Kington Medical Practice

Quality Report

The Surgery
Kington
Eardisley Road
Herefordshire
HR5 3EA
Tel: 01544 230302
Website: www.kingtonmedicalpractice.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	Good
Are services safe?	Requires improvement
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Kington Medical Practice on 26 November 2015. Overall the practice is rated as good

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. However, not all risks were assessed and managed. Some significant events had not been recorded and the practice had no evidence of the learning and action that had taken place as a result.
- Risks to patients were assessed and generally well managed and the practice had a number of policies and procedures to govern activity.
- Not all required employment checks were completed for non-clinical staff carrying out chaperone duties or for staff who had unsupervised access to patients and there was no risk assessment to show how the practice reached these decisions.
- A programme of clinical audits was underway. One completed audit cycle showed how the practice had used the results to make improvements. The GPs had prioritised direct patient care due to their recruitment problems which reduced the time available for structured clinical meetings.
- Urgent appointments were available on the day they were requested and unwell children under the age of two were seen as soon as they arrived at the practice. A nurse practitioner ran a walk in service four days a week (increased to five shortly after the inspection) for patients with minor illnesses. The practice established this to help maintain a responsive service to the practice population by increasing the number of appointments.
- The practice provided a responsive service to large numbers of older patients living in local care homes; many of these patients had complex care and treatment needs which needed frequent GP input. At

Summary of findings

the time of the inspection the practice also provided a service to a 10 bed intermediate care unit to enable patients to be discharged from hospital in a timely way.

- National data showed that the practice worked in line with national guidance to provide an effective service for patients experiencing poor mental health and patients living with dementia.
- The practice responded constructively to support families living in circumstances which might make them vulnerable.
- Patients spoke highly of the practice team and were complimentary about the care and treatment they received. They said they were treated with compassion, dignity and respect but had concerns about the GP recruitment problem and the impact of this on continuity of care and the future of the practice.
- The practice team were open about the challenges they faced at the practice and had sought solutions to help them maintain the service. In September 2015 they entered into an arrangement with an external healthcare company to gain support with administration, governance and GP recruitment. Two GPs from this organisation planned to become executive partners at the practice.

The areas where the provider must make improvements are:

- Improve recruitment arrangements, including written policies and procedures to ensure all necessary employment and ongoing checks are completed for staff.
- Ensure that all significant events are recorded to show any remedial action taken and to provide for the foundations for shared learning and implementation of improvements. Where necessary the practice must also inform CQC of significant events.
- Formally review and risk assess security arrangements for the dispensary.

In addition the provider should:

- Review the provision of regular clinical meetings, training and shared learning opportunities.
- Continue to use the results of the national GP patient survey and other patient feedback to consider how further improvements could be made in respect of access to the service.
- Effectively communicate the role and responsibilities of the external healthcare organisation in supporting the practice.

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?

Requires improvement

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

- Staff generally understood their responsibilities to raise concerns, and to report incidents and near misses. However, three serious issues had not been recorded as significant events and the practice had not identified that these should also have been reported to CQC.
- Recruitment procedures did not reflect the requirements set out in the fundamental standards. The practice had not obtained, or risk assessed the need for a disclosure and barring (DBS) check for non-clinical staff who carried out chaperone duties or had unsupervised access to patients. (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).
- Medicines' safety was well managed.
- Staff had a good understanding of the processes to follow when they had concerns about children or adults whose circumstances placed them at risk of harm.
- The practice had a range of health and safety related measures. These included arrangements for the safe management of fire safety and infection control.

Are services effective?

Good

The practice is rated as good for providing effective services.

- Data showed patient outcomes were in line with or better than CCG and national averages in most clinical and public health areas.
- Staff assessed needs and delivered care in line with current evidence based guidance.
- Staff had the skills, knowledge and experience to deliver effective care and treatment but were overstretched due to the difficulties they were having recruiting more GPs. The partners were aware of this and all staff had agreed to prioritise patient care.
- There was evidence of appraisals and personal development plans for staff.
- Staff worked with multidisciplinary teams to understand and meet the range and complexity of people's needs.

Summary of findings

- Regular clinical meetings did not take place to provide the GPs and practice nursing team with opportunities to review, share and discuss clinical guidelines. Most training was being done using computer based training resources which staff felt did not encourage shared learning.
- The nursing team ensured they completed their required continuous professional development (CPD) by keeping their knowledge and skills up to date but needed to do important updates in their own time because of the pressures on the practice.

Are services caring?

Good

The practice is rated as good for providing caring services.

- Data showed that patients rated the practice in line with others for providing a caring service.
- Patients and staff at local care homes provided us with a positive view of the compassion and commitment of the GPs.
- The GPs frequently provided out of hours care to patients at the end of life, particularly those in remote areas to ensure continuity of care and make it more likely that they would be able to remain at home rather than being admitted to hospital.
- Information for patients about the services available was easy to understand and accessible.
- We saw and heard staff speaking with patients with respect and in a caring way. We noted that staff understood the importance of confidentiality and that the practice had processes to support this.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services.

- The practice was aware of the impact of its low GP numbers on its patient population. It had engaged with the NHS England Area Team and the Clinical Commissioning Group to discuss the situation.
- Patients said they found it difficult to make an appointment with a named GP and were concerned that reliance on locum GPs had an impact on continuity of care. The most recent patient survey results for access reflected this concern. However, urgent appointments were available the same day and children under two were seen immediately.
- The practice had set up an advanced nurse practitioner led walk in clinic for patients with minor illnesses. This was providing an additional 100 appointments every week.

Summary of findings

- The practice had modern, spacious facilities and was well equipped to treat patients.
- The GPs visited some patients at home not only because of poor health but also because of lack of transport in many remote areas of their catchment area.
- The practice provided a responsive GP service to over 150 patients living or staying in seven care homes in the surrounding area. At the time of the inspection this included daily visits to a 10 bed intermediate care unit.
- The GPs reviewed the needs of patients nearing the end of life and when appropriate provided prescriptions for anticipatory medicines to reduce the potential for unplanned hospital admissions during weekends.
- The practice dispensary provided a collection and delivery service for prescriptions.
- Information about how to complain was available and evidence showed that the practice responded quickly to issues raised.

Are services well-led?

Good

The practice is rated as requires improvement for being well-led.

- The partners were open and transparent in describing the challenges they faced in maintaining the service they provided to the community. It was evident that the partners were working very long hours to achieve this. Patients, the PPG and practice staff were concerned about the future of the practice.
- In September 2015 the practice entered into an arrangement with an external healthcare organisation. The intention of this was to stabilise the practice by gaining support with finance, administration, governance and GP recruitment. Two GPs from this organisation were joining the practice as executive partners and the practice was intending to send us the required applications to add them to the practice's CQC registration. These GPs would have a role in practice governance rather than providing face to face patient care. We found that communication with the practice team regarding the details of these arrangements had been limited.
- The practice had a number of policies and procedures to govern activity.
- The practice had a patient participation group but members found it difficult to attract new members and did not feel the practice fully engaged with them in developing the service.

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

Good

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

- The GPs provided home visits for those patients who were unable to come to the practice due to poor health or limited mobility. They also did home visits for patients with no access to transport in remote parts of the practice catchment area.
- The percentage of patients aged 65 or over who received a seasonal flu vaccination in 2013/14 was lower than the CCG and national averages but the practice had identified and addressed the reasons for this.
- The practice provided a responsive service to over 150 patients living or staying in local care homes including three providing nursing care to patients with complex physical care needs and those living with the effects of advanced dementia.
- Information was made available to out of hours and ambulance services to help ensure that patients at the end of their lives received the care and treatment they wished in the place of their choosing.
- The practice had a palliative care register and met with other health professionals to discuss the needs of those patients. The GPs frequently provided out of hours care to patients at the end of life, particularly those in remote areas to ensure continuity of care and make it more likely that they would be able to remain at home rather than being admitted to hospital.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions.

- Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority.
- National data for 2014/15 showed that the practices performance for managing the health of patients with long term conditions was generally in line with CCG and national averages. Data in respect of how well patients' diabetes was controlled was lower than local and national averages.
- Longer appointments and home visits were available when needed. This included home visits for patients with no access to transport in remote parts of the practice catchment area.

Summary of findings

Families, children and young people

Good

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

- The practice had systems to identify and follow up children living in disadvantaged circumstances and who were at risk of harm. The practice team knew local families well and liaised with other professionals involved in safeguarding.
- The practice nurses worked in partnership with health visitors to ensure that all children received the childhood vaccinations they needed. This included making individual arrangements in specific circumstances.
- Childhood immunisation rates were comparable to the CCG averages and in a number of cases higher.
- Some appointments were available for children outside of school hours between 4pm and 6pm. Children under the age of two were prioritised to be seen as soon as they arrived at the practice.
- A practice nurse ran a weekly well woman and young person's clinics one afternoon a week. This normally ended at 6pm but the practice told us that on occasions they extended this based on individual need.
- The premises were suitable for families with children because there was ample car parking and space in the practice for prams and pushchairs.

Working age people (including those recently retired and students)

Requires improvement

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

- The practice had a lower percentage of working age patients, students and the recently retired than the national average. Extended hours GP services were available through a local GP federation between 6pm and 8pm on weekdays and 8am to 8pm at weekends but these were provided at other sites which involved journeys of 14 miles or more from Kington. In addition, a GP- led walk-in centre open 8am-8pm, 365 days a year was available in Hereford and it is now possible for patients to register outside their home area, for example, near to their work or study place. The practice was in continued dialogue with the Clinical Commissioning Group and other practices to find workable solutions either individually or as part of a federated approach within Taurus Healthcare (of which it is a shareholder member), to providing improved access to primary care services.

Summary of findings

- Patients could book appointments or order repeat prescriptions online. The practice provided a free prescription delivery service to patients and collected prescriptions daily Monday – Thursday, from 4 villages within its catchment area.
- Some health promotion advice was displayed on noticeboards at the practice.

People whose circumstances may make them vulnerable

Good

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

- The practice held a register of patients living in vulnerable circumstances including travellers and those with a learning disability. Home visits or longer appointments were available for these patients when needed.
- The practice provided annual health checks for people with a learning disability.
- Staff were aware of their responsibilities and what action they should take in respect of adults and children whose circumstances made them vulnerable or placed them at risk of harm.
- The practice responded constructively to support families living in circumstances which might make them vulnerable.
- The practice was aware of the risks to patients living in remote areas and took steps to ensure they could respond to their needs in emergencies; for example they always had portable oxygen available when going out on home visits.

People experiencing poor mental health (including people with dementia)

Good

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

- Performance in respect of mental health was generally good, for example 93.6% of patients experiencing poor mental health had an agreed care plan. Performance for monitoring aspects of physical health for this group of patients was also better than the CCG and national average.
- The practice had a high prevalence of patients diagnosed with dementia. Their performance for providing face to face reviews in the previous 12 months was 84.1%. This was 2.7% below the CCG and 0.1% above the national average. The practice had zero exception reporting for this.

Summary of findings

- The practice worked with multi-disciplinary teams in the case management of people experiencing poor mental health and those with dementia. A specialist mental health worker was based at the practice once a month and a specialist dementia worker had a weekly clinic there.
- The practice worked in partnership with three local care homes which provided nursing care for patients with complex needs arising from living with dementia. Staff at one care home where patients lived with significant behavioural difficulties due to dementia told us the practice was responsive when urgent situations arose.

Summary of findings

What people who use the service say

As part of our inspection we asked for CQC comment cards to be completed by patients before our inspection. We received 22 completed cards, 15 of these contained only positive comments whilst the other seven were mainly positive but commented that the practice needed more GPs. Overall patients were complimentary about the care and treatment they received and the commitment shown by staff. Patients commented on the helpfulness of the practice team and the prompt and attentive care they received. A number of patients also commented on the cleanliness and attractiveness of the practice building.

During the inspection we spoke with 14 patients, four of whom were members of the practice's patient participation group. A PPG is a group of patients registered with a practice who work with the practice team to improve services and the quality of care. They provided a mixed but balanced picture of their experience of using the practice. Most commented positively about their care and treatment. However, they also spoke of their concerns about the lack of permanent GPs and resulting pressure on the three GP partners, reliance on locum GPs, and the impact on this on continuity of care. Patients also had concerns regarding the future of the practice.

We spoke with the managers of three local care homes providing short and long term nursing care for approximately 150 of the practice's patients. One of the homes also had a 10 bedded intermediate care unit which could be used for patients of any GP practice to provide short term care following discharge from hospital. These managers provided a consistently positive picture of the caring and responsive service the practice provided to people living in or staying at those homes whilst also reflecting on the challenges faced by the GPs due to being short staffed.

The national GP patient survey results published on 4 July 2015 showed the practice had lower satisfaction rates for some topics than the local and national averages. There were 116 responses and a response rate of 46.2%. Satisfaction levels were lower than average mainly in respect of access to the service, for example :

- 64.1% found it easy to get through to this surgery by phone compared with a CCG average of 79.5% and a national average of 74.4%.
- 30.4% with a preferred GP usually got to see or speak to that GP compared with a CCG average of 65.1% and a national average of 60.5%.
- 78.4% were able to get an appointment to see or speak to someone the last time they tried compared with a CCG average of 88.6% and a national average of 85.4%.
- 59.6% described their experience of making an appointment as good compared with a CCG average of 79.4% and a national average of 73.8%.
- 17.4% usually waited 15 minutes or less after their appointment time to be seen compared with a CCG average of 68.4% and a national average of 65.2%.

The practice was aware of patients' concerns about availability of appointments and had introduced a nurse led minor illness walk in clinic four days a week. This provided 100 additional appointments a week and was very popular with patients. They were also making every effort to recruit more GPs.

Responses in respect of the care and treatment from the GPs and nurses were more positive, for example:

- 86.6% said the last GP they saw or spoke to was good at giving them enough time compared with a CCG average of 89.1% and a national average of 86.8%.
- 84.6 said the last GP they saw or spoke to was good at treating them with care and concern compared with a CCG average of 87.9% and a national average of 85.1%
- 98.5% had confidence and trust in the last nurse they saw or spoke to compared with a CCG average of 97.9% and a national average of 97.2%.

Overall 61% of patients who completed this national survey described their experience of the practice as good compared with the CCG average of 88.7% and the national average of 85.2%.

Summary of findings

Areas for improvement

Action the service MUST take to improve

- Improve recruitment arrangements, including written policies and procedures to ensure all necessary employment and ongoing checks are completed for staff.
- Ensure that all significant events are recorded to show any remedial action taken and to provide for the foundations for shared learning and implementation of improvements. Where necessary the practice must also inform CQC of significant events.
- Formally review and risk assess security arrangements for the dispensary.

Action the service SHOULD take to improve

- Review the provision of regular clinical meetings, training and shared learning opportunities.
- Continue to use the results of the national GP patient survey and other patient feedback to consider how further improvements could be made in respect of access to the service.
- Effectively communicate the role and responsibilities of the external healthcare organisation in supporting the practice.

Kington Medical Practice

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector**.** The team included a GP specialist advisor, a practice manager specialist advisor, an Expert by Experience and a CQC pharmacist inspector.

Background to Kington Medical Practice

Kington Medical Practice is in on the edge of the Herefordshire market town of Kington. It has around 7,250 patients spread over a catchment area of 600 square miles in rural Herefordshire and Powys. The practice provides primary medical care to people living in two care homes in Kington and another in the nearby village of Lyonshall. The practice has on site car parking with spaces for patients with disabilities nearest to the entrance. The practice has a higher than average population of patients in all age groups over 50 and a lower than average population of patients under 40. The practice catchment is not in an area of significant social and economic deprivation but has significant challenges. These are due to the geography of the area making some outlying areas difficult to reach due to both distance and terrain, particularly in bad weather.

The practice moved in 2012 from town centre premises they occupied for many years to a purpose designed building on the outskirts of the town. At the time of its conception the practice's vision for the building was to provide a spacious, well designed community resource. In addition to the GP practice and dispensary the building contains a fully equipped dental practice and consultation rooms for other health professionals. Unfortunately the project encountered numerous problems and only the GP practice and dispensary are in full time use. A number of GPs have left the practice and the remaining three partners have been unable to recruit. This has had an impact on the practice's ability to maintain access to appointments for patients and provide continuity of care. The practice closed two branch surgeries because they were unable to provide GP cover across three sites.

The three remaining GP partners and the practice manager, (also a partner) had been working hard over the last two years to maintain services to patients and had been supported in this by the whole practice team. During the inspection we were informed that the practice manager is leaving at the end of December 2015. In September 2015 the practice entered into an arrangement with an external healthcare company to gain support with administration, governance and GP recruitment. Two GPs from this company were intending to become executive partners of the practice.

The practice is open between 8.30am and 6pm from Monday to Friday. The dispensary is open from 9am to 6pm Monday to Friday. One of the practice's two advanced nurse practitioners runs a walk in clinic for patients with minor illnesses on four days a week from 8.30am to 4pm. Following the inspection the practice told us that this had been extended to five days a week. The practice provides patients with information about Taurus Healthcare an organisation owned and managed by a federation of Herefordshire GPs which provides extended hours GP services between 6pm and 8pm on weekdays and from 8am to 8pm at weekends from three locations in the county.

The practice has three GP partners and two regular locum GPs. There are two nurse practitioners, four practice nurses and a health care assistant. The clinical team are

supported by a practice manager and a team of administrative staff and receptionists. The practice is a dispensing practice and has an experienced team of dispensary staff.

The practice provides a range of minor surgical procedures.

The practice has a patient participation group (PPG). A PPG is a group of patients registered with a practice who work with the practice team to improve services and the quality of care.

The practice has a General Medical Services (GMS) contract with NHS England.

The practice does not provide general out of hours services although it does provide some out of hours cover for patients nearing the end of life. Information for general out of hours cover is provided for patients. This service is provided by Primecare, a national health care provider. The service is accessed by using the NHS 111 telephone number. Primecare operate from a number of sites across Herefordshire one of which is in Kington town centre.

Why we carried out this inspection

We inspected this service as part of our comprehensive inspection programme under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This 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.

Please note that references to the Quality and Outcomes Framework data in this report relate to the most recent information available to CQC at the time of the inspection.

How we carried out this inspection

Before the inspection, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 26 November 2015. During our inspection we spoke with a variety of staff including GPs, nurse practitioners, a practice nurse, the practice manager and members of the dispensary, reception and administration teams.

We spoke with the four members of the patient participation group (PPG). A PPG is a group of patients registered with a practice who work with the practice team to improve services and the quality of care. We reviewed 22 CQC comment cards completed by patients and carers to provide information about their views and experiences of the service. On the day of the inspection we spoke with 10 patients. We also spoke with the managers of three local care homes which between them provide a service to over 150 patients registered at the practice.

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)

Requires improvement

Are services safe?

Our findings

Safe track record and learning

Staff were aware of the practice's system for reporting and recording significant events and knew that reporting forms were available on the practice's computer system. The practice held specific significant event meetings very four to six weeks. Immediate discussions were arranged if necessary depending on the urgency of an incident. However, we noted that there had been three incidents at the practice which had not been recorded as significant events and which may also have fallen within the scope of incidents CQC should be informed of. These were a break in and theft of medicines, a burst pipe and a structural concern with the building. The practice had not informed us of these incidents and had not been aware of the requirement to do so. The practice had a system for receiving and checking national patient safety alerts and sharing information with the GPs, dispensary staff and other members of the team as appropriate.

The dispensary team had clear procedures for reporting and learning from medicines incidents and errors. Incidents were logged efficiently and reviewed promptly to minimise the chance of similar errors occurring again.

Overview of safety systems and processes

The practice had arrangements to safeguard children and adults whose circumstances might make them vulnerable. These reflected relevant legislation. Local safeguarding information, including important contact information, was available for staff to refer to. One of the GPs was the practice's safeguarding lead and staff knew who this was. Staff demonstrated they understood their responsibilities and had received safeguarding training relevant to their role. The GPs and advanced nurse practitioners had completed level three safeguarding training and many of the staff we spoke with were doing updates using an online training resource. The managers of three local care homes confirmed that the GPs were familiar with safeguarding arrangements and one gave us an example of how a GP had worked with them to raise concerns about the health and well-being of a patient.

The practice arranged chaperones to be present during examinations and treatment when needed. We saw only one notice in the practice to make patients aware. In view of the spacious waiting areas and different areas patients might choose to sit this was not sufficiently noticeable. We learned that some non-clinical staff acted as chaperones but had not all received training for this role. However, staff we asked about the role understood their responsibilities and how to fulfil the role sensitively and effectively. We found that the practice had not obtained disclosure and barring service (DBS) checks for these staff and had not completed a risk assessment to show whether how they had decided not to do so. 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 began the process of obtaining checks for these staff as soon as this was identified during the inspection.

We observed that the premises were visibly clean and tidy and a number of patients commented on this. A member of non clinical staff and a practice nurse were responsible for general cleanliness and for infection control. Clear cleaning schedules were available for the practice cleaner who kept a written record of the cleaning they did each day. Practice nurses and the GPs were responsible for the cleaning of medical equipment. There was an infection control policy and annual infection control audits were undertaken.

Kington Medical Practice is a dispensing practice. The practice had appropriate written procedures in place for the production of prescriptions and dispensing of medicines. These were regularly reviewed and accurately reflected current practice. The practice was signed up to the Dispensing Services Quality Scheme to help ensure processes were suitable and the quality of the service was maintained. The dispensary staff had either completed appropriate training or had substantial experience in the role and all had their competency reviewed annually.

We found that repeat prescribing was undertaken in line with national guidance. The dispensary had processes 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. The practice held stocks of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse). Staff followed set procedures for the security of these medicines including recording, storage and destruction.

The practice showed us two dispensary related audits that had been undertaken in the last two years. One of these

was a completed audit where the dispensary was able to demonstrate the changes resulting since the initial audit. Following each audit, changes to processes were made where needed and the audit repeated to ensure outcomes for patients had improved. The practice monitored the prescribing of specific high risk medicines in accordance with national guidance.

Blank prescriptions were securely stored and the practice had a system to monitor the use of pads for handwritten prescriptions and other restricted use stationery such as death certificates. They did not have a similar system for prescription sheets used for printed prescriptions. The practice addressed this before the end of the inspection.

We checked medicines stored in the medicine and vaccine refrigerators. We found stock was stored securely and only accessible to authorised staff. There was a policy for ensuring that medicines were kept at the required temperatures which described the action to take in the event of a potential failure. Staff monitored and recorded room and refrigerator temperatures to ensure medicines were stored at the appropriate temperature.

The nurses used Patient Group Directions (PGDs) to administer vaccines and other medicines that had been produced in line with legal requirements and national guidance. We saw sets of PGDs that had been updated. We saw evidence that nurses had received appropriate training and been assessed as competent to administer the medicines referred to under a PGD.

We discussed overall security issues for the safe and secure storage medicines in the dispensary in the light of the break in at the practice in August 2015. The practice discussed the incident with relevant bodies, including the police and Clinical Commissioning Group at the time but did not record it as a significant event. The practice had not carried out a formal risk assessment following the incident.

We reviewed the recruitment arrangements for the practice and found that the required employment checks were not always carried out. The recruitment policy did not reflect the requirements for these checks as set out in the fundamental standards which set out the requirements for the standards registered providers must comply with. In particular we found that the practice had no recruitment records for locum GPs working at the practice. They told us these GPs were sourced by the company supporting them with practice management and governance. On the day of the inspection the practice could not provide information to show what recruitment checks this company carried out for locum GPs they provided for the practice. Following the inspection a clinical director from the company sent us evidence showing that legal requirements were met regarding this. They told us that this information should have been available to us when we were at the practice. The practice did not however have recruitment records available for a GP locum they appointed previously and were unable to provide evidence that they had done key checks such as a DBS check or that they routinely checked the General Medical Council register of GPs or the NHS England performers list.

We found that the practice did not have an organised system for monitoring the registration status of the nurses working at the practice to assure themselves that the nurses had maintained their professional registration. For example, the last recorded check that one of the nurses remained registered with the Nursing and Midwifery Council was in September 2013.

We checked the recruitment records for a sample of non-clinical staff. The practice had not obtained all of the required information for some of these staff. The practice had no risk assessment to establish which staff they should obtain DBS checks for. We identified that they had not obtained DBS checks for some staff whose roles involved chaperoning or who had unsupervised access with patients.

Monitoring risks to patients

The practice had some procedures for monitoring and managing risks to patient and staff safety. There was member of staff with responsibility for day to day housekeeping and maintenance. The building was owned by an external organisation which was responsible for the general management of the building. Staff told us this company was efficient at rectifying any problems.

- The practice had an up to date fire risk assessment, carried out weekly fire alarm tests and used any false fire alarms as fire drills. There was an automated system for printing a list of people in the building to assist the fire marshals when carrying out a roll call. Fire safety was covered during staff induction.
- Electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly.

Requires improvement

Are services safe?

- The practice had a variety of other risk assessments and supporting tests and checks to monitor safety of the premises such as control of substances hazardous to health, infection control and legionella.
- There had been problems with the practice building one of which was ongoing and involved a faulty floor in an office. Plans were in hand for this to be rectified and the practice had been assured that the room was safe for staff to use.

The practice was acutely aware of the impact for patients of their ongoing inability to recruit permanent GPs to work at the practice. The practice had two and a half full time equivalent GPs all of whom worked in excess of their set hours, for example by working on their days off. The practice used locum GPs to maintain a safe level of service for patients but recognised that their patients would prefer to have the continuity of a permanent team of GPs. The practice informed the external company when locum cover was needed and they made the booking arrangements. The non-clinical staff team was generally well staffed although there were vacancies for a receptionist and an administrator. Staff told us they provided cover amongst themselves to make sure that everything was done.

Arrangements to deal with emergencies and major incidents

- There was an emergency call facility on the practice computer system which staff could use to alert others to any emergency.
- Emergency equipment, including oxygen and a defibrillator was available and staff all knew where these were kept. All staff received annual basic life support and defibrillator training.
- Emergency medicines were easily accessible to staff in a secure area of the practice and staff knew their location.
- We saw records showing that staff checked the equipment and emergency medicines regularly to ensure they were in date and available for use. All the medicines we checked were in date.
- The practice needed a reliable supply of portable oxygen cylinders. This was because the practice was 20 miles from the nearest hospital and often used oxygen during home visits. They also needed a supply in case bad weather prevented deliveries. We found that a large number of oxygen cylinders were being stored in one room which increased the risk in the event of a fire. Staff took action to disperse these when we raised this with them.
- The practice had a comprehensive business continuity plan in place for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff.

Good

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 circulated new local and national clinical guidelines such as those from NICE to help ensure that clinical staff were up to date. Staff also had access to this information on the practice computer system. The GPs told us how they used this to deliver care and treatment that met patients' needs.
- The GPs were open with us in explaining that they were currently not able to have regular clinical meetings to discuss and share this information due to the pressure of not having enough permanent GPs.

Management, monitoring and improving outcomes for people

The practice participated in the Quality and Outcomes Framework (QOF). QOF is a voluntary system intended to improve the quality of general practice and reward good practice. The most recent results published in October 2015 for 2014/15 showed the practice had achieved 96.4% of the total points available. This was 1.5% below the average for practices in the CCG area but 2.9% above the national average. The practice's exception reporting was 8.2% and in line with the CCG and national averages. Exception reporting relates to patients on a specific clinical register who can be excluded from individual QOF indicators. For example, if a patient is unsuitable for treatment, is newly registered with the practice or is newly diagnosed with a condition. Examples of data from 2014/15 showed:

- The practice's performance for all but three of the clinical areas measured under QOF was in line with CCG and national averages and in a number of cases was better.
- Performance in respect of mental health was generally good, for example 93.6% of patients experiencing poor mental health had an agreed care plan. This was 2% above the CCG average and 5.3% above the national average. Performance for monitoring aspects of physical health for this group of patients was also better than the CCG and national average.
- The practice had a high prevalence of patients diagnosed with dementia. Their performance for providing face to face reviews in the previous 12 months was 84.1%. This was 2.7% below the CCG and 0.1% above the national average. The practice had zero exception reporting for this.
- Most of the measures for diabetes were better than or in line with CCG and national averages.

The practice system for recalling patients for reviews was based on their date of birth. As a result patients with more than one condition received a review of their overall health during one review and did not have to return to the practice several times. Blood tests were co-ordinated to fit in with each patient's review appointment so the results were available for this. The clinicians used structured templates for all long term condition reviews to ensure the reviews were thorough and reflected best practice guidelines.

We saw four clinical audits completed by GPs at the practice. One of these was a completed audit cycle in relation to long acting contraception. As a result of this audit the practice had improved their recall system to ensure they monitored patients' ongoing contraceptive needs. It had also enabled them to improve planning of the number of appointments that they needed to make available. The practice planned to continue with further cycles of this audit. Two audits related to prescribing of medicines in line with Herefordshire CCG prescribing guidelines. These described the work the practice did to ensure patients were prescribed the preferred medicine for their long term conditions. A date to repeat this audit had been set. The other audit we were shown related to patients on a specific treatment who needed certain blood tests before receiving an injection. The practice had established the criteria by which to measure the success of this work when they repeated the audit and a date for this was set. One of the GPs had started an audit in respect of contraceptive coils they had fitted.

The practice highlighted to us that they were aware they had high hospital referral rates which they attributed to the very high proportion of older patients (twice the national average) registered with the practice including over 150 living in three care homes. These care homes all provided nursing care for patients with complex and multiple care needs including patients living with the effects of advanced dementia related illnesses. They hoped to re-introduce meetings to review hospital referrals. These had been

Good

Are services effective?

(for example, treatment is effective)

successful previously but had not taken place recently because of lack of time. The care home managers we spoke with confirmed that the practice worked closely with them and communicated effectively.

Effective staffing

Staff had the skills, knowledge and experience to deliver effective care and treatment.

- The practice had an induction programme for newly appointed non-clinical members of staff. This covered subjects the practice considered to be mandatory such as safeguarding and fire safety.
- Protected learning time was arranged approximately every six weeks. This was used mainly for completing mandatory courses using computer training resources. Staff told us this limited their opportunities to share and discuss their learning because staff were completing the training in their own rooms or at their own desks.
- Nurses we spoke with told us they ensured they completed their required continuous professional development (CPD) by keeping their knowledge and skills up to date. They told us that in recent times they had needed to do updates in their own time because of the pressures on the practice.
- Staff appraisal was taking place annually so that staff learning needs could be identified and to provide the necessary foundations for the GPs revalidation but there were limited practice based opportunities for shared learning and development.

Coordinating patient care and information sharing

Staff had access to the information they needed to plan and deliver patients' care and treatment through the practice's patient record system computer system. This included individual patient records including investigation and test results and general information such as NHS patient information leaflets. Members of the non-clinical staff team who were responsible for making sure the GPs had up to date and accurate information about patients understood their roles and responsibilities.

The practice shared information about patients nearing the end of life with out of hours and ambulance services. They worked with local care homes to assess very unwell patients at the end of the week to anticipate their needs and reduce the potential for unplanned hospital admissions at the weekends.

The GPs took part in meetings and worked in partnership with other professionals. These included district nurses, health visitors, and Macmillan nurses. The practice also had links with a specialist dementia worker based with the local NHS dementia team who was at the practice once a week. A GP told us that they had particularly noted benefits to patients and their families as a result of the support provided by the specialist dementia worker. A specialist primary care mental health worker also provided support to the practice and was there once a month.

Consent to care and treatment

Staff took steps to gain patients' consent to care and treatment in line with legislation and guidance.

- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005.
- When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance.
- Where a patient's mental capacity to consent to care or treatment was unclear the GP or practice nurse assessed the patient's capacity and, where appropriate, recorded the outcome of the assessment.
- Staff at three local care homes confirmed that the GPs worked in partnership with them and patients' families in situations where a patient lacked capacity to give consent and were thorough and sensitive in their approach to this. They told us the GPs were very good about exploring the best option for a patient.

Health promotion and prevention

A practice nurse ran a weekly well woman and young person's clinics one afternoon a week. This normally ended at 6pm but the practice told us that on occasions they extended this based on individual need. This provided confidential advice about contraception, breast awareness, reproductive health advice and cervical screening. The practice also provided contraceptive checks for patients taking the pill or using long acting contraceptive methods during this clinic.

Good

Are services effective?

(for example, treatment is effective)

The practice's uptake for the cervical screening programme was 80.1%, which was better than the national average of 77.09%. A specialist diabetes nurse visited the practice every two months to hold a joint clinic with a practice nurse for patients' diabetes reviews. Patients with lung related health problems had a 30 minute annual health review during which the nurse provided smoking cessation and lifestyle guidance. National data showed that the practice had provided smoking cessation advice to 98.9% of patients needing this compared with the CCG average of 96.7% and the national average of 94.6%.

Childhood immunisation rates for the vaccinations given were comparable to CCG averages. For example, childhood immunisation rates for the various vaccinations given to under two year olds ranged from 89.8% to 98.3% and 90.8%% to 96.9% for five year olds

Flu vaccination rates for the over 65s were 57.2%, and at risk groups 45.7%. These were lower than the CCG and national averages. The practice was aware of this and had identified that more patients had actually received vaccines. District nurses and nurses at local care homes administered vaccines for many of the practice's patients. The practice had established that the numbers involved had not been accurately captured. They had discussed this with the district nurses and care homes and expected to have more accurate information for the current flu season.

The practice nursing team provided health checks for new patients and for patients aged 40 – 74 and information was available about the shingles vaccine for patients in the relevant age groups.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We observed that members of staff were friendly, polite and caring towards patients and their families or carers.

- The practice provided curtains in consulting rooms to maintain patients' privacy and dignity during examinations.
- We saw that consultation and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.
- Reception staff explained they could offer to speak with patients in a private room if they did not wish to speak about something at the reception desk.

We received 22 completed CQC comment cards. The overall theme of patients' comments was complimentary about the care and treatment they received and the commitment shown by staff. Patients commented on the helpfulness of the practice team and the prompt and attentive care they received. Some patients commented specifically on their appreciation of the care and attention their GP had continued to provide in spite of the challenges faced by the practice.

During the inspection we spoke with 14 patients including four members of the patient participation group who came to meet with us as a group. They provided a mixed but balanced picture of their experience of using the practice. Most commented positively about their care and treatment but also spoke of their concerns about the lack of permanent GPs and resulting pressure on the three GP partners, reliance on locum GPs, and the impact on this on continuity of care.

Staff signed confidentiality agreements and were not allowed access to the records for any patients with whom they had relationships outside the practice. We saw evidence that this was monitored to ensure patient confidentiality was not compromised.

Results from the national GP patient survey published in July 2015 showed patients were generally satisfied that the practice team treated them with compassion, dignity and respect although their results were slightly lower than average, for example:

- 86.3% said the GP was good at listening to them compared with the CCG average of 91.3% and national average of 88.6%.
- 86.6% said the GP gave them enough time compared to the CCG average of 89.1% and national average of 86.8%.
- 94.1% said they had confidence and trust in the last GP they saw compared to the CCG average of 96.8% and national average of 95.3%.
- 84.6% said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 87.9% and national average of 85.1%.
- 86% said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 91.7% and national average of 90.4%.
- 98.5% had confidence and trust in the last nurse they saw or spoke to compared with the CCG average of 97.9% and the national average of 97.2%.
- 79% patients said they found the receptionists at the practice helpful compared to the CCG average of 90% and national average of 86.9%.

Care planning and involvement in decisions about care and treatment

Several patients described how their GP had worked hard to establish what their health issues were and supported them with their care and treatment.

The managers of the three local care homes told us that the GPs always involved patients in any discussions about their care and treatment. They told us that they stayed as long as they needed to give each person the attention needed. Staff at all three homes were aware of the pressures on the practice and staff from two specifically wanted us to know that in spite of this they never felt the GPs rushed through their visits.

However, results from the national GP patient survey published in July 2015 showed patients were less positive about their involvement in planning and making decisions about their care and treatment than the local and national averages. For example:

- 79.4% said the last GP they saw was good at explaining tests and treatments compared with the CCG average of 89% and national average of 86.3%.

Good

Are services caring?

- 74.4% said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 84.5% and national average of 81.5%

Some patients identified that this was due to the reliance on locum GPs which had an impact on the continuity of their care however well a locum GP dealt with them during an appointment.

Patient and carer support to cope emotionally with care and treatment

We saw information for patients in the reception and waiting room areas about Herefordshire Carers Support (HCS) a local charity providing support and advice to carers of all ages. One of the practice staff was their carer link worker whose role involved working in partnership with HCS to help make sure carers were identified, registered as carers at the practice and offered information about HCS.

The GPs frequently provided out of hours care to patients at the end of life, particularly those in remote areas to provide continuity of care and reduce the potential for them having to die in hospital rather than at home. Staff gave us an example of compassionate care involving a GP attending an important personal event to provide care and treatment to a patient to enable them to attend. Managers at three local care homes told us that the GPs were kind and considerate towards their patients, had a good rapport with staff and were compassionate and helpful in their dealings with families.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

Kington GP practice had a rural catchment area of 600 square miles on the western edge of Herefordshire and in Powys with some remote, mountainous areas which could be difficult to reach, particularly in bad weather. Historically the practice also had branch surgeries in two villages in the western part of the county. They had reached a decision with agreement from NHS England in 2014 to close the branch practices. This was due to their inability to recruit sufficient GPs to maintain a service across all three sites. When the practice moved to their new building in 2012 a specific problem was created for patients who did not have their own transport. This was because the practice was not on a bus route. The practice had liaised with the bus company providing local bus services and negotiated to have a bus stop at the practice.

In spite of the challenges faced by the practice they endeavoured to provide a range of services for the practice population, for example:

- The practice provided a responsive GP service to over 150 patients living or staying in seven care homes in the surrounding area. Patients in three of the homes had complex nursing care needs and many were living with dementia. One of the homes had a 10 bed intermediate care unit. At the time of the inspection the practice had a contract with the local NHS acute Trust to provide daily medical support to patients using that service. This included seeing patients on admission which sometimes took place out of hours. Following the inspection the practice informed us that they had resigned from the contract for this service due to workload and to enable their GPs to focus on core services at the practice.
- The GPs worked in close partnership with care home staff to monitor patients' health and worked proactively with them to meet patients' needs. For example, one of the care homes told us GPs had visited patients nearing the end of life at the end of the week to review their care needs and provided prescriptions for anticipatory medicines. This reduced the potential for unplanned hospital admissions during weekends.
- Staff at one of the care homes highlighted that the GPs always responded promptly when a GP was required to attend with a mental health consultant to arrange hospital admissions under the Mental Health Act.
- The GPs made home visits to patients unable to visit the practice because of poor health or limited mobility. They explained that home visits had increased after the closure of the branch surgeries because they now visited some patients who lived in remote areas and had no transport to get to the practice. The practice provided data showing that between 3 August 2015 and 28 September 2015 they carried out 368 visits to patients in care homes and 209 to patients living at home. This ranged from 43 to 75 visits a week.
- The practice dispensary provided a collection and delivery service for prescriptions. The patient participation group survey in 2015 identified that 48 of the patients who responded were using this service. We learned that the delivery driver made additional emergency deliveries as well as planned deliveries.
- The practice booked double appointments for older patients and those with dementia when needed.
- Patients with learning disabilities were seen for annual physical health checks and longer appointments were booked for this if needed.
- The GPs made home visits when needed to patients who were settled travellers, including children with significant health needs and felt they had established a trusting relationship with families there. They aimed to provide this community with a flexible service
- The practice nurses had worked in partnership with health visitors to arrange a targeted childhood vaccination clinic in specific circumstances where individual appointments were a problem for a large family.
- The practice used a computer translation programme when a patient needed written information in a language other than English. This facility was also available on the practice website.
- At certain times of year the practice had additional patients due to seasonal agricultural workers registering with the practice. Staff told us they established each patient's language needs when they registered.

Good

Are services responsive to people's needs?

(for example, to feedback?)

- Children under the age of two were seen immediately when they arrived at the practice.
- The practice was well designed for patients using wheelchairs, pushchairs etc. There were open spaces, wide corridors and doorways, and three well equipped accessible toilets for patients with physical disabilities.

Access to the service

The practice was open for appointments between 8.30am and 6pm Monday to Friday. The dispensary was open from 9am to 6 pm Monday to Friday.

The practice did not provide an extended hours service and were not currently in a position to do so due to their GP numbers. The practice was not required to do so under the current GP contract. The practice stated they were in continued dialogue with the Clinical Commissioning Group and other practices to find workable solutions either individually or as part of a federated approach within Taurus Healthcare (of which it is a shareholder member), to providing improved access to primary care services.

Patients could obtain appointments from 8am and between 6pm and 8pm with Taurus Healthcare. This is a local primary care organisation operated by a federation of Herefordshire GPs which provides extended hours GP services in three locations in the county. There was also a GP Access Centre in Hereford offering walk-in appointments from 8am to 8pm 365 days a year.

The practice gave priority to patients needing to be seen the same day and the telephone system had a facility which prioritised calls if patients selected the option that their call was urgent.

Results from the national GP patient survey published in July 2015 showed that patients' satisfaction with how they could access care and treatment was lower than local and national averages, for example:

- 60% of patients were satisfied with the practice's opening hours compared with the CCG average of 75.9% and national average of 75.7%.
- 64.1% of patients said they could get through easily to the surgery by phone compared with the CCG average of 79.5% and national average of 74.4%.
- 59.6% of patients described their experience of making an appointment as good compared with the CCG average of 79.4% and national average of 73.8%.
- 17.4% of patients said they usually waited 15 minutes or less after their appointment time compared with the CCG average of 68.4% and national average of 65.2%.

The practice was aware of and concerned about these low survey results. They were honest in acknowledging the difficulties the practice was dealing with and openly discussed this with us. Their problems included the loss of several GPs over the previous three years and the practice's inability to recruit new partners or salaried GPs. The practice were working to recruit more GPs and following input from the patient participation group (PPG) had started a walk in clinic from 8.30am to 4pm four days a week for patients with minor illnesses.

The walk in clinic was run by one of their advanced nurse practitioners. This provided at least 100 additional consultations every week and between January 2015 and the day of the inspection 4,006 had taken place. The practice told us that this initiative was very popular with patients, and this was echoed in the information we received from patients. Staff explained that if the number of patients waiting to be seen at the walk in clinic grew too large for the nurse practitioner to see themselves, the duty GP stepped in to see some of the patients. Staff told us this had had a beneficial effect in respect of patient access, including telephone response times. This was because many patients used the walk in service which freed up the telephone lines for patients wanting to book a specific time for their appointment.

During the inspection we observed reception staff dealing with telephone calls from patients. We noted that staff were polite, offered patients options for the time of their appointment and were mindful of patients' individual needs.

On Saturdays and Sundays, Primecare, the local GP out of hours provider was based at a town centre health and social care centre which also provided a minor injuries service. Information about how to contact Primecare was provided on the practice website.

Listening and learning from concerns and complaints

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

Good

Are services responsive to people's needs?

(for example, to feedback?)

- The complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England.
- There was a designated responsible person who handled all complaints in the practice and this was overseen by one of the GP partners.
- We saw that the practice website had brief information about how to make a complaint to the practice.

We looked at six complaints received in the last 12 months and that the practice had dealt with these in an appropriate and timely way. The practice had sent written acknowledgements to patients who complained and had written records of their investigations. We saw that the practice had sent patients written explanations and apologies. In one case we saw that the patient involved had written back to the practice in appreciation of the thoroughness with which their concerns were considered.

Are services well-led?

Good

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

Our findings

Vision and strategy

We discussed the practice's vision and strategy with the GPs and other staff. They were open and transparent in describing to us that they felt in 'survival mode'. It was evident that the whole team were working hard to maintain the service they provided to the community. They told us that in spite of the difficulties they had faced during the previous three years they had kept going because they did not want to let the community down. Several staff, patients and the managers of three local care homes spoke highly of the GPs' efforts and the long hours they worked to achieve this.

In September 2015 the practice entered into an arrangement with an external healthcare company. The intention of this was to stabilise the practice by gaining support with finance, administration, governance and GP recruitment. We were told that two GPs from this company had recently joined the practice as executive partners and the practice was intending to send us the required applications to add them to the practice's CQC registration. These GPs were not planning to be involved in practice governance rather than providing face to face patient care.

Governance arrangements

During the inspection we found that:

- The GP partners, nurses and non-clinical staff had designated roles and responsibilities and were aware of how their work contributed to the overall running of the practice.
- GPs were involved in a range of clinical audits but there was no established system of clinical governance meetings to monitor quality and to make improvements. The GPs recognised this should be happening but had prioritised face to face patient contact due to their recruitment problems.
- Staff meetings took place approximately every six months. Specific significant event meetings were attended by all practice staff so that learning from these could be shared. Minutes of meetings were sent to all staff by email.
- The practice had a number of policies and procedures to govern activity

Leadership, openness and transparency

The partners in the practice had the experience and commitment to provide high quality care but were overstretched due to the difficulties the practice had experienced. This had an impact on their ability to provide proactive leadership because they had prioritised face to face patient contact. The patient participation group (PPG), some other patients and some staff were unclear and concerned about the future of the practice and how the service was going to move forward. A PPG is a group of patients registered with a practice who work with the practice team to improve services and the quality of care.

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

The practice obtained patients' feedback through the PPG which carried out an annual survey on behalf of the practice. The PPG explained that they did not feel that the practice team fully engaged with them to work together for the benefit of the practice, patients and local community. They were concerned that their role was not evolving and were frustrated by this. We were told that the two new partners met with the PPG the week after our inspection to discuss plans with them.

- The practice feedback from patients annually through the patient participation group (PPG) and through complaints received. There was a PPG which met regularly but were struggling to attract new members.
- The PPG had played a significant role in the introduction of a nurse led walk in clinic four days a week. They had also prompted the provision of high seat chairs with arms for patients with mobility difficulties to supplement the modern low level seating in the waiting areas.
- We received mixed views from practice staff regarding the extent to which they were involved in developing and improving the service or consulted about their views. Some said they were listened to and supported whilst others felt this was an area for 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 **Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.** Regulation 19 • The practice did not have effective recruitment arrangements, including written policies and procedures to ensure all necessary pre-employment checks for staff were carried out. • The practice did not have a process to check that staff have appropriate and current registration with a professional regulator. Regulation 19(3) and Schedule 3 and Regulation 19(4)

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 **Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.** Regulation 12 • The practice had not recorded all significant events or reported them externally as well as internally to provide opportunities to monitor remedial action and improvements, and provide opportunities for shared learning. • Following a break in at the practice dispensary the practice had not completed a full review of security arrangements to minimise the risk of this happening again.

This section is primarily information for the provider

Requirement notices

The practice was unaware of the requirement to inform CQC of certain events as set out in the Care Quality Commission (Registration) Regulations 2009 (Part 4)

Regulation 12(1) and (2) (a) and (b)