Dr Plana & Partners

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Dr Plana & Partners on 28 June 2016. We inspected the practice's main site at 71 Sherard Road SE9 6ER, and its branch sites at 444-446 Rochester Way SE9 6LJ and 115 Tudway Road SE3 9YX. Overall the practice is rated as inadequate.

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

- Risks to patients were not assessed or managed enough to keep patients safe. This was in relation to the absence of evidence of training for several staff that was relevant to their roles, ineffective fire safety and infection control processes, the absence of risk assessments at the practice's branch sites, and ineffective medicines management systems. The practice had not assessed the risks associated with the absence of defibrillators and oxygen for use in medical emergencies.
- Data for 2014/2015 showed several patient outcomes were significantly below local and national averages in relation to the Quality and Outcomes Framework clinical targets; the practice had not adequately addressed some of these areas in order to make improvements to patient outcomes.The practice provided evidence, after the inspection, that in 2015/2016 clinical performance had improved but this data had not been independently verified or published at the time of our inspection.
- Audits had been conducted and we saw evidence that some audits had driven improvements to patient outcomes; however, the practice did not have any formal processes in place to continuously monitor and improve clinical and overall performance.
- The majority of patients said they were treated with compassion, dignity and respect, but there were no policies or arrangements to allow people with no fixed address to register as patients to receive on-going care at the practice.

Summary of findings

- Patients found it difficult to get appointments and they had faced long waiting times after arriving for appointments. The practice had not adequately addressed this or implemented any action plans to make improvements.
- There was limited health and support information, and information about services at the Rochester Way branch site.

- The practice had a number of policies and procedures to govern activity, and all staff we spoke with felt supported and valued by the practice's leaders; however record keeping, such as for governance meetings and training received, was limited.
- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Reviews and investigations of incidents were thorough, and patients received apologies where appropriate.

The areas where the provider must make improvements are:

- Ensure emergency medicines and equipment are available in sufficient quantities across all sites with effective systems in place for monitoring them, ensure nurses are authorised to administer medicines, and ensure there are adequate systems in place to allow staff to raise an alarm in emergencies.
- Ensure there are effective systems in place for infection control and prevention, and for monitoring risks across all sites.
- Ensure all staff complete training (including basic life support), training is updated at appropriate intervals with records kept of training received, and include safeguarding, fire safety, infection control, health and safety and confidentiality in staff inductions.
- Ensure all staff have a good understanding of the practice's procedures, implement an effective system for documenting practice processes, and ensure there are systems and processes to identify and improve where quality is being compromised.

In addition the provider should:

- Review the process for recording consent.
- Provide information for patients, including translation services available, in appropriate languages and formats.
- Review how patients with caring responsibilities are identified and recorded on the clinical system to ensure information, advice and support is made available to them, and ensure homeless patients are able to register to receive on-going continuity of care.
- Review the need to install panic alarms in the disabled toilets.
- Ensure the business continuity plan includes emergency contact numbers for all staff.

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

Professor Steve Field CBE FRCP FFPH FRCGPChief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Inadequate

The practice is rated as inadequate for providing safe services.

- Staff understood their responsibilities to raise concerns and to report incidents and near misses. When things went wrong reviews and investigations were thorough and lessons learned were communicated widely to support improvement, and patients received a verbal and written apology.
- Arrangements for identifying, recording and managing risks, issues and implementing mitigating actions were not robust; the practice had not conducted risk assessments for Legionella or fire safety at its Rochester Way and Tudway Road branch sites.
- The practice had a limited amount of emergency medicines and equipment available, and there were ineffective processes in place for monitoring and managing medicines.
- There were ineffective infection control and fire safety processes in place.
- Staff understood their responsibilities in relation to reporting safeguarding concerns; we requested but were not provided with evidence of safeguarding children and vulnerable adults training for several staff.

Are services effective?

Requires improvement

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

- Data from the Quality and Outcomes Framework (QOF) showed patient outcomes were below average for several outcomes in comparison to local and national averages.
- Multidisciplinary working was taking place but was informal and record keeping was limited or absent.
- We requested but were not provided with evidence of mandatory training for safeguarding, fire safety and information governance for several staff, and basic life support training for three staff members.
- Staff assessed needs and delivered care in line with current evidence based guidance, with the exception of consent which a nurse told us they sought verbally but did not routinely record for procedures such as vaccinations.

Summary of findings

- The practice did not have formal arrangements for working with other health care professionals on the case management of patients; this occurred on an informal, ad-hoc basis where care plans were reviewed and updated for patients with complex needs.
- Clinical audits demonstrated quality improvement.
- There was evidence of appraisals and personal development plans for all staff.

Are services caring?

Good 

The practice is rated as good for providing caring services.

- Data from the national GP patient survey published in January 2016 showed patients rated the practice as average in comparison to local and national averages for several aspects of care.
- The majority of patients commented that 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, but there was a lack of information available for carers at the practice's Rochester Way and Tudway Road branch sites.
- We saw that staff treated patients with kindness and respect, and maintained patient and information confidentiality.

Are services responsive to people's needs?

Requires improvement 

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

- Data from the national GP patient survey published in January 2016 showed patients rated the practice as average for some aspects of accessibility and below average for others in comparison to local and national averages.
- There were no policies or arrangements to allow people with no fixed address to register or be seen at the practice.
- Practice staff 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. They participated in Greenwich CCG's Year of Care scheme with an aim to improving outcomes for patients with chronic obstructive pulmonary disease, diabetes, heart failure and hypertension.

Summary of findings

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

Are services well-led?

Inadequate

The practice is rated as inadequate for being well-led.

- Arrangements in place for monitoring and improving quality and identifying risk did not operate effectively. This was in relation to inadequate systems for monitoring and managing medicines, ineffective infection control and fire safety processes, and the absence of risk assessments for the practice's two branch sites.
- The practice had reviewed feedback from the national GP patient survey published in January 2016 but had not addressed areas in which they had been rated below local or national averages in order to improve patient satisfaction.
- Record keeping was limited, such as for evidence of training received and for governance meetings.
- The practice told us they held regular governance meetings but these meetings were not routinely documented. They also told us they held daily clinical meetings.
- All staff had received inductions, but induction checklists did not cover safeguarding, confidentiality, fire safety or infection control. All staff had received regular performance reviews.
- The practice had a number of policies and procedures to govern activity.
- The practice had a vision and all staff were aware of this. However, there were no documented business plans to ensure their informal strategy was delivered, monitored and reviewed.
- There was a documented leadership structure and all staff felt supported by the practice's leaders, but we found the leadership arrangements did not support the delivery of high quality care in several areas.

Summary of findings

The six population groups and what we found

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

Older people

Inadequate

The practice is rated as inadequate for the care of older people. The practice is rated as inadequate for being safe and well-led, requires improvement for being effective and responsive, and good for being caring. The issues identified as inadequate overall affects all patients including this population group.

- The practice was responsive to the needs of older people, and offered home visits and urgent appointments for those with enhanced needs.
- Nationally reported data showed that outcomes for patients for conditions commonly found in older people were average. For example, 76% of patients with hypertension had well-controlled blood pressure in the previous 12 months of 2014/2015. This was in line with the local Clinical Commissioning Group average of 81% and the national average of 84%.

People with long term conditions

Inadequate

The practice is rated as inadequate for the care of people with long-term conditions. The practice is rated as inadequate for being safe and well-led, requires improvement for being effective and responsive, and good for being caring. The issues identified as inadequate overall affects all patients including this population group.

- Performance for diabetes related indicators varied. For example, 72% of patients with diabetes had well-controlled blood sugar in the previous 12 months of 2014/2015, which was in line with the local Clinical Commissioning Group (CCG) average of 72% and the national average of 78%. However, 76% of patients with diabetes had received the annual flu vaccine in 2014/2015, which was below the CCG average of 90% and the national average of 94%. the practice told us performance had declined in 2015/2016, but the data provided had not been published or independently verified at the time of our inspection:
- All patients with a long-term condition had a named GP; however the practice was below average for performing structured annual reviews to check their health and medicines needs were being met.
- 55% of patients with asthma had a review of their condition in the previous 12 months of 2014/2015, which was below the CCG

Summary of findings

average of 74% and the national average of 75%. The practice told us performance had improved in 2015/2016, but the data provided had not been published or independently verified at the time of our inspection:

- 67% of patients with chronic obstructive pulmonary disease had a review of their condition in the previous 12 months of 2014/2015, which was below the CCG average of 87% and the national average of 90%. The practice told us performance had improved in 2015/2016, but the data provided had not been published or independently verified at the time of our inspection:
- For those patients with the most complex needs, the named GP worked with relevant health and care professionals on an informal ad-hoc basis to deliver a multidisciplinary package of care.
- Longer appointments and home visits were available when needed.
- Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority.

Families, children and young people

Inadequate

The practice is rated as inadequate for the care of people with long-term conditions. The practice is rated as inadequate for being safe and well-led, requires improvement for being effective and responsive, and good for being caring. The issues identified as inadequate overall affect all patients including this population group.

- There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of attendances to Accident and Emergency. However, 23 out of 1000 patients had emergency admissions in the previous 12 months of 2014/2015, which was above the local Clinical Commissioning Group (CCG) average of 12/1000 and the national average of 15/1000.
- Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals.
- Performance for cervical screening in 2014/2015 was average. For example, 78% of women aged 25 to 64 years had a record of a cervical screening test, which was in line with the local CCG average of 82% and the national average of 82%.
- Appointments were available outside of school hours and the premises were suitable for children and babies.

Summary of findings

- Joint working with midwives and health visitors occurred on an ad-hoc and informal basis.

Working age people (including those recently retired and students)

Inadequate

The practice is rated as inadequate for the care of people with long-term conditions. The practice is rated as inadequate for being safe and well-led, requires improvement for being effective and responsive, and good for being caring. The issues identified as inadequate overall affect all patients including this population group.

- The practice had adjusted the services it offered to ensure they were accessible, flexible and offered continuity of care for this population group.
- Extended hours opening was offered from 6.30pm to 7.00pm three days a week, and from 9.00am to 12.00pm on Saturdays at the main site.
- The practice offered online services such as appointment booking and repeat prescription ordering.
- Health promotion advice was offered but there was limited accessible health promotion material available at its Rochester Way branch site.

People whose circumstances may make them vulnerable

Inadequate

The practice is rated as inadequate for the care of people with long-term conditions. The practice is rated as inadequate for being safe and well-led, requires improvement for being effective and responsive, and good for being caring. The issues identified as inadequate overall affect all patients including this population group.

- The practice held a register of patients with a learning disability; they offered longer appointments to these patients.
- There were no policies or arrangements to allow people with no fixed address to register or be seen at the practice.
- The practice did not have formal arrangements for working with other health care professionals on the case management of vulnerable patients; this occurred on an informal, ad-hoc basis.
- The practice informed vulnerable patients about how to access various support groups and voluntary organisations.
- We requested but were not provided with evidence of safeguarding children and vulnerable adults training for several members of staff. This training for a member of staff had not been updated in line with current recommendations.

Summary of findings

- 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.

People experiencing poor mental health (including people with dementia)

Inadequate

The practice is rated as inadequate for the care of people with long-term conditions. The practice is rated as inadequate for being safe and well-led, requires improvement for being effective and responsive, and good for being caring. The issues identified as inadequate overall affect all patients including this population group.

- Performance for mental health related indicators was below average. For example, 65% of patients with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive, agreed care plan in their records in 2014/2015; this was below the local Clinical Commissioning Group (CCG) average of 85% and the national average of 88%. The practice told us performance had improved in 2015/2016, but the data provided had not been published or independently verified at the time of our inspection:
- Performance for dementia related indicators was below average. For example, 75% of patients with dementia had a face-to-face review in the previous 12 months of 2014/2015; this was below the CCG average of 84% and the national average of 84%. the practice told us performance had improved in 2015/2016, but the data provided had not been published or independently verified at the time of our inspection:
- The practice did not have formal arrangements for working with other health care professionals on the case management of patients with dementia; this occurred on an informal, ad-hoc basis.
- The practice carried out advance care planning for patients with dementia.
- The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations.
- The practice did not have a system in place 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 on 7 January 2016. Three hundred and ninety-four survey forms were distributed and 128 were returned, which represented approximately 1% of the practice's patient list. Results showed that patient satisfaction with the service varied in comparison to local and national averages. They were rated average in some areas and below average in others.

- 64% of patients found it easy to get through to this practice by phone compared to the local Clinical Commissioning Group (CCG) average of 73% and the national average of 73%.
- 74% of patients described the overall experience of this GP practice as good (CCG average 81%, national average 85%).
- 54% of patients were able to get an appointment to see or speak to someone the last time they tried (CCG average 70%, national average 76%).
- 60% of patients said they would recommend this GP practice to someone who has just moved to the local area (CCG average 75%, national average 79%).

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 24 comment cards, 15 of which were positive about the standard of care received; these patients said they found staff to be helpful and caring. There were nine negative comments from patients; seven regarding difficulties with getting appointments and two regarding dissatisfaction with the attitude of staff on occasion.

We spoke with two patients during the inspection. Both patients said they had found it difficult to get appointments when needed, they had faced long waiting times and the side effects of medicines prescribed by the practice had not been explained to them.

The practice's May 2016 NHS Friends and Family Test showed that out of 141 survey respondents, 77% were either likely or extremely likely to recommend the practice to a friend or family member; 15% were either unlikely or extremely unlikely to do so, and eight percent were neither likely nor unlikely to do so.

Dr Plana & Partners

Detailed findings

Our inspection team

Our inspection team was led by:

a CQC Lead Inspector**.**The team included a CQC Inspection Manager, a GP Specialist Advisor and a practice manager Specialist Advisor.

Background to Dr Plana & Partners

The practice operates from three sites in the London Borough of Greenwich. Its main site is located at 71 Sherard Road in Eltham; there is a branch site at Rochester Way in Eltham, and a second branch site at Tudway Road in Kidbrooke. Dr Plana & Partners is one of 42 GP practices in the Greenwich Clinical Commissioning Group (CCG) area. There are approximately 10,000 patients registered at the practice, and the practice has been caretaking for another practice Henley Cross Medical Practice (which has approximately 4,500 patients) since May 2016.

Dr Plana & Partners is registered with the Care Quality Commission (CQC) to provide the regulated activities of diagnostic and screening procedures, family planning, maternity and midwifery services, surgical procedures and treatment of disease, disorder or injury.

The practice has a personal medical services (PMS) contract with the NHS and is signed up to a number of enhanced services (enhanced services require an enhanced level of service provision above what is normally required under the core GP contract). These enhanced services include dementia, improving online access, influenza and pneumococcal immunisations, minor surgery, patient participation, risk profiling and case management, rotavirus and shingles immunisation, services for violent patients, and unplanned admissions.

The practice has an above average population of patients aged from five to 59 years. Income deprivation levels affecting children and adults registered at the practice are above the national average.

The clinical team includes four male GP partners, a female GP partner, a female salaried GP, a female nurse prescriber (who was on long term leave at the time of our inspection), two female practice nurses, and two health care assistants. The GPs provide a combined total of 42 fixed sessions per week. The clinical team is supported by a practice manager, three reception supervisors and 20 administrative/reception staff. The practice is a training practice for GP trainees.

The practice's three sites are open from 8.00am to 6.30pm Monday to Friday, and its Sherard Road main site is open from 9.00am to 12.00am on Saturdays. All sites are closed on Sundays and bank holidays. Appointments with the GPs are available from 9.00am to 12.30pm and from 1.00pm to 6.30pm Monday to Friday. Appointments with nurses are available from 8.30am to 6.00pm Monday to Friday. Extended hours are provided from 6.30 to 7.00pm on Tuesdays, Wednesdays and Thursdays, and from 9.00am to 12.00pm on Saturdays at the Sherard Road main site.

The premises at the three sites are arranged over two floors of purpose-built buildings. At the Sherard Road main site, there is a waiting area, a reception area, seven consulting rooms, a treatment room. There are two toilets on the ground floor. There is off-street car parking available. The practice's entrance and toilet are wheelchair-accessible and there are baby changing facilities.

Detailed findings

At the Rochester Way branch there is a waiting area, a reception area, a patient toilet, and two consulting/ treatment rooms on the ground floor.

At the Tudway Road branch there is a waiting area, a reception area, a patient toilet, a treatment room and three consulting rooms on the ground floor.

The practice has opted out of providing out-of-hours (OOH) services. Patients needing urgent care out of normal hours are advised to contact the OOH number 111 which directs patients to a local contracted OOH service or Accident and Emergency, depending on patients' medical urgency.

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 28 June 2016. During our visit we:

- Spoke with a range of staff including the GPs, the practice manager, a practice nurse, a health care assistant and three members of the reception/ administration staff.
- Spoke with patients who used the service.
- Observed how patients were being cared for and talked with carers and/or family members.
- Reviewed an anonymised sample of the personal care or treatment records of patients.
- Reviewed 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 a system in place for reporting and recording significant events. The practice held a meeting attended by the manager and clinical staff in April 2016, at which significant events were discussed.

- Staff told us they would inform the practice manager of any incidents and there was a recording form available on the practice's computer system. The incident recording form supported the recording of notifiable incidents under the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).
- We saw evidence 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.
- The practice carried out a thorough analysis of the significant events.

We reviewed safety records, incident reports, patient safety alerts and minutes of meetings where these were discussed. We saw evidence that lessons were shared and action was taken to improve safety in the practice. For example, following an incident involving a patient being administered a medicine without the necessary health monitoring checks, staff were advised to ensure they did not issue further prescriptions and to refer to the patient's GP. The incident was discussed with staff in order to prevent a similar occurrence.

Overview of safety systems and processes

The practice had some systems, processes and practices in place to keep patients safe and safeguarded from abuse, but these arrangements did not always reflect relevant legislation and local requirements.

- The practice told us all GPs had received safeguarding children training to level 3 but they did not provide us with evidence of this for any of the GPs when requested. After our inspection the practice sent us evidence of this training for three GPs; two documents were dated in September 2014 and June 2016 and the third was not dated so we could not determine on what date the training had been completed. One document showed that only one out of three modules of the training had been completed. The practice told us other staff had received training for safeguarding children and vulnerable adults, but we were not provided with evidence of this for a nurse, two health care assistants, and six non-clinical staff. Safeguarding training, which should be updated every three years, had not been updated for a nurse since 2012. Of the training certificates we reviewed, nurses were trained to child safeguarding level 2 and adult safeguarding, and non-clinical staff were trained to child safeguarding level 1 and adult safeguarding.
- Safeguarding 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 adults and children. The GPs attended safeguarding meetings when possible and always provided reports where necessary for other agencies. Staff demonstrated they understood their responsibilities.
- Notices in the waiting areas advised patients that chaperones were available if required. Two members of staff acted as chaperones; however, only one of them had received training and a Disclosure and Barring Service (DBS) check for the role. Training had been booked for the other chaperone and their DBS check was in progress. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).

The practice did not maintain appropriate standards of cleanliness and hygiene in all areas.

- We observed the premises at the main site and the Tudway Road site to be clean and tidy, but at the Rochester Way site, we found what appeared to be dried blood smeared next to a light switch in the patient toilet. The walls in the toilet, reception and waiting areas were not clean. There was no toilet paper available; patients were required to request it from the receptionists. At the Sherard Road main site, the toilet paper dispenser was not in use. There were completed cleaning schedules dating up to 2012 to indicate which areas of the premises were to be cleaned, but none had been

completed more recently. The practice manager told us they had experienced problems with their cleaning contractor and they were due to meet with them to discuss improvements needed.

- The practice did not have records of the immunity status of their cleaners and clinical staff.
- The flooring in a clinical room at the Sherard Road main site had come away from the walls, presenting an infection risk. The practice manager informed us they had received a quote for this to be rectified but there had been no confirmation of a date for the necessary work to be carried out.
- The practice manager was the non-clinical infection control clinical lead at the main site, and the lead GP was the clinical infection control lead across all three sites. There was an infection control protocol in place and staff had received up to date training.
- Annual infection control audits were undertaken for the main site and we saw evidence that action was taken to address any improvements identified as a result; however, this had not been documented. Infection control audits had been conducted for the branch sites on Rochester Way and Tudway Road in 2014 but they had not been repeated in 2015, and should be conducted annually. Actions completed for the branch sites had not been documented. There were some outstanding actions yet to be completed such as the replacement of sinks to comply with current regulations; the practice told us this would not be financially viable to complete because the GP partners who owned the premises had intentions to sell the Rochester Way site within a year and demolish the Tudway Road site within three years due to a compulsory purchase order by Greenwich local authority.

The arrangements for managing medicines in the practice (including obtaining, prescribing, recording, handling, storing, security and disposal) were not robust enough to keep patients safe.

- There were no effective processes in place to monitor the expiry dates of medicines. At the Rochester Way site we found two vaccines, an emergency medicine, three boxes of local anaesthetic solution and two packets of smoking cessation medicines that were out of date by up to four years; the practice manager assured us they would destroy these medicines. At the Tudway Road site we found an emergency medicine which had expired in April 2016; staff replaced this medicine when we brought it to their attention.
- We found that the vaccines fridge temperatures had not been recorded on six working days between January and May 2016. A second thermometer for this fridge was not working and staff were not aware of this when we brought it to their attention.
- Processes were in place for handling repeat prescriptions which 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. The majority of blank prescription forms and pads were securely stored, but prescription paper stored in printers at the main site were stored in an unlocked room overnight. There were systems in place to monitor the use of prescription pads at the main site and the Rochester Way site, but not at the Tudway Road site.
- Patient Group Directions (PGDs) that had been adopted by the practice to allow nurses to administer medicines in line with legislation were not fit for purpose; 22 out of 24 PGDs we reviewed had not been signed by an authorising manager (PGDs provide a legal framework that allows some registered health professionals to supply and/or administer a specified medicine to a pre-defined group of patients, without them having to see a GP).
- We reviewed one personnel file of a recently recruited member of staff and found appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and DBS checks.

Monitoring risks to patients

Risks to patients were not always well-assessed and well-managed.

- We requested but were not provided with any fire risk assessments for either of the practice's branch sites on Rochester Way and Tudway Road. A fire risk assessment had been conducted for the Sherard Road main site that had not been reviewed since 2010. The practice told us

they did not conduct regular fire evacuation drills. Fire action plans in staff areas at had not been completed with details of the fire meeting points; a member of staff we spoke with was not clear on where the meeting points were for staff and patients. There were no fire action plans in any of the patient areas to keep patients informed of actions to take in the event of a fire. There were no fire safety marshals allocated and the practice manager and all clinical staff had not received any fire safety training; the practice manager informed us after the inspection that this training would be received in September 2016. There were boxes stored at the base of a staircase which formed part of the fire exit pathway. The practice told us they conducted monthly checks of fire alarms to ensure they were in good working order but these checks were not documented.

- There were some procedures in place for monitoring and managing risks to patient and staff safety. The practice had risk assessments in place at the main site and branch sites to monitor safety of the premises such as control of substances hazardous to health and health and safety. A Legionella risk assessment had been conducted for the main site in March 2016, but not for the branch sites (Legionella is a term for a particular bacterium which can contaminate water systems in buildings).
- All electrical equipment was recently checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly.
- There was a health and safety policy available with a poster in the reception areas.
- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system in place for all the different staffing groups to ensure enough staff were on duty.

Arrangements to deal with emergencies and major incidents

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

- There were no instant messaging system on the computers and no panic buttons in any consultation or treatment room to alert staff to an emergency. The practice told us they could send raise an alarm via telephone calls or emails in emergencies.
- Most staff had received basic life support training but we were not provided with evidence of training for two clinical and seven non-clinical staff. The practice manager told us they had conducted risk assessments to mitigate the need for this training for three non-clinical staff; however, the United Kingdom's Resuscitation Council guidelines state that this training should be completed annually by all staff working in primary care settings such as GP practices. This training had not been completed annually for most staff; the practice informed us they were unaware of recent changes in guidelines regarding this.
- The practice did not have a defibrillator available at any of its three sites, and they had not conducted any risk assessments to mitigate the risk of not having them available. There was oxygen available with adult and children's masks at the main site, but not at the two branch sites at Rochester Way and Tudway Road. The practice had not assessed the risks of not having oxygen available. First aid kits and accident books were available.
- Some emergency medicines were easily accessible to staff in a secure area of the practice and all staff we spoke with knew of their location. An emergency medicine used for treating asthma at the Rochester Way branch had expired in July 2015 and another used for treating suspected heart problems had expired in April 2016.
- The practice did not have sufficient quantities of emergency medicines at its branch sites, and it had not conducted any risk assessments to determine which emergency medicines should be available. For example, at the Tudway Road site, there were no emergency medicines for the treatment of asthma, bacterial meningitis, epilepsy, or diabetic hypoglycaemia. At the Rochester Way site, there were no emergency medicines for bacterial meningitis, diabetic hypoglycaemia or epilepsy.

Inadequate

Are services safe?

- The practice had a business continuity plan in place for major incidents such as power failure or building damage. The plan did not include emergency contact numbers for staff.

Requires improvement

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

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

- The practice had systems in place to keep all clinical staff up to date. Staff had access to guidelines from NICE and used this information to deliver care and treatment that met patients' needs.
- The practice did not monitor that these guidelines were followed.

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 80.7% of the total number of points available, which was below the national average of 94.7%. It had a QOF clinical exception reporting rate of 3.4%, which was below the national average of 5.8% (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). The practice provided evidence, after the inspection, that in 2015/2016 their QOF achievement had improved to 88%; this data had not been independently verified or published at the time of our inspection.

This practice was an outlier for several QOF (or other national) clinical targets when compared to local Clinical Commissioning Group (CCG) and local averages, and we were not satisfied that they had taken adequate action to monitor and implement actions to improve their performance. Data from 2014/2015 showed that in the previous 12 months:

- Performance for mental health related indicators was significantly below average. For example, 65% of patients with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive, agreed care plan in their records (CCG average 85%, national average 88%). In addition, 50% of patients with poor mental health had a record of their alcohol consumption (CCG average 86%, national average 90%).The practice told us they offered patients care plans and recorded their alcohol consumption but that this may have been poorly recorded by clinicians. The practice provided evidence, after the inspection, that for patients with poor mental health in 2015/2016 performance for documenting care plans for had improved to 72%, and performance for documenting their alcohol consumption had improved to 54%. This data had not been independently verified or published at the time of our inspection.
- Performance for chronic obstructive pulmonary disease (COPD) indicators was significantly below average. For example, 67% of patients with COPD had received a review of their condition (CCG average 87%, national average 90%). The practice told us performance for asthma and COPD had declined since their asthma and COPD recall nurse had left the practice for maternity leave, and that they had struggled to send sufficient appointment recall letters to patients. The practice provided evidence, after the inspection, that in 2015/2016 performance for reviewing patients with COPD had improved to 70%; this data had not been independently verified or published at the time of our inspection.
- Performance for asthma related indicators was below average. For example, 55% of patients with asthma had received a review of their condition (CCG average 74%, national average 75%). The practice provided evidence, after the inspection, that in 2015/2016 performance for reviewing patients with asthma had improved to 62%; this data had not been independently verified or published at the time of our inspection.
- Performance for most diabetes related indicators was average, but it was below average for others. For example, 76% of patients with diabetes had received the annual flu vaccine (CCG average 90%, national average 94%). The practice told us this may have been due to poor recording of checks carried out by clinicians; they told us they had addressed this with their clinical staff. They also told us diabetic patients on their list were not pro-active at attending screening appointments. The practice provided evidence, after the inspection, that in

Requires improvement

Are services effective?

(for example, treatment is effective)

2015/2016 performance for administering the annual flu vaccine to patients with diabetes had declined to 72%; this data had not been independently verified or published at the time of our inspection.

- The practice's emergency admissions rate was 23 out of 1000 patients. This was above the CCG average of 12/1000 and the national average of 15/1000. The practice told us they were trying to reduce patient reliance on Accident and Emergency by referring patients to volunteer services such as Age Concern and to local urgent care centres.
- Performance for dementia related indicators was average. For example, 75% of patients with dementia had received a face-to-face review of their care (CCG average 84%, national average 84%). The practice provided evidence, after the inspection, that in 2015/2016 performance for administering the annual flu vaccine to patients with diabetes had improved to 87%; this data had not been independently verified or published at the time of our inspection.
- Performance for hypertension related indicators was average. For example, 75% of patients with hypertension had well-controlled blood pressure (CCG average 81%, national average 84%). The practice told us they had purchased a 24 hour blood pressure monitoring unit in the previous eight months to improve the monitoring of patients with hypertension.

  There was evidence of quality improvement including clinical audit.
- The practice told us there had been 12 clinical audits completed in the previous two years. We were able to review five audits, all of which were completed two cycle audits where the improvements made were implemented and monitored.
- Findings were used by the practice to improve services. For example, an audit conducted in September 2015 on anticoagulation prescribing for patients with the heart condition atrial fibrillation identified 19 patients who were receiving anticoagulation therapy without a documented reason, and 47 patients who were receiving dual or triple anticoagulation therapy against guidelines. A second cycle of this audit was conducted in February 2016; it showed that the number of patients receiving anticoagulation therapy without a documented reason had reduced to 10, and the number of patients receiving dual or triple anticoagulation therapy had reduced significantly to seven.
- The practice participated in local audits and external peer review. They told us they also participated in local and national benchmarking to compare their performance to other practices. The GP had received accreditation to provide training to GP trainees.

Effective staffing

- The practice had an induction programme for all newly appointed staff. It covered general practice processes and protocols but it did not cover topics such as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality.
- The practice told us they ensured role-specific training and updating for relevant staff. For example, for those reviewing patients with long-term conditions; however, the practice's performance for reviewing patients with health indicators related to poor mental health, chronic obstructive pulmonary disease and some diabetes indicators was below local and national averages.
- Staff administering vaccines and taking samples for the cervical screening programme had received specific training which had included an assessment of competence. Staff who administered vaccines could demonstrate how they stayed up to date with changes to the immunisation programmes, for example by access to on line resources and discussion at practice meetings.
- All staff had received an appraisal within the last 12 months.
- There was no formal system in place to assess or monitor the learning needs of staff. The practice told us all staff had received training for safeguarding, but we were not provided with evidence of this for several members of staff when requested. They told us three staff members had not received basic life support training, and that several had not received fire safety training. The practice manager told us after the inspection that fire safety training would be arranged in September 2016. All staff had received infection control training.

Coordinating patient care and information sharing

Requires improvement

Are services effective?

(for example, treatment is effective)

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 on-going care and treatment. This included when patients moved between services, including when they were referred, or after they were discharged from hospital. The practice did not have formal arrangements for working with other health care professionals on the case management of patients; this occurred on an informal, ad-hoc basis where care plans were reviewed and updated for patients with complex needs.

Consent to care and treatment

Not all staff members sought patients' consent to care and treatment in line with legislation and 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. However, a nurse told us they did not always record that they had sought consent from patients for procedures such as the administration of vaccines.
- Most of the staff we spoke with 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.
- The process for seeking consent was not monitored.

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, those at risk of developing a long-term condition.
- Patients requiring support with alcohol cessation were referred to local services.
- The nurses provided diet advice and the health care assistant provided smoking cessation advice.

The practice's uptake for the cervical screening programme was 78%, which was comparable to the local Clinical Commissioning Group average of 82% and the national average of 82%. There was a policy to offer telephone reminders for patients who did not attend for their cervical screening test. There were systems in place to ensure results were received for all samples sent for the cervical screening programme and the practice followed up women who were referred as a result of abnormal results. The practice told us they also encouraged their patients to attend national screening programmes for bowel and breast cancer screening.

In 2014/2015, childhood immunisation rates for the vaccinations given to children aged under two years ranged from 70% to 77% and five year olds from 56% to 76%.

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

Good

Are services caring?

Our findings

Kindness, dignity, respect and compassion

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

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

Fifteen of the 24 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. Nine of the cards contained comments about difficulties getting appointments, and two highlighted dissatisfaction with the attitude of staff on occasion.

We spoke with two patients during the inspection, and two members of the practice's Patient Participation Group (PPG) shortly after the inspection. They told us they found staff to be caring, but expressed difficulties getting appointments when needed.

Results from the national GP patient survey published on 7 January 2016 showed the majority of patients felt they were treated with compassion, dignity and respect. The practice was rated average in comparison to local Clinical Commissioning Group (CCG) and national averages for its satisfaction scores on consultations with GPs and nurses. For example:

- 85% of patients said the GP was good at listening to them (CCG average 85%, national average 89%).
- 81% of patients said the GP gave them enough time (CCG average 81%, national average 87%).
- 91% of patients said they had confidence and trust in the last GP they saw (CCG average 93%, national average 95%).
- 77% of patients said the last GP they spoke to was good at treating them with care and concern (CCG average 80%, national average 85%).
- 93% of patients said the last nurse they spoke to was good at treating them with care and (CCG average 84%, national average 91%).
- 78% of patients said they found the receptionists at the practice helpful (CCG average 88%, national average 87%).

Care planning and involvement in decisions about care and treatment

Patients we spoke with during the inspection 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, but they said clinical staff did not always adequately explain prescribed medicines to them. Patient feedback from the comment cards we received was positive in this regard. We saw that care plans were personalised.

Results from the national GP patient survey published on 7 January 2016 showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. Results were mostly in line with local Clinical Commissioning Group (CCG) and national averages. For example:

- 76% of patients said the last GP they saw was good at involving them in decisions about their care (CCG average 76%, national average 82%).
- 86% of patients said the last nurse they saw was good at involving them in decisions about their care (CCG average 79%, national average 85%).
- 77% of patients said the last GP they saw was good at explaining tests and treatments (CCG average 81%, national average 86%).

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

- Staff told us that translation services were available for patients who did not speak or understand English. There was a notice in the reception area of the Tudway Road branch site informing patients this service was available, but there were no such notices at the main site or the Rochester Way branch site.

Good

Are services caring?

- 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 areas 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 53 patients as carers (less than 1% of the practice list). There was written information available at the Sherard Road main site to direct carers to the various avenues of support available to them, but there was no such information at the Rochester Way and Tudway Road branch sites. The practice told us they were able to refer carers to local support groups.

Staff told us that if families had suffered bereavement, their usual GP contacted them by telephone and patients were given advice on how to find a support service.

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. For example, the practice participated in Greenwich CCG's Year of Care scheme which commenced in September 2015, with an aim to improve outcomes for patients with chronic obstructive pulmonary disease, diabetes, heart failure and hypertension. At the time of our inspection, the practice had not assessed the impact of this scheme on outcomes for its patients, as the scheme had not reached completion.

- The practice offered extended hours appointments three evenings a week at all of its three sites, and on one Saturday morning at its Sherard Road main site for working patients who could not attend during normal opening hours.
- The practice offered online services such as appointment booking and repeat prescription ordering.
- There were longer appointments available for patients with a learning disability.
- Homeless patients without a fixed address were not able to register as patients to receive on-going care, and the practice did not explain any rationale for this.
- Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice.
- The practice had 24 hour ambulatory blood pressure monitoring equipment available, which enabled patients to avoid potentially long waits for this service from secondary care.
- Same day appointments were available for children and those patients with medical problems that required same day consultation.
- Patients were able to receive travel vaccines available on the NHS.
- There were disabled facilities; however, there were no emergency pull cords in any of the disabled toilets. The practice manager informed us that staff would be able to hear if patients using the toilet were in distress.
- There were no hearing loops available at for patients with hearing difficulties; staff told us they would speak clearly for patients who could lip read, and they could arrange sign language interpreters for patients if needed.
- Translation services were available but were not advertised at the main site or the Rochester way branch site.
- Staff held events up to twice yearly to raise money in support of a large cancer charity and other local charities. They informed us that they occasionally did grocery shopping for elderly or housebound patients, and delivered blood samples to the local hospital for them. On the day of our inspection, a member of staff collected a member of the practice's Patient Participation Group (PPG) from their home so that they could attend the PPG meeting.

Access to the service

The practice was open from 8.00am to 6.30pm Monday to Friday. Appointments with the GPs were available from 9.00am to 12.30pm and from 1.00pm to 6.30pm Monday to Friday. Appointments with nurses were available from 8.30am to 6.00pm Monday to Friday. Extended hours appointments were provided from 6.30 to 7.00pm on Tuesdays, Wednesdays and Thursdays, and from 9.00am to 12.00pm on Saturdays at the Sherard Road main site. The branch sites at Rochester Way and Tudway Road were closed on Saturdays, and all three sites were closed on Sundays and Bank holidays.

Appointments could be pre-booked up to nine weeks in advance with GPs, and up to 12 weeks in advance with nurses and health care assistants, and same day urgent appointments were available Monday to Friday.

All of the four patients we spoke with told us they had experienced difficulties getting appointments when they needed them, and that they had faced long waiting times after arriving for booked appointments. Results from the national GP patient survey published on 7 January 2016 showed that patients' satisfaction with how they could access care and treatment varied; it was in line with local Clinical Commissioning Group (CCG) and national averages in some areas and below average in others:

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

- 81% of patients were satisfied with the practice's opening hours (CCG average 73%, national average 78%).
- 64% of patients said they could get through easily to the practice by phone (CCG average 73%, national average 73%).
- 54% of patients were able to get an appointment to see or speak to a GP or nurse the last time they tried (CCG average 70%, national average 76%).
- 42% of patients said they did not normally have to wait too long to be seen (CCG average 51%, national average 58%).

We raised these results with practice manager who informed us they had recently reviewed the results of the survey. They told us they felt the survey reflected patients' perceptions and they thought the practice was performing well. They did not discuss or provide evidence of any plans in place to address or make improvements to the areas in which they were performing below average. The practice had, however, responded to similar feedback to its own practice survey by recruiting two additional GPs in order to provide additional appointments for patients.

The practice had a system in place to assess:

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

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

Listening and learning from concerns and complaints

The practice had an effective system in place 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 leaflets were available to help patients understand the complaints system.

We looked at five complaints received in the previous 12 months and found they were dealt with in a timely way, with openness and transparency. Lessons were learnt from individual concerns and complaints and action was taken to as a result to improve the quality of care. For example, following a complaint about the attitude of a member of staff during an appointment, the complaint was investigated and discussed with the staff member, and the practice apologised to the patient.

Are services well-led?

Inadequate

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

Our findings

Vision and strategy

The practice had a vision to provide good quality care for patients but we found they had not developed any robust strategies to support the delivery of this.

- The practice had a mission statement which was displayed in the waiting area at the Tudway Road branch site to make patients aware. Staff we spoke with knew and understood the practice's values.
- The practice discussed an informal strategy to improve monitoring of their performance and to improve documentation of various processes, but there were no documented business or action plans to ensure that this strategy was monitored, implemented and reviewed.

Governance arrangements

Governance arrangements did not support the delivery of good quality care, and there were several areas which required improvement.

- Arrangements for identifying, recording and managing risks, issues and implementing mitigating actions required improvement. For example, the practice had not conducted risk assessments in relation to the limited amount of emergency medicines available at its branch sites, the absence of medical equipment, and for fire safety and legionella at its branch sites.
- The practice did not maintain appropriate standards of infection prevention and control in all areas. Some areas were visibly dirty, and systems to monitor the quality of cleaning were not in use.
- Fire safety systems were not robust; there were no allocated fire marshals, no documented checks to ensure alarm systems were in good working order, and there was an absence of information for patients and staff on actions to take in the event of a fire.
- There was limited documentation of some of the practice's processes, such as training received and governance meetings.
- Some staff had not received training that was appropriate to their roles. For example, we requested but were not provided with evidence of information governance, safeguarding and fire safety training for several staff, and basic life support raining for three staff members.
- There was some evidence of quality improvement including clinical audit; however, the practice did not have any formal processes in place to continuously monitor and improve clinical and overall performance. They had not adequately addressed performance for the Quality and Outcomes Framework that was below average. For example, performance for indicators related to asthma, chronic obstructive pulmonary disease and diabetes were between 14% and 40% below local and national averages, and there were no systematic or documented plans in place to improve this. The practice provided evidence after the inspection that showed performance had improved by up to 7%; this data had not been independently verified or published at the time of our inspection.
- Practice specific policies were implemented and were available to all staff.
- An understanding of the performance of the practice was maintained by most staff, but the lead GP was not aware that the practice kept a log of significant events.

Leadership and culture

On the day of our inspection we found that the practice's leaders had not ensured safe and high quality care. There were deficiencies in the management of several of the practice's processes. However, staff told us the practice's leaders were approachable and always took the time to listen to all members of staff.

The provider was aware of and had systems in place to ensure compliance with the requirements of the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).This included support training for all staff on communicating with patients about notifiable safety incidents. The partners encouraged a culture of openness and honesty. The practice had systems in place to ensure that when things went wrong with care and treatment:

- The practice gave affected people reasonable support, truthful information and a verbal and written apology.

Are services well-led?

Inadequate

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

- The practice kept written records of verbal interactions as well as written correspondence.

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

- Staff told us the practice held regular team meetings but these had not always been routinely documented. We were, however, provided with evidence of a meeting held in April 2016 where a range of topics were discussed. The practice told us they held daily clinical meetings; they provided a copy of a clinical meeting held in July 2015.
- Staff told us there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and felt confident and supported in doing so.
- Staff said they felt respected, valued and supported by the leaders in the practice. They told us they were involved in discussions about how to run and develop the practice, and that the partners encouraged all members of staff to identify opportunities to improve the service delivered by the practice.

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

- The practice had gathered feedback from patients through its active patient participation group (PPG) of five members, and through surveys and complaints received. The practice had reviewed patient feedback from the national GP patient survey published in January 2016 but they had not addressed areas for which they had been rated below local or national averages in order to improve patient satisfaction.
- The PPG met every three months, carried out patient surveys and submitted proposals for improvements to the practice management team. Although the PPG members we spoke with felt the practice had not responded to all of their suggestions for improvements such as, for example, improving the décor of the Rochester Way branch site, improving the telephone system, and repairing display screens in waiting areas, they had responded to feedback regarding the appearance of the premises at the Sherard Road main site by re-painting the waiting area.
- The practice had gathered feedback from staff through informal discussions, staff meetings and appraisals. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management, and that they felt involved and engaged to improve how the practice was run.

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 17 HSCA (RA) Regulations 2014 Good governance **How the regulation was not being met:** The registered person failed to maintain securely records in relation to persons employed in the carrying on of the regulated activities, and in the management of the regulated activities. They failed to assess, monitor and improve the quality of the services provided in the carrying on of the regulated activities. • They failed to maintain records of mandatory training for all staff. • They failed to ensure processes such as actions completed from infection control audits were documented. • They failed to establish effective systems to monitor and respond appropriately to areas of the service where quality was being compromised. This was in breach of regulation 17 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Staffing **How the regulation was not being met:** The registered person failed to ensure persons employed in the provision of regulated activities received appropriate and necessary training to enable them to carry out the duties they were employed to perform.

This section is primarily information for the provider

Requirement notices

- They had failed to ensure all staff had received basic life support training.
- Their induction programme was not comprehensive enough to prepare staff for their role.

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

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **How the regulation was not being met:** • The registered person did not do all that was reasonably practicable to assess, monitor, manage and mitigate risks to the health and safety of service users. • They failed to ensure the proper and safe management of medicines, and failed to ensure emergency equipment and medicines were available in sufficient quantities. • They failed to ensure nurses were properly authorised to administer medicines. • They failed to implement effective systems for infection control and prevention, and fire safety. • They failed to conduct risk assessments relating to the health, safety and welfare of people using services. • They failed to ensure there were adequate systems in place for staff to raise an alarm in emergencies. This was in breach of regulation 12 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.