Radnor House Surgery and Ascot Medical Centre

Quality Report

25 London Road
Ascot
Berkshire
SL5 7EN
Tel: 01344 874011
Website: www.radnorhousesurgery.co.uk

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

Ratings

Overall rating for this service	Inadequate
Are services safe?	Inadequate
Are services effective?	Requires improvement
Are services caring?	Requires improvement
Are services responsive to people's needs?	Inadequate
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 Radnor House Surgery and Ascot Medical Centre on 2 March 2016. The practice is rated as Inadequate for Safe, Responsive and Well Led and Requires Improvement for Effective and Caring. Overall the practice is rated as Inadequate.

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

- Staff were not clear about reporting incidents, near misses and concerns and there was no evidence of learning and communication with staff.
- Staff reported feeling that they were not communicated with and felt vulnerable as they were often unsupported by the leaders of the practice.
- Patients were at risk of harm because systems and processes were not in place to keep them safe. For example, appropriate recruitment checks on staff had not been undertaken prior to their employment and there were gaps in training required to keep patients safe.
- The practice had a number of policies and procedures to govern activity, but many were overdue a review.
- Data showed patient outcomes were low compared to the locality and nationally.
- Patients told us they found it difficult to make an appointment at a time to suit them, although urgent appointments were usually available on the day they were requested.
- The practice had no clear leadership structure, insufficient leadership capacity and limited formal governance arrangements across both practice sites.
- The majority of patients said they were treated with compassion, dignity and respect. However, not all felt cared for, supported and listened to.

There were, however some areas of good practice;

- Eight clinical audits had been carried out and were used to drive improvements in patient outcomes.

Summary of findings

- The practice had sought feedback from patients and had an active patient participation group.

The areas where the provider must make improvements are:

- Introduce robust processes for reporting, recording, acting on and monitoring significant events, incidents and near misses.
- Ensure recruitment arrangements include all necessary employment checks for all staff.
- Put systems in place to ensure all staff are kept up to date with mandatory training in line with national guidance and guidelines.
- Implement and improve formal governance arrangements including systems for assessing and monitoring risks and the quality of the service provision.
- Provide staff with appropriate policies and guidance to carry out their roles in a safe and effective manner which reflect the requirements of the practice.
- Clarify the leadership structure and ensure there is leadership capacity to deliver all improvements.
- Ensure systems to monitor quality outcomes are monitored to demonstrate improvements in patient outcomes have been achieved.
- Communicate more effectively with staff, offering them appropriate management support.
- Ensure safeguarding training and updates are implemented for all staff at the appropriate level.

The areas where the provider should make improvement are:

- Improve processes for making appointments.
- Review how carers are identified and recorded on the patient record system to ensure information, advice and support is made available to all.
- Ensure actions identified in infection control audit are documented once completed.
- Consider how emergency medicines are stored, particularly in relation to the accessibility of emergency medicines 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 so a rating of inadequate remains 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.

Special measures will give people who use the practice the reassurance that the care they get should improve

Professor Steve Field (CBE FRCP FFPH FRCGP)
Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Inadequate

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

- Staff understood their responsibilities to raise concerns, and to report incidents and near misses. However, reporting was inconsistent and not all incidents were escalated appropriately. Some opportunities to raise incidents had been missed, so safety was not improved. When the practice had identified incidents, reviews and investigations were not thorough enough and lessons learnt were not communicated widely enough to support improvement. Patients did not always receive a verbal and written apology.
- There was insufficient attention to ensuring staff had received appropriate training and updates to safeguard children and vulnerable adults from abuse. The safeguarding policies had not been reviewed after the merger of the two practices in April 2015.
- There was no audit trail to establish that medicine safety alerts received by the practice had been reviewed and action taken as a result.
- Patients were at risk of harm because systems and processes had weaknesses and were not implemented in a way to keep them safe. For example, recruitment checks for new staff were inconsistent and risk assessments had not been carried out in relation to control of substances hazardous to health.

Are services effective?

Requires improvement

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

- Data showed patient outcomes were low compared to the locality and nationally. For example,
- Childhood immunisations for under five year olds scored lower than local and national averages.
- Data showed cervical screening was 78% which was below the national average of 82%.
- There was limited recognition of the benefit of an appraisal process for staff and there was no defined recording system in place to document mandatory training and updates.
- Multidisciplinary working was taking place but was generally informal and record keeping was limited or absent.

However, therewere someexamples of good practice;

Summary of findings

- The practice had an ongoing programme of audit and was using changes identified to drive improvement in performance to improve patient outcomes.
- Staff assessed needs and delivered care in line with current evidence based guidance.

Are services caring?

Requires improvement

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

- Data from the National GP Patient Survey showed patients rated the practice similar to others for many aspects of care. For example, 90% said the GP was good at listening to them compared to the CCG average of 90% and national average of 89%.
- The practice had not recognised that their carers register had not been appropriately updated or maintained.
- The majority of patients said they were treated with compassion, dignity and respect.
- Information for patients about support services was available.
- We saw staff treated patients with kindness and respect, and maintained patient information confidentiality.

Are services responsive to people's needs?

Inadequate

The practice is rated as inadequate for providing responsive services.

- Although the practice had reviewed the needs of its local population, it had not put in place a plan to secure improvements for all of the areas identified.
- Feedback from patients reported that access to a named GP and continuity of care was not always available quickly, although urgent appointments were usually available the same day. For example, 41% patients said they always or almost always see or speak to the GP they prefer compared to the CCG average of 54% and national average of 59%.
- Patients could get information about how to complain in a format they could understand. However, not all complaints identified had been responded to and there was no evidence that learning from complaints had been shared with staff.

However, there was an example of good practice;

- Both practices had adequate supplies of equipment and facilities required to treat patients and meet their needs.

Summary of findings

Are services well-led?

Inadequate

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

- The practice did not have a clear vision and strategy. Staff were not clear about their responsibilities in relation to the merger of the two practices.
- There was a documented leadership structure however, some staff felt unsupported by management at times and they were not always sure who to approach with issues.
- The practice had a number of policies and procedures to govern activity, but many of these had not been reviewed or updated to reflect the merger of the two practices.
- There were inconsistent systems and processes for monitoring and managing risks with some unidentified or recognised.
- There was little evidence of completed induction checklists for many new members of staff and not all staff had received regular performance reviews or attended staff meetings and events.
- Systems which recorded and monitored patient outcomes and quality of care showed lower achievement in some clinical indicators.

However, there was an example of good practice;

The practice sought feedback from patients and had an active patient participation group (PPG).

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 provider was rated as inadequate for safe, responsive and well-led and requires improvement for effective and caring. The issues identified as inadequate overall affected all patients including this population group.

- Nationally reported data showed that outcomes for patients for conditions commonly found in older people were below local and national averages. For example, the percentage of patients with hypertension (high blood pressure) achieving a target measurement was 77% which was below the CCG average of 83% and national average of 84%.

However, there was one example of good practice;

- Longer appointments and home visits were available for older people when needed, and this was acknowledged positively in feedback from patients. The leadership of the practice had started to engage with this patient group to look at further options to improve services for them.

People with long term conditions

Inadequate

The provider was rated as inadequate for safe, responsive and well-led and requires improvement for effective and caring. The issues identified as inadequate overall affected all patients including this population group.

- Diabetes indicators for 2014/15 show the practice achieved 78% compared to the CCG average of 94% and national average of 89%.
- Longer appointments and home visits were available when needed.However, not all these patients had a named GP, a personalised care plan or structured annual review to check that their health and care needs were being met

There were, however, examples of good practice;

- Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority.
- For those patients with the most complex needs, the GPs worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Summary of findings

Families, children and young people

Inadequate

The provider was rated as inadequate for safe, responsive and well-led and requires improvement for effective and caring. The issues identified as inadequate overall affected all patients including this population group.

- Immunisation rates for the standard childhood immunisations were mixed.
- The practice's uptake for the cervical screening programme was 77% which was below the CCG average of 83% and the national average of 82%.

There were, however, examples of good practice;

- 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 A&E attendances.
- Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this.
- Appointments were available outside of school hours and the premises were suitable for children and babies.

Working age people (including those recently retired and students)

Inadequate

The provider was rated as inadequate for safe, responsive and well-led and requires improvement for effective and caring. The issues identified as inadequate overall affected all patients including this population group.

- The age profile of patients at the practice is mainly those of working age, students and the recently retired but the services available did not fully reflect the needs of this group.
- There was varied uptake for both health checks and health screening. For example, bowel cancer screening rates for patients aged 60 to 69 in the last two and a half years was 54% compared to the CCG average of 55% and national average of 58%.

There were, however, examples of good practice;

- The practice offered extended opening hours for appointments two days per week, patients could book appointments and order repeat prescriptions online.
- The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group.

Summary of findings

People whose circumstances may make them vulnerable

Inadequate

The provider was rated as inadequate for safe, responsive and well-led and requires improvement for effective and caring. The issues identified as inadequate overall affected all patients including this population group.

- Most staff knew how to recognise signs of abuse in vulnerable adults and children.
- Most 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.
- It had carried out annual health checks for patients with a learning disability, but these were poorly evidenced and difficult to find.

There were, however, examples of good practice;

- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability.
- The practice worked with multi-disciplinary teams in the case management of vulnerable patients.
- It had told vulnerable patients about how to access various support groups and voluntary organisations.

People experiencing poor mental health (including people with dementia)

Inadequate

The provider was rated as inadequate for safe, responsive and well-led and requires improvement for effective and caring. The issues identified as inadequate overall affected all patients including this population group.

- Mental health indicators for 2014/15 showed the practice achieved 89% which is below the CCG average of 96% and national average of 93%.
- 73% of patients diagnosed with dementia had their care reviewed in a face to face meeting in the last 12 months, which is below the CCG average of 83% and the national average of 84%.
- Depression indicators for 2014/15 showed the practice achieved 60% which is below the CCG average of 94% and national average of 92%.

There were, however, examples of good practice;

- The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations.

Summary of findings

- The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those with dementia.
- The practice carried out advance care planning for patients with dementia.
- The practice had a system in place to follow up patients who had attended accident and emergency where they may have been experiencing poor mental health.

Summary of findings

What people who use the service say

The national GP patient survey results were published in January 2016. The results showed the practice was performing in line with local and national averages. 275 survey forms were distributed and 109 were returned. This represented 40% response rate, which is 2% of the practice's patient list.

- 86% found it easy to get through to this surgery by phone compared to the CCG average of 74% and a national average of 73%.
- 89% were able to get an appointment to see or speak to someone the last time they tried compared to the CCG average of 87% and a national average of 85%.
- 85% described the overall experience of their GP surgery as fairly good or very good compared to the CCG average of 85% and a national average of 85%.
- 74% said they would definitely or probably recommend their GP surgery to someone who has just moved to the local area compared to the CCG average of 77% and a national average of 78%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 20 comment cards which were nearly all positive about the standard of care received. Nineteen of the cards expressed overall satisfaction with the care received, with only one card offering a negative view towards their care and treatment.

We spoke with seven patients during the inspection. All seven patients said they were happy with the care they received and thought staff were approachable, committed and caring. There were some negative views about the appointments system with six patients stating they were unable to get an appointment when they needed one. The timescales ranged from two patients getting a same day appointment to three patients waiting for up to 14 days for an appointment.

Published friends and family test data suggest 74% of patients would recommend this practice, which was comparable with local practices in the area.

Areas for improvement

Action the service MUST take to improve

- Introduce robust processes for reporting, recording, acting on and monitoring significant events, incidents and near misses.
- Ensure recruitment arrangements include all necessary employment checks for all staff.
- Put systems in place to ensure all staff are kept up to date with mandatory training in line with national guidance and guidelines.
- Implement and improve formal governance arrangements including systems for assessing and monitoring risks and the quality of the service provision.
- Provide staff with appropriate policies and guidance to carry out their roles in a safe and effective manner which reflect the requirements of the practice.
- Clarify the leadership structure and ensure there is leadership capacity to deliver all improvements.
- Ensure systems to monitor quality outcomes are monitored to demonstrate improvements in patient outcomes have been achieved.
- Communicate more effectively with staff, offering them appropriate management support.
- Ensure safeguarding training and updates are implemented for all staff at the appropriate level.

Action the service SHOULD take to improve

- Improve processes for making appointments.
- Review how carers are identified and recorded on the patient record system to ensure information, advice and support is made available to all.
- Ensure actions identified in infection control audit are documented once completed.

Summary of findings

- Consider how emergency medicines are stored, particularly in relation to the accessibility of emergency medicines for all staff.

Radnor House Surgery and Ascot Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

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

Background to Radnor House Surgery and Ascot Medical Centre

Radnor House Surgery and Ascot Medical Centre offer primary medical services to approximately 5,150 patients in the Ascot area. The two practices merged on 1 April 2015 and there were plans to move into a purpose built medical centre in October 2015. A senior member of the nursing team had retired in March 2015 just before the merger occurred, meaning the practice needed to recruit an additional nurse. One of the senior partners had taken early retirement in August 2015. This was followed in quick succession by other GPs leaving the practice, which lead to a single GP with overall responsibility for over 5000 patients. In addition, the planned move was delayed and the merger plan was not implemented effectively. The practice have now recruited the additional staff required and are in negotiation with a local hospital trust to secure a purpose built premises to accommodate their combined needs.

Patients are able to access both Radnor House Surgery and Ascot Medical Centre, which are located approximately one mile from one another. The practices are located in an area of low deprivation, meaning few patients are affected by social or economic deprivation locally. The patient list has a higher proportion of adults, both male and female, in the 45 to 69 age group, meaning a higher proportion of working age patients are registered at this practice.

The practice has two GP partners (both male), four salaried GPs (all female), two practice nurses (both female) and one Health Care Assistant (female). The clinical staff are supported by two practice managers, 12 receptionist and administration staff and a medical secretary. The practice is a training practice for GP trainees and currently has one GP trainee working with them.

The premises at Radnor House surgery is a three storey converted dwelling with an entrance pathway to the side of the building. There are two disabled access doors to the rear of the building with ramp access directly into clinical rooms. The disabled toilet facilities are on the ground floor and are available from reception, down one step, or through one of the GP consultation rooms. The reception area and waiting room are on the ground floor, with one consultation room and one treatment room also on the ground floor. On the first floor there is another consultation room, accessible by stairs only. There is a disabled parking space to the rear of the building which is accessed via a side road onto a gravel driveway. There is limited parking to the front of the building and patients are encouraged to use one of the Ascot Racecourse car parks nearby. Although access is restrictive due to the design of the building, the practice have ensured there is access for all who require it and can offer an alternative choice at Ascot Medical Centre.

Ascot Medical Centre is situated within the grounds of Heatherwood Hospital site. It is a purpose built ground

level building with easy access for disabled patients. The entranceway has wide entrance doors which lead to a corridor from which all consultation and treatment rooms are accessible. The reception area is clearly signed with the waiting area across the hallway. There are toilet facilities available including disabled access with wide doorways.

The opening hours at Radnor House Surgery are:

- Mondays between 8.30am and 6pm.
- Tuesdays between 8.30am and 5pm.
- Wednesdays to Fridays 8.30am to 6pm.

The opening hours at Ascot Medical Centre are:

- Mondays to Thursdays between 8am and 6.30pm and Fridays between 8am and 5pm.

Appointments for both sites are variable due to clinician availability and patient need. The practice patient information leaflet shows appointment times as follows;

- Mondays from 9am to 11.20am in the morning and 3pm to 5.20pm in the afternoon.
- Tuesdays from 9am to 10.50am in the morning and 3pm to 5.20pm in the afternoon.
- Wednesdays from 8.30am to 10.50am in the morning and 2.30pm to 4.50pm in the afternoon.
- Thursdays and Fridays from 9am to 11.20am in the morning and 3pm to 5.20pm in the afternoon.

Extended hours are available on Tuesday mornings between 7.30am and 8am at Radnor House Surgery and Thursday evenings between 6.30pm and 7.30pm at Ascot Medical Centre.

The practice has opted out of providing the out-of-hours (OOH) service. This service is accessed via the NHS 111 telephone number. Advice on how to access the OOH service is clearly displayed on the practice website, on the practice door and over the telephone when the surgery is closed. When the practice is closed for learning (eight half days per year) the patients are directed to an out of hours service via a different telephone contact number.

All services are provided from:

Radnor House Surgery

25 London Road

Ascot

Berkshire

SL5 7EN

and

Ascot Medical Centre

Gate 3

Heatherwood Hospital

Ascot

SL5 8AA

We visited both sites as part of our inspection. There have been no previous inspections of this practice.

Dr John Rawlinson is currently registered with CQC as a sole provider of the regulated activities at Radnor House surgery and Ascot Medical Centre. CQC were unaware that Dr Edward Williams had become a GP partner with Dr John Rawlinson in January 2016. Therefore, the partnership of Dr Rawlinson and Dr Williams is currently carrying on the regulated activities at Radnor House surgery and Ascot Medical Centre without being registered to do so (which is breach of Section 10 of the Act). They are aware that they are required to submit an application to register as a partnership. On the day of inspection, they provided evidence that they had applied for their DBS checks and commenced the registration forms to register as a GP partnership with CQC.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme.

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.

Detailed findings

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations, such as NHS England and the Clinical Commissioning Group to share what they knew. On announcing the inspection we spoke with both practice managers who provided key correspondence for the inspection. We carried out an announced visit on 2 March 2016.

During our visit we:

- Spoke with three GPs, two nurses, five reception staff and two practice managers.
- We spoke with seven patients who used the service and six members of the patient participation group.
- 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 an inconsistent approach for reporting and recording significant events across both practice sites. Staff reported significant events differently at both practices. We found evidence of eleven significant events recorded. However, the investigations of these events were limited.

- Staff from both practices told us they would inform the practice manager of any incidents and there was a recording form available on the practice's computer system. However, there was inconsistency in how these were reported, investigated, recorded and reviewed. We found incidents affecting patients, which had been reported but had not been identified for investigation. For example, a notebook in the reception area of Radnor House Surgery was used to record incidents by the reception team. The notebook had not been reviewed by the practice manager and potential serious events were missed. Other incidents had been reported and investigated but did not record an outcome. We found a further example of a significant event that had not been recorded in the file despite actions being taken and external advice sourced.
- The practice was unable to demonstrate they carried out a thorough analysis of the significant events.
- There was minimal evidence of significant events being routinely discussed at meetings.
- Learning was not shared with staff to improve safety. For example, we saw minutes of a meeting in December 2015 where a significant event was discussed and an outcome described for learning to be shared. However, the practice was unable to demonstrate that they had shared the incident as a learning objective. Staff were unable to describe any recent safety incidents and were unaware of any learning outcomes

Overview of safety systems and processes

The practice did not have clearly defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from abuse. There were two practice policies with slightly different processes and staff safeguarding training records were poorly documented.

- Policies were in place to safeguard children and vulnerable adults from abuse. However, these were overdue a review to ensure they reflected the current circumstances of the practice merger, included full contact details for the local authority safeguarding teams and were in line with relevant legislation. We noted there were notices in the consultation and treatment rooms and at reception with contact names and addresses for these organisations. Staff we spoke with were unaware of how to access the safeguarding policies
- There was a lead member of staff for safeguarding, although not all staff could identify who the lead was. The GPs attended safeguarding meetings when possible and always provided reports where necessary for other agencies. For example, one of the GPs showed us evidence of their involvement in a child protection case conference where six weekly multi-disciplinary team meetings were held at the surgery during a complex child protection case. There was a clear audit trail of information sharing and communication with stakeholders.
- Clinical staff were able to describe their responsibilities with regard to safeguarding but the practice was unable to provide evidence of up to date training for most clinical and non-clinical staff. The practice provided us with certificates for child safeguarding training for nine staff and adult safeguarding for five staff, within two days of the inspection. However, we noted that only two of the seven GPs and one of the two nurses had undertaken both child and adult safeguarding training to the appropriate level. One GP had certificates dated November 2010 and another showed only level two had been attained. Only Three GPs and two practice nurses had up to date safeguarding adults training.
- Some non-clinical staff could recall receiving safeguarding training but the practice could not provide evidence to support this. Only four non-clinical staff had received child safeguarding training to the appropriate level and there were no records of adult safeguarding training.
- A notice in the waiting room advised patients that chaperones were available if required. All staff who acted as chaperones were trained for the role and we found all but one member of staff had received a Disclosure and Barring Service check (DBS check), this had been applied for. (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 maintained appropriate standards of cleanliness and hygiene. We observed the premises to be clean and tidy. One of the practice nurses and one of the GPs shared responsibility for infection control. They liaised with the local infection prevention teams to keep up to date with best practice. There was an infection control protocol in place and staff had received up to date training. An infection control audit of both sites had been undertaken in January 2016 and areas for improvement identified. However, there was no action plan with review dates for completion. For example, the audit identified a wall mounted liquid soap in one of the toilets was unavailable, a sink in a GP consultation room did not meet with required standards and a swing lid bin was in use, which should be a pedal operated one. The practice manager informed the inspector the replacement bin and wall mounted soap dispenser were on order within a few days of the inspection visit.
- The arrangements for managing medicines, including emergency drugs and vaccines, in the practice did not always keep patients safe (including obtaining, prescribing, recording, handling, storing and security). Medicines and Healthcare products Regulatory Agency alerts (MHRA) were received by email to the practice managers who disseminated these to relevant clinicians. There was no audit trail of how many of these had required action or if the actions had been completed.
- The practice carried out regular medicines audits, with the support of the local CCG pharmacy team, to ensure prescribing was in line with best practice guidelines for safe prescribing. Patient Group Directions (PGDs) had been adopted by the practice to allow nurses to administer medicines in line with legislation. (PGDs are written instructions for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment).
- The practice had a system for production of Patient Specific Directions (PSDs) to enable Health Care Assistants to administer vaccinations after specific training when a GP or nurse was on the premises. (PSDs are written instruction, from a qualified and registered prescriber for a medicine including the dose, route and frequency or appliance to be supplied or administered to a named patient after the prescriber has assessed the patient on an individual basis).
- We reviewed seven personnel files and found not all the appropriate recruitment checks had been undertaken prior to employment. For example, one had missing references and two files had references which did not cover the preceding five years as stipulated in the recruitment policy. We also noted one reference for a GP was a verbal reference which had not been documented. The nurses had no Nursing and Midwifery Council checks in their files and these were not routinely checked. One of the practice managers ran a check of the nurse's registration with the Nursing and Midwifery Council and provided us with the evidence of this on the day after our inspection. In addition, one of the locum GPs had very little in the way of background checks and the practice were only able to offer some of the information after phoning them at home on the day of the inspection.
- DBS checks were identified in most staff files. However, two staff files contained DBS checks carried out within the last three years from another provider and there was no evidence this had been risk assessed for their current employment.
- Hepatitis B status was not available for all clinical staff and some had not had a blood test to check for suitable levels of antibodies for over ten years. (Hepatitis B is a blood borne virus that can be transmitted by direct exposure to infected blood or other body fluids contaminated with infected blood).
- 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.

Monitoring risks to patients

Risks to patients were assessed but not all were managed effectively.

- The control of substances hazardous to health (COSHH) policy contained blank risk assessment and appendices documents, including an audit sheet for monitoring all risks had been identified and actions taken. However, no COSHH risk assessment had been undertaken by the practices. (COSHH requires employers to control substances that are hazardous to health, to prevent or

reduce workers exposure to hazardous substances in the workplace. Substances covered by COSHH include flammable gases and chemicals, such as Oxygen and most cleaning agents).

- There were procedures in place for monitoring and managing risks to patient and staff safety. There was a basic health and safety policy available with a poster in the reception office which identified local health and safety representatives. The practice had up to date fire risk assessments and carried out regular fire drills.
- The practice had undertaken portable appliance testing (PAT) in October 2015. Most electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly. However, we found a blood pressure monitor in a GPs bag that was overdue a check by five months.
- Radnor House Surgery had an up to date Legionella test and Ascot Medical Centre had requested theirs from their landlord, but it was not available on the day of inspection. They supplied evidence of the legionella check for Ascot Medical Centre after the inspection. (Legionella is a term for a particular bacterium which can contaminate water systems in buildings).
- 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 that enough staff were on duty. We noted some staff roles worked across both sites. The practice told us, since they had recruited the new GPs, they rarely used locum GPs (a locum GP provides temporary cover on an as required basis). A locum GP was available for work at the practice to cover sickness and holidays, when the practice were short of three GPs at the same time.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to respond to emergencies and major incidents, although inconsistency at each site meant two different procedures for clinical staff were required.

- There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency.
- The practice was unable to evidence that all staff had received annual basic life support training. As there was no training log, the practice were unable to identify how many of the staff had received basic life support training. In the seven personnel files we looked at we found one GP and one practice nurse with no record of training and one GP and one reception team member who were overdue an update.
- The practice had a defibrillator and oxygen available at each premises. A first aid kit and accident book were available.
- There were different systems in place for storing emergency medicines at each practice. At Radnor House Surgery the emergency medicines were stored in a basket in the treatment room. At Ascot Medical Centre the treatment room had a drawer for the emergency medicines which was not removable or transferable. Within two days of our visit the practice nurses had undertaken a risk assessment and implemented a grab box for the medicines. We noted that at both sites the practice nurses locked the treatment room doors when they were not there. This meant that emergency medicines and equipment were not easily accessible to staff when the doors were locked. All the medicines we checked at both sites were in date and fit for use.

The practice was updating their business continuity to include post-merger information and planning. This included plans in place for major incidents such as power failure or building damage. The policy required additional information regarding the two sites, for example, location of the fuse box and water stop valve at Ascot Medical Centre and the contact details for the security system at Radnor House Surgery.

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.

- Staff had access to guidelines from NICE and used this information to deliver care and treatment that met patients' needs.
- The practice monitored that these guidelines were followed through random sample checks of patient records and protected time for peer support.

However, during a routine check of patient records, we found that one of the GPs was unable to access guidelines for a high risk medicine that required specific blood test monitoring. In addition, an audit of high risk medicines used in the treatment of rheumatoid conditions, found that guidelines had not been followed and routine medicines were not always prescribed.

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 showed the practice achievement for 2014/15 was 88% of the total number of points available, with 3% exception reporting. This was below the national exception rate of 9%. (Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects). Data for 2014/15 showed;

- Performance for diabetes related indicators was 83% which was lower when compared to the CCG average of 94% and national average of 89%.
- The percentage of patients with hypertension (high blood pressure) having regular blood pressure tests was 93% which was below the CCG average of 99% and national average of 98%.
- Performance for mental health related indicators was 91% which was below the CCG average of 96% and national average of 93%.

The practice was aware of their poor QOF achievement for diabetes, hypertension and mental health. We were told there had been many technical difficulties merging the two practice lists in April 2015 and integrating them into one, which had impacted on their QOF scores. In addition the practice was reviewing the coding of patient records.

We were shown a number of clinical audits. In addition to locally enhanced services audits for 2014/15, we were shown eight audits of which one was a completed audit where the improvements made were implemented and monitored. This particular audit resulted in ensuring regular blood tests and reviews were carried out for patients taking a high risk medication. The practice had identified that 50% of their patients audited were not being monitored appropriately. Learning was shared with the clinical team and the repeat audit showed this had improved to 100% of patients.

Other findings were used by the practice to make improvements. For example, recent action taken as a result included updating the patient dementia list and recalling the identified patients for a yearly review. At the time of the inspection, there were 11 patients on the register, of which eight had care plans. One of the GP partners had recognised the amount of patients identified appeared low and actions were in place to improve this.

Two other audits had been undertaken to review patients on long term medicines, following guidance from the local medicines optimisation team.

Effective staffing

The practice was unable to demonstrate that staff had the skills, knowledge and experience to deliver effective care and treatment.

- The practice had an induction programme and a staff handbook for all newly appointed staff. It covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality. However, five members of staff who joined between October 2014 and January 2016 had no evidence of a completed induction pack in their personnel files.

Requires improvement

Are services effective?

(for example, treatment is effective)

- The practice was able to demonstrate how they ensured some role-specific training and updating for relevant staff for example, for those reviewing patients with long-term conditions. We were shown evidence where staff administering vaccinations and taking samples for the cervical screening programme had received specific training which had included an assessment of competence. In addition, staff who administered vaccinations could demonstrate how they stayed up to date with changes to the immunisation programmes, for example by access to on line resources and continuous professional development. One of the nurses had completed a course to optimise diabetes patient medicines.
- The learning needs of staff were not clearly identified as there was no training log to record learning undertaken or identify training requirements and updates. Staff had access to appropriate e-learning to meet their training needs and to cover the scope of their work, but the practice were unable to evidence most of the training undertaken on the system. We were told that updates had been provided during half day closures when protected time was established for learning, however, the practice was unable to provide copies of the training record and staff who attended.
- Some staff had received an appraisal within the last 12 months, but they were poorly documented on the computer system and not printed or signed to confirm they had been completed or objectives and actions agreed. The practice were unable to establish how many staff had received appraisals due to an ineffective system for recording staff records.

Coordinating patient care and information sharing

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

- This included care and risk assessments, care plans, medical records and investigation and test results. Information such as NHS patient information leaflets were also available.
- The practice shared relevant information with other services in a timely way, for example when referring patients to other services. We saw an example where a GP referral for a suspected cancer under the "two week wait" scheme was processed in less than half an hour after the patient had left the practice.

Staff worked together and with other health and social care services to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. This included when patients moved between services, including when they were referred, or after they were discharged from hospital. The practice had a robust system for following up on patients discharged from hospital, including a GP telephone call or visit within three days of the discharge to ensure the patient received appropriate and timely support.

Consent to care and treatment

Staff sought patients' consent to care and treatment in line with legislation and guidance. The practice nurses showed us Mental Capacity Act (MCA) 2005 information cards that were available in the treatment and consultation rooms.

- Clinical staff were able to demonstrate the relevant consent and decision-making requirements of legislation and guidance, including MCA but there were no formal records of training in MCA and Deprivation of Liberty Safeguards.
- When providing care and treatment for children and young patients, staff carried out assessments of capacity to consent in line with relevant guidance.
- Where a patient's mental capacity to consent to care or treatment was unclear the GP or practice nurse assessed the patient's capacity and, recorded the outcome of the assessment.
- The process for seeking consent was monitored through records audits. For example, an audit of the insertion and removal of intra-uterine contraceptive devices showed 100% of patients had been asked for and had documented consent agreement.

However, during a routine check of patient records we found no recorded consent agreement included in the notes for one patient undergoing a specific treatment. This appeared to be a one-off, as we found other examples of consent agreements in other patient records.

Supporting patients to live healthier lives

Requires improvement

Are services effective?

(for example, treatment is effective)

The practice had identified patients who may be in need of extra support. These included patients in the last 12 months of their lives, carers, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation. For example, 28 patients were on the learning disabilities register and 11 patients were recorded on the dementia register. We were told these patients had a system alert so they could be identified as requiring extra support during a consultation.

The practice's uptake for the cervical screening programme was 77%, which was below the CCG average of 83% and the national average of 82%. There was a policy to offer reminders for patients who did not attend for their cervical screening test. The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening. The most recent data showed the practice had achieved 80% screening for breast cancer in 50 to 70 year old females in the last three years, compared to the CCG average of 74% and national average of 72%. Bowel cancer screening rates for patients aged 60 to 69 in the last two and a half years was 54% compared to the CCG average of 55% and national average of 58%.

Childhood immunisation rates for the vaccinations given were mixed. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 92% to 100% compared to the CCG range of 84% to 95% and five year olds from 77% to 84% compared to the CCG range of 85% to 96%.

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. Where healthy lifestyle support was required, patients were signposted to the relevant service.

Requires improvement

Are services caring?

Our findings

Kindness, dignity, respect and compassion

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

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

Almost all of the 20 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. Two cards documented concerns over the availability of appointments and waiting times and another suggested continuity of care was compromised by seeing two or three different doctors. One overall negative comment was received regarding patient perception of their clinical care.

We spoke with six members of the patient participation group. They told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. Comment cards highlighted that staff responded compassionately when they needed help and support was provided when required.

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

- 90% said the GP was good at listening to them compared to the CCG average of 90% and national average of 89%.
- 91% said the GP gave them enough time compared to the CCG average of 86% and national average of 87%.
- 93% said they had confidence and trust in the last GP they saw compared to the CCG average of 96% and national average of 95%.
- 87% said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 85% and national average of 85%.
- 86% said the nurse was good at listening to them compared to the CCG average of 91% and national average of 91%.
- 88% said the nurse gave them enough time compared to the CCG average of 92% and national average of 91%.
- 97% said they had confidence and trust in the last nurse they saw compared to the CCG average of 98% and national average of 97%.
- 90% said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 92% and national average of 91%.
- 88% said they found the receptionists at the practice helpful compared to the CCG average of 85% and national average of 87%.

Care planning and involvement in decisions about care and treatment

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

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

- 86% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 85% and national average of 86%.
- 81% said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 81% and national average of 82%.

Requires improvement

Are services caring?

- 85% said the last nurse they saw was good at explaining tests and treatments compared to the CCG average of 90% and national average of 90%.
- 79% said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average of 85% and national average of 85%.

Staff told us that translation services were available for patients who did not have English as a first language, although not everyone was aware this was available. We were told that if a patient required a translator they would most often bring in a relative or friend to provide the translation. There were instances where the GPs had used a search engine site to offer translation during a consultation.

Patient and carer support to cope emotionally with care and treatment

Notices in the patient waiting room told patients how to access a number of support groups and organisations, including carers support and a local veterans group.

The practice's computer system alerted GPs if a patient was also a carer. The practice had only identified 16 patients as carers, which represented less than a half per cent (0.3%) of the practice list. Written information was available to direct carers to the various avenues of support available to them. The practice were unaware their figures were so low and reflected that it may be from a coding issue.

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

Inadequate

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

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

- The practice offered extended hours at each site for patients who could not attend during normal opening hours.
- There were longer appointments available for patients with specific health needs, such as, patients with a learning disability or elderly patients with complex medical needs.
- Home visits were available for older patients and patients who would benefit from these.
- Same day appointments were available for children and those with serious medical conditions.
- Patients were able to receive travel vaccinations available on the NHS and were referred to other clinics for vaccines available privately.
- There were disabled facilities and translation services available at both sites. Ascot Medical Centre had a hearing loop.
- Patients with a disability were encouraged to use the Ascot Medical Centre site as it was more accessible. If a disabled patient required treatment at Radnor House Surgery, the reception team ensured they could access the rear doors and booked the downstairs consultation room. For example, reception staff at Radnor House Surgery told us about a patient who used an electric wheelchair and had been a patient there for many years. They had an agreed plan for when the patient attended that involved the patient coming to reception to let them know they were there. The reception team would then ensure the GPs room was free on the ground floor to let the patient in via the rear entrance door. This system had worked well for many years and fully met the patient's needs. The patient did not feel it necessary to attend Ascot Medical Centre.

Access to the service

The practice opening times varied at each site. However, one or other practice site was open between 8am and 6.30pm Monday to Friday. Appointments were from the following times;

- Mondays 9am to 11.20am and 3pm to 5.20pm.
- Tuesdays 9am to 10.50am and 3pm to 5.20pm.
- Wednesdays 8.30am to 10.50am and 2.30pm to 4.30pm.
- Thursdays 9am to 11.20am and 3pm to 5.20pm.
- Fridays 9am to 11.20am and 3pm to 5.20pm.

Extended surgery hours were offered on Tuesday mornings between 7.30am and 8.30am at Radnor House Surgery and Thursday evenings between 6.30pm and 7.30pm at Ascot Medical Centre. In addition to pre-bookable appointments that could be booked up to six weeks in advance, urgent appointments were also available for patients that needed them. In addition, the practice could signpost patients to see a nurse or GP at a medical hub for evening or weekend appointments. The hub sites were based in Windsor or Maidenhead.

Results from the national GP patient survey showed that patient's satisfaction with how they could access care and treatment was mixed in comparison to local and national averages.

- 69% of patients were satisfied with the practice's opening hours compared to the CCG average of 69% and national average of 75%.
- 86% patients said they could get through easily to the surgery by phone compared to the CCG average of 74% and national average of 73%.
- 41% patients said they always or almost always see or speak to the GP they prefer compared to the CCG average of 54% and national average of 59%.

Many patients told us on the day of the inspection that they were unable to get appointments when they needed them, although our review of the appointments system showed us that appointments were available for emergencies and telephone consultations. The practice had recognised the issues with patient access to services. Since October 2015 they had successfully recruited a new GP partner and two additional salaried GPs. We were told this was to ensure patients had access to GPs but was too soon to evidence any positive impact.

Listening and learning from concerns and complaints

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

Inadequate

Are services responsive to people's needs?

(for example, to feedback?)

- The practice had a merged complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England.
- There was a designated responsible person at each site who handled all complaints in their own practice. However, there was no system in place to ensure the complaints had been investigated, logged centrally and information shared.
- We saw that information was available in the waiting room and on the practice website to help patients understand the complaints system.

We looked at ten complaints received in the last 12 months. We found the complaints for each site were available separately and not all had been added to the central list held at Radnor House Surgery. In addition, five additional complaints were logged in the reception incident book at the reception of Radnor House Surgery and there was no evidence these had been acknowledged or followed up.

The practice were unable to demonstrate how verbal complaints were documented or managed. Of the complaints documented and investigated we did see evidence that they had been dealt with in a timely way. The patients were offered a verbal or written apology and learning was highlighted.

Learning outcomes included ensuring the patient was made aware of which site their appointment was being made for, checking patient identifying information when booking appointments and offering an apology regardless of event outcome. However, the practice was unable to demonstrate where these had been discussed at meetings and the learning outcomes shared with staff.

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 was unable to demonstrate a clear vision to deliver high quality care and promote good outcomes for patients. Discussions with staff had not been optimised and the two practices were still using different process and systems. There was no clear vision or guiding values. Staff were unclear about their responsibilities in relation to the practice strategy and objectives. The managers had not engaged effectively with staff after the merger had happened in April 2015 and staff were unaware of future plans for the practice or the relocation to one building. It was apparent that the loss of the GPs in quick succession to one another had impacted greatly on the merger plans which had not been fully implemented.

Governance arrangements

The practice had not merged its governance frameworks which supported the delivery of care. This had led to elements of the governance system and processes being ineffective across both sites. Policies and procedures that were in place were not easily sourced by staff, were often duplicated and many were overdue a review.

- There was an unclear staffing structure and staff were often unaware of their own roles and responsibilities.
- Practice specific policies (post-merger) were not fully implemented and although we were told they were available to all staff, many could not find them when asked. Policies were often duplicated and many were overdue a review.
- There was little understanding of the performance of the practice amongst staff.
- A programme of clinical and internal audit had been undertaken.
- Systems which recorded and monitored patient outcomes and the quality of care and treatment showed poor or lower achievement in some clinical indicators, when compared with other practices in the CCG or nationally.
- There were inconsistent arrangements for identifying, recording and managing risks, issues and poor records of implementing mitigating actions. For example, a COSHH risk assessment had not been undertaken, staff recruitment checks were missing and significant events and complaints were not always identified, investigated or recorded. Actions were not always taken and the learning from such events shared with staff.

Leadership and culture

The leadership team did not have the necessary experience, capacity or capability to lead effectively and ensure sustainable change following the merger in April 2015. The partners could not demonstrate they prioritised the provision of safe and responsive care through effective quality monitoring and oversight for the whole practice. The practice had inconsistent systems in place for knowing about notifiable safety incidents. Each site had its own way of reporting serious events and complaints and there was no central log to record these. Details of outcomes had not been disseminated to staff and learning had not been shared.

- Where safety incidents had been established we saw evidence that the practice gave affected patients reasonable support, truthful information and a verbal or written apology.
- We were unable to identify written records of verbal interactions as well as written correspondence and a report book in the reception of Radnor House Surgery had been overlooked and not reviewed.

There was an unclear leadership structure in place and evidence of co-ordinated management and systems across both sites was limited. Staff told us that the lead GP was rarely seen at the Ascot Medical Centre and efforts to establish cross site working by the non-clinical staff had not been successful. Only one of the GP partners was openly visible in both practices and staff told us they were approachable and always took the time to listen to all members of staff.

- Some of the staff we spoke with on the day of inspection stated that they welcomed the CQC inspection and were concerned about the practice culture and inconsistent management. Staff told us there were separate cultures between the two practice sites and co-ordinated leadership was not evident.
- Practice staff had the opportunity to raise any issues with the practice manager or GP partners at either site but did not feel confident in doing so as support was

Are services well-led?

Inadequate

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

limited to the site, with no one person taking responsibility overall. We noted a team away day was last held in 2012. The practice was looking to hold another in 2016.

- Some of the staff we spoke with told us that they did not feel respected, valued or supported and felt vulnerable in their roles, with some long term staff questioning why they were still there.
- Staff told us there were no regular whole team meetings and they were not involved in discussions about how to run and develop the practice. Many felt the lack of a whole team meeting discouraged them from identifying opportunities to improve the service delivered by the practice.
- Regular monthly management meetings between the practice managers and partners had recently resumed (December 2015 to February 2016).

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

The practice encouraged and valued feedback from patients, the public and staff. It sought patients' feedback and engaged patients in the delivery of the service.

- The practice had gathered feedback from patients through the patient participation group (PPG) and through surveys. There was an active PPG which met regularly, carried out patient surveys and submitted proposals for improvements to the practice management team. For example, the PPG successfully intervened with the local council to protect the two disabled parking spaces and raised £1500 for the practice to purchase a new spirometer (a piece of equipment used to measure breathing capacity in patients with lung disorders). They had also been asked to assist in the wording of a zero tolerance approach to patients who had been abusive to staff.

The practice could not evidence they had gathered feedback from staff as there were no whole team meetings and appraisals were limited. The half day protected learning sessions were used for training and gave staff groups an opportunity to convene a meeting. We were told that the GPs often attended local or CCG events during closure days and so were absent from the practice during many of these occasions.

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 12 HSCA (RA) Regulations 2014 Safe care and treatment **How the regulation was not being met:** The registered person was unable to demonstrate how they responded to Patient Safety Alerts, recalls and rapid response reports issued from the Medicines and Healthcare products Regulatory Agency and through the Central Alerting System. This was in breach of regulation 12(1)(2)(b) 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 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **How the regulation was not being met:** The registered person was not ensuring that effective systems were in place to offer appropriate safeguarding training to the level required. Staff records were not logged or monitored to ensure they were regularly updated. Safeguarding policies had not been effectively reviewed or updated and not all staff were able to access them in a timely way. This was in breach of regulation 13(1)(2)(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints **How the regulation was not being met:** The registered person was not ensuring systems and processes were established between the main practice and branch practice to enable a consistent approach to dealing with complaints. There were no effective systems to make sure complaints were investigated and appropriate action taken without delay. This was in breach of regulation 16(1)(2) 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 **How the regulation was not being met:** We found the registered provider did not operate effective systems to ensure staff received training appropriate to their role, including Safeguarding children and adults, Mental Capacity Act, basic life support and regular appraisals. This was in breach of regulation 18(2)(a) 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 19 HSCA (RA) Regulations 2014 Fit and proper persons employed **How the regulation was not being met:** Not all information specified under Schedule 3 was available, or in evidence of being routinely monitored. This included a lack of criminal background checks, references and documented evidence of clinical staff registrations with professional bodies. This was in breach of regulation

This section is primarily information for the provider

Requirement notices

19(2)(a)(b) 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 17 HSCA (RA) Regulations 2014 Good governance **How the regulation was not being met:** The registered person did not have systems and processes that enabled them to identify and assess risks to the health and safety of service users including: • Recording, investigating, responding to and monitoring of serious incidents and complaints was poor. • Risk assessments of control of substances hazardous to health were missing. • We found the registered provider was not ensuring that induction plans were completed and were unable to offer evidence of Hepatitis B status for clinical staff. The registered provider had not recognised the benefit of a centralised recording system of staff training to monitor staff training and updates. • Concerns relating to safeguarding processes and training had not been identified. • Policies and protocols were not merged and overdue a review, including business contingency plans and health and safety policy. • Limited information sharing and no whole staff meetings This was in breach of regulation 17(1) (2) (b) (c) (d)(i)(ii) (e) & (f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.