staff qualified and competent to do so.

Blood result interpretation was not always undertaken by suitably qualified and competent staff.

There was a lack of systems in place to ensure all clinicians are kept up to date with national guidance and guidelines.

Suitable recruitment arrangements were not consistently applied in line with Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 must be in place and include all the necessary employment checks for all staff.

There were no formalised systems in place for checking staff registration with their professional bodies.

Non clinical staff who provided a chaperone service had not been risk assessed and did not have police checks completed with the Disclosure and Barring Service (DBS).

Staff training was not effectively recorded and monitored. There was no management system in pace to ensure staff worked within the scope of their qualifications, skills and experience.

This section is primarily information for the provider

Enforcement actions

There was no copy of the fire risk assessment at Wilnecote Surgery and no evidence of recent staff fire awareness training. Staff had not attended regular fire drills-some staff could not recall attending a fire drill for over two years.

There was no practice disaster recovery plan accessible to staff at Wilnecote Surgery.

There was no clear strategy for the future of the practice.

Regulation 17(1) (2) (a) (b) (d) (e) (f)