Hatherleigh Medical Centre

Quality Report

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Hatherleigh
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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.

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out a focussed follow up inspection of a warning notice issued during an inspection of Hatherleigh Medical Centre on 13 December 2016. This wide ranging review was performed to check on the progress of actions taken following an inspection we made in April 2016. We requested an action plan following the inspection in April 2016 which detailed the steps they would take to meet their breach of regulation.

Summary of findings

During our latest inspection on 13 December 2016 we found the provider had started to make the necessary improvements.

This report covers our findings in relation to the requirements and should be read in conjunction with the previous comprehensive report published in August 2016. This can be done by selecting the 'all reports' link for Hatherleigh Medical Centre on our website at www.cqc.org.uk

Our key findings at this inspection were as follows:

The practice had started to improve the systems, processes and practices in place to keep people safe. For example there had been:

- Improvements made to a new locum pack to ensure it had guidance for reporting welfare concerns of patients
- Improvements to the content and organisation of recruitment records
- Introduction of a fire risk assessment new fire detection and alarm system.
- A review of the control of substances hazardous to health (COSHH) risk assessment.
- A weekly review of staffing numbers and skill mix across both practices managed by the provider. However, we noted the provider was not open for all their contracted hours and information about opening times for patients was misleading.
- Additional nursing and dispensary staff had been recruited.
- Improvements in the way patient's care and treatment
- Review the induction training programme to ensure it included mandatory training including safeguarding and infection control training.
- Improvements of systems to ensure all administrative tasks and processes had been followed up or completed including referrals to secondary care.
- Introduction of secure storage of patient's records and additional space provided for patients who wished to discuss issues privately at the reception area.
- A new website and patient leaflet introduced; however, some information required updating.
- Improvements in information on how to complain including information on the website and providing leaflets and posters.
- Improvements to some governance processes. Policies had been reviewed and the number of clinical audits had increased and demonstrated improvements in patient care. New secure systems introduced to back up data.
- Medicines were well managed. However, we saw that the GP had prescribed controlled drugs several times for a family member over a period of 4 days in July 2016. This is not recommended by the General Medical Council (GMC).
- Reported improvements in the culture and leadership. We were informed that more management tasks were being delegated and there was a sense of team developing. Staff said there were still improvements to be made but morale had improved with the addition of additional new staff.
- A new Patient Participation Group set up and had met the week before the inspection to discuss how the group would work.
- Communication was better and done both informally and formally through an increased number of meetings.
- The providers did not demonstrate they had the capacity to lead effectively over the two GP practice locations they managed.

However, there were also areas of practice where the provider still needed to make improvements.

Importantly, the provider must:

Demonstrate assurances and competence of how the management of the two locations, considering the

Summary of findings

geography of the locations coupled with the clinical management and leadership commitments of the partners, would provide safe, effective, caring, responsive and well led services.

Introduce and maintain governance systems to monitor and ensure that:

- New staff have the qualifications, competence, skills and experience to do so safely.
- Information for patients, risk assessments and policies do not contain conflicting information.
- Evidence of recruitment has taken place on transfer to more permanent employment at the practice.
- Assessment of environmental risk take place to ensure the premises are safe to use.
- Processes are in place to ensure prescribing is managed properly.
- Sufficient staff are made available to ensure the practice is accessible during contracted hours.
- Introduce systems to monitor staff training.

In addition the provider should:

- Improve documentation of clinical audit to demonstrate learning points and possible improvements.
- Provide evidence to show all staff are competent in dealing with emergencies. and be aware of the Mental Capacity Act 2005.
- Complete the staff appraisals programme
- Introduce systems to ensure receive the support and guidance they need.
- Ensure consistent and accurate information is provided regarding opening times and appointment times.

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?

Duing our inspection on 14 April 2016 we identified a number of concerns in regard of systems, processes and governance of patient safety. Since the inspection in April 2016 the practice had started to improve the systems, processes and practices in place to keep people safe. For example;

- Improvements to a new locum pack
- Improvements to recruitment records
- Introduction of a fire risk assessment new fire detection and alarm system.
- A review of the control of substances hazardous to health (COSHH) risk assessment.
- A weekly review of staffing numbers and skill mix across both practices managed by the provider.
- Additional staff being recruited.
- Improvements to the management of medicines and the dispensary. However, we saw that the GP had prescribed controlled drugs several times for a family member over a period of 4 days in July 2016. This is not recommended by the General Medical Council (GMC). The GP referred himself to the GMC for this.

We also noted that the practice premises risk assessment had still not been reviewed since 2012 ad evidence was not provided to show that all staff had received emergency first aid training.

Are services effective?

During our inspection on 14 April 2016 we identified a number of concerns in regard of systems, processes and governance of effective patient care and treatment. Since the inspection in April 2016 the practice had started to:

- Improve the way patient's care and treatment not always demonstrate learning points and possible improvements which could then be used for GP appraisal and revalidation purposes.
- Improve systems to ensure all administrative tasks and processes had been followed up or completed including referrals to secondary care.

However, we found that no evidence was provided to show that systems and processes had been implemented to ensure staff appraisals had been performed and there were no systems in place to keep an overview of staff training.

Summary of findings

We saw that staff had not received awareness training in the Mental Capacity Act 2005.

Are services caring?

During our inspection on 14 April 2016 we identified concerns in regard of systems, processes and governance of patient care. Since the inspection in April 2016 there had been improvements in the way:

- Information for patients was provided. For example, a new website and patient leaflet had been introduced. However, further improvements were necessary to ensure information leaflets in the waiting room reflected current advice.

However, further improvements were necessary to ensure carers received the support and guidance they needed.

Are services responsive to people's needs?

During our inspection on 14 April 2016 we identified a number of concerns in regard of systems, processes and governance of responding to patient needs.

Since the inspection in April 2016 there had been some improvements to the information provided to patients about access to services. However, there continued to be inconsistent information provided about opening times.

Patients we spoke with had not experienced problems getting an appointment.

Information on how to complain had improved. This included providing information on the website and providing leaflets and posters to inform patients of how they could make a complaint.

Are services well-led?

During our inspection on 14 April 2016 we identified a number of concerns in regard of systems, processes and governance of the service. Since the inspection in April 2016 we have seen evidence of increased staffing and improvements of systems and processes and documentation. However, we continued to have concerns capacity to lead the practice.

- There were no assurances provided of how the management of the two GP locations, considering the geography of the locations coupled with the clinical commitments of the partners and use of locum staff, would provide safe, effective, caring, responsive and well led services.

We saw evidence the providers had reacted to the previous inspection findings but still had further improvements to make. For example:

Summary of findings

- We saw improvements to governance processes. Policies had been reviewed and the number of clinical audits had increased and demonstrated improvements in patient care. New storage facilities had been built for patient records and secure systems introduced to back up data.
- Changes to the induction programme had been made, however, there was no system in place to monitor and ensure that new staff completed training.
- Recruitment files had been updated and organised and contained references; however induction training following recruitment had not been completed for some staff.
- Fire and COSHH risk assessments had been completed but environmental risk assessment of the external premises had not yet been completed.
- Medicines were generally well managed. However, we found issues with prescribing controlled drugs.
- Staff said the culture, morale and leadership was beginning to improve. We were informed that more management tasks were being delegated and there was a sense of team developing. Staff said there were still improvements to be made but the addition of additional new staff had helped. Staff also stated communication was better and done both informally and formally through an increased number of meetings. We were told there was not yet a formal programme of meetings..
- A new Patient Participation Group had been set up and had met the week before the inspection to discuss how the group would work.
- There had not been a further in house patient survey performed to gather patient views on the changes being implemented across the two GP locations.

Summary of findings

What people who use the service say

We spoke with four patients during the inspection and one representative from the patient participation group.

All five patients said they were satisfied with the care, said it was easy to get an appointment and told us they were involved in their care and treatment and thought staff were approachable, committed and caring.

Areas for improvement

Action the service MUST take to improve

Introduce and maintain governance systems to monitor and ensure that:

- New staff have the qualifications, competence, skills and experience to perform their roles safely.
- Information for patients, risk assessments and policies do not contain conflicting information.
- Evidence of recruitment has taken place on transfer to more permanent employment at the practice.
- Assessment of environmental risk take place to demonstrate the premises are safe to use.
- Processes are in place to ensure prescribing is managed properly.
- Sufficient staff are made available to ensure the practice is accessible during contracted hours.
- Introduce systems to monitor staff training.

Action the service SHOULD take to improve

- Improve documentation of clinical audit to demonstrate learning points and possible improvements.
- Provide evidence to show all staff are competent in dealing with emergencies. and be aware of the Mental Capacity Act 2005.
- Introduce systems to ensure receive the support and guidance they need. This is to include appraisals.
- Ensure consistent and accurate information is provided regarding opening times and appointment times.

Hatherleigh 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 CQC inspection manager, and a CQC pharmacy inspector.

Background to Hatherleigh Medical Centre

Hatherleigh Medical Practice provides primary medical services to people living in Hatherleigh and the surrounding areas. The practice provides services to a primarily older population and is situated in a rural location where many patient families are involved in farming. The village of Hatherleigh also serves a number of commuters, who work in the large towns with major hospitals approximately 30 miles from the practice. At the time of our inspection there were 2,180 patients registered at the practice.

The practice is owned by two partners, the main GP and a practice nurse, who also manages the practice. They took over Hatherleigh Medical practice as the registered providers in October 2015. The partners also have a GP practice registered separately with CQC approximately 10 miles from the Hatherleigh practice. Both practices provide a service to approximately 3540 patients; 2150 of these use the services at Hatherleigh and 1300 at Shebbear. The partners work as a GP and nurse at the practice, and also work at and manage this second GP practice. In addition they own and manage a separately CQC registered care home for 12 people. The partners hold managerial and financial responsibility for running the business.

At the time of inspection the GP team consisted of five GPs (three male and two female). The provider works at Hatherleigh five days a week. The provider has secured four long term locums to provide continuity for patients. One GP works regular sessions on Mondays, Wednesdays and Thursdays every week. The other GP locums work various sessions depending on demand and need.

A new practice nurse now works at Hatherleigh Medical Centre and one of the partners works as a nurse practitioner in pre bookable sessions. The nurses are supported by a health care assistant who works flexible hours over two days. There were additional dispensary staff, reception staff, administrators and domestic staff.

Hatherleigh Medical Centre website and patient leaflet advertises opening times as Monday to Friday from 8.30am until 6pm with a 1pm- 2pm session for lunch when calls are transferred to the out of hours provider. Outside of the 8.30 and 6pm hours a service is provided by another health care provider who is accessed by patients dialling the national NHS111 service.

Between 9am and 10.30am and between 4pm and 5pm the practice runs an open surgery whereby patients are able to walk in and wait to see a nurse or GP without a pre booked appointment. The practice has been offering Saturday morning appointments if they were required since January 2016. These are not advertised in the patient leaflet or on the website.

Routine appointments are available daily and are bookable up to three months in advance or further into the future according to the patient's wishes. Urgent appointments are made available on the day and telephone consultations also take place.

Hatherleigh Medical Centre offers an on-site dispensing service for patients living outside of a one mile radius of Hatherleigh.

Detailed findings

This report relates to the regulatory activities being carried out at:

Hatherleigh Medical Centre

Pipers Meadow

Hatherleigh

EX20 3JT

Why we carried out this inspection

We carried out this inspection at Hatherleigh Medical Centre on 13 December 2016 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 was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, and to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

We visited the practice and reviewed documentation to check on the progress of actions taken following the comprehensive inspection we completed in April 2016.

We inspected the practice, in part, against the five questions we ask about services, "is the service safe, effective, caring, responsive and well led"? This is because the service had previously not met regulatory requirements relating to these domains. As all five domains were only inspected in part we were not able to rate the population groups at this visit.

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations, including NHS England, to share what they knew. We carried out an announced visit on 13 December 2016. During our visit we:

- Spoke with a range of staff including nurses, visiting health care professionals, locum GPs and administration and dispensary staff and spoke with four patients and a representative from the patient participation group who used the service.
- Observed how patients were being cared for and talked with carers and/or family members
- Reviewed an anonymised sample of the personal care or treatment records of patients.

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?

Are services safe?

Our findings

During our inspection on 14 April 2016 we identified a number of concerns in regard of systems, processes and governance of patient safety. Since the inspection in April 2016 the practice had started to improve the systems, processes and practices in place to keep people safe. For example;

- Improvements to a new locum pack
- Improvements to recruitment records
- Introduction of a fire risk assessment new fire detection and alarm system.
- A review of the control of substances hazardous to health (COSHH) risk assessment.
- A weekly review of staffing numbers and skill mix across both practices managed by the provider.
- Additional staff being recruited.
- Improvements to the management of medicines and the dispensary. However, we saw that the GP had prescribed controlled drugs several times for a family member over a period of 4 days in July 2016. This is not recommended by the General Medical Council (GMC). The GP referred himself to the GMC for this.

We also noted that the practice premises risk assessment had still not been reviewed since 2012 ad evidence was not provided to show that all staff had received emergency first aid training.

Are services effective?

(for example, treatment is effective)

Our findings

Duing our inspection on 14 April 2016 we identified a number of concerns in regard of systems, processes and governance of effective patient treatment. These included concerns in regard of:

- Clinical audits;
- Staff recruitment, record keeping and training; and
- Monitoring of clinical systems such as patient referrals.

At this inspection in December 2016 we noted some improvements in the systems, processes and governance of safety but also some areas which required further improvement.

Management, monitoring and improving outcomes for people

Our findings showed that the GP had performed at least ten audits which were used to monitor clinical outcomes for patients. New computer software was being used to set up systems to audit and monitor chronic disease management. Audits were also being performed on high risk medicines to ensure patient safety. The results of the audits were shared with other GPs and nurses who worked in the practice and were stored within a folder for easy access. The results were also discussed at regular clinical meetings with minutes kept for reference. However, these minutes and audit records did not always demonstrate learning points and possible improvements which could then be used for GP appraisal and revalidation purposes.

Effective staffing

We found that:

- The induction training programme had been redesigned and now covered practice identified training including safeguarding training and infection control training. However, three of the new staff who had started work in April and September had not yet received infection control training and one who had started work in September had not received safeguarding training.
- There were no records to show that staff appraisals had been performed. The practice manager informed us these were planned but had not yet been started. However, they added that new staff had received probation reviews.
- The practice manager had not developed an overview of staff training.

Consent to care and treatment

During this inspection we saw that staff had not received awareness training in the Mental Capacity Act 2005.

Supporting patients to live healthier lives

We saw that the Registered Manager performed daily and weekly checks on the administrative tasks to ensure all processes had been followed up or completed. This included referrals to secondary care. A log book had also been set up to monitor this process.

Are services caring?

Our findings

Duing our inspection on 14 April 2016 we identified concerns in regard of systems, processes and governance of patient care. These included concerns in regard of:

- Promoting patient confidentiality;
- Information about services and opening times; and
- Carer information.

At this inspection in December 2016 we noted some improvements in the systems, processes and governance of safety but also some areas which required further improvement.

Kindness, dignity, respect and compassion

We found patients had access to a side room within the reception area for privacy and confidential conversations. We saw this being used.

National patient survey results from July 2016 for GP consultations continued to be below national averages and significantly below averages from the CCG. Three results remained the same, one had reduced by 2% and two had increased by 1%. For example:

- 81% of patients said the GP was good at listening to them compared to the clinical commissioning group (CCG) average of 91% and the national average of 89%.
- 80% of patients said the GP gave them enough time compared to the CCG average of 90% and the national average of 87%.
- 87% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 96% and the national average of 95%.
- 78% of patients said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 90% and the national average of 85%.
- 95% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 93% and the national average of 91%.
- 99% of patients said they found the receptionists at the practice helpful compared to the CCG average of 85% and the national average of 73%.

The practice manager told us they were waiting for the January 2017 results to monitor this and hoped the additional staff would improve patient satisfaction.

Care planning and involvement in decisions about care and treatment

We found that:

- A new website and patient leaflet had been introduced. A new poster was displayed on the front door indicating that the practice was open from 8.30am to 6pm between Monday and Friday and between 9am and 11am on Saturdays. However, staff did not give consistent information about opening times and we noted the practice was closed between 1pm and 2pm with the main doors being locked.
- Information leaflets produced by the practice and available in the waiting room of the practice were still out of date and did not necessarily reflect current advice. The practice manager told us they had printed off new leaflets but had not put these out yet.
- A shortcut on the computer system had been introduced so staff could access the translation and interpretation services.

Patient and carer support to cope emotionally with care and treatment

We found that the website had been updated and included a link to the Devon carers service. However, the practice did not provide written information to give to carers.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Duing our inspection on 14 April 2016 we identified concerns in regard of systems, processes and governance of responsive services. These included concerns in regard of:

- Assessing the external premesis and providing disabled persons parking;
- Providing consistent information to patients; and
- Effective complaints management.

At this inspection in December 2016 we noted some improvements in the systems, processes and governance of safety but also some areas which required further improvement.

Responding to and meeting people's needs

We noted there had not been a formal assessment of the premises but a disabled parking bay had been provided. The Registered Manager said this was following feedback from patients.

Access to the service

We saw there continued to be inconsistent information provided about opening times. For example:

- The new patient leaflet stated the practice opening hours were from 8.30am and 6pm with a lunch break of between 1pm and 2pm.
- A poster on the front door stated that the practice was open between 8.30 and 6pm Monday and Friday and 9am and 11pm on Saturdays.
- Information on NHS Choices website stated the practice was open between 8.30 and 1pm between Monday and Friday and closed at 6pm on Monday, 6.30pm on Tuesday, 1pm on Wednesday, 6pm on Thursday and 4pm on Friday.
- Four staff we spoke with told us that the practice was not open until 6pm on Wednesday and Friday afternoons. One member of staff said the practice was open until 1pm on Wednesdays until 1pm and 4pm on Friday. Another member of staff said the practice was shut on Fridays at 4pm and were uncertain about Wednesday afternoons and another member of staff said the practice shut at 4.30 on Wednesday, 5pm on Thursday and 4pm on Friday.
- The practice website stated that surgery times at the practice were between 8.30 and 6pm Monday to Friday. The Registered manager told us there were also Saturday morning clinics until 11am although these were not advertised on the website.
- We were given a phone diversion rota from 23 November 2016 document used by staff. This stated that the telephone line was to be opened at 8am and then transferred to Devon Doctors between 1pm and 2pm. The document stated that calls from 6pm on a Monday and Tuesday would be transferred to answer phone and would be transferred to the registered managers mobile phone from 4.30pm on a Wednesday. The document then stated that calls from Hatherleigh would be transferred to the second practice at 5pm on a Thursday and 4pm on a Friday.

We spoke with three patients about getting an appointment. All three said they did not experience any problems.

Listening and learning from concerns and complaints

We found improvements had been made. For example,

- Information on how to complain had been included on the practice website. Posters and leaflets were available in the reception area informing patients how to complain.
- The manager had introduced a summary of complaints and were in the process of employing the services of an external consultant to train staff in complaints management and staff training.

Are services well-led?

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

Our findings

At our last inspection in April 2016 we had concerns about the leadership at the practice. We found that the delivery of high-quality care was not assured by the leadership, governance or culture in place. There was no effective system for identifying, capturing and managing issues and risks. Significant issues that threaten the delivery of safe and effective care had not been identified or adequately managed. The leadership team ran two GP practices and a registered care home. It was not clearly identified how the management of the three locations, considering the geography of the locations coupled with the clinical commitments of the partners, worked.

At this inspection in December 2016 we continued to have concerns about the capacity for the providers to effectively lead the practice. Whilst we saw evidence of improvement since the last inspection there continued to be evidence that the leadership team struggled to manage two GP practices. For example, Inspections were performed at both practices on the same day. The registered manager was called to respond to issues raised at the second inspection and had to travel to the second practice. This left the practice for half an hour with no leadership cover until the practice manager arrived at Hatherleigh. Although the registered manager had employed additional staff there were no assurances provided of how the management of the locations, considering the geography of the locations coupled with the clinical commitments of the partners, would provide safe, effective, caring, responsive and well led services.

Vision and strategy

We found that:

- The visions and values had been included on the new website but not within the practice leaflet. The vision and guided values of the practice on the website were listed as:

- Care close to the patient.

- Provide holistic care for the patients minimising the travelling to the hospitals.

- Improve the access of the patients to the health services.

- Respect the family and cultural environment of the patient.

- Cooperation with other health services and teams.

- Development of skills mix in the working team.

- The practice had secured one CCG contract to provide NHS service from both its locations. They had not submitted an application to change their CQC registration to align with this contract.

Governance arrangements

We found:

- The registered manager and practice manager had started to review all policies and introduced a shortcut on the computer system so all staff could access the policies. We saw examples of policies which had been updated including management of safety alerts, waste management, complaints management and chaperoning policy. However, we also saw some documents which had been updated which continued to contain out of date or conflicting information. For example, the fire risk assessment contained conflicting information about when the building was occupied. We saw that patient information leaflets produced by the practice in the waiting room continued to be out of date and could provide misleading advice to patients.
- The number of clinical audits had increased and demonstrated improvements in patient care, although recordkeeping for this did not always clearly demonstrate learning or improvement in service quality.
- A new storage system had been built for the secure storage of paper patient records.
- A system had been introduced to ensure computer back up tapes were held securely. This included use of fire retardant storage facilities and off site access.
- The induction programme had been updated to include mandatory training. However, there was no system in place to monitor and ensure that new staff completed this training. We saw evidence that not all new staff had completed training in safeguarding or infection control. The practice manager had not introduced a system to keep an overview of this training and governance systems had not identified where appraisals had not been carried out.
- Recruitment files had been updated and organised and contained references. However, one file for a locum GP contained a reference written by another locum who did not have managerial responsibility and the second referee was the practice manager. This member of staff

Are services well-led?

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

had started work at the practice as a locum so had been initially recruited by an agency. The practice manager had not obtained assurances of evidence of this recruitment on transfer to more permanent employment at the practice.

- Some risk assessments had been completed. These included fire risk assessments and COSHH risk assessments. An environmental risk assessment of the external premises had not been completed.
- There were systems in place to manage medicines. However, governance of prescribing controlled drugs had not identified prescribing for a family member which was not recommended by the General Medical Council (GMC). We were made aware the GP concerned had referred this incident to the GMC on the day of the inspection. The other partner in the practice was unable to explain why governance arrangements had not identified this occurrence as being of potential risk to the practice.
- The practice had set up a basic system to monitor significant events and identify trends; however, there was no evidence to show this process had been started.
- Gaining and responding to patient feedback to identify areas of practice improvement remained an outstanding area for improvement.

Leadership and culture

At this inspection staff said the culture and leadership was beginning to improve. We were informed that more management tasks were now being delegated and there was a sense of team developing. Staff said there were still improvements to be made but morale had started to improve with the addition of additional new staff. We saw minutes of meetings which demonstrated that communication was improving; however, meetings were not held regularly.

Evidence from the patient appointment system, the unclear practice opening times and comments from staff indicated the provider lacked capacity to lead the practice effectively despite the improvements seen. Similarly evidence from the incomplete governance arrangements, the practice managers inability to locate information when requested and errors of judgement in regard of medicines management indicated the capability of the provider was compromised through lack of capacity to maintain a full oversight of the practice.

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

We found

- A new PPG group had been set up. This had two members who had met the week before the inspection to discuss how the group would work. The PPG representative informed us they were due to attend the local PPG forum to get ideas on how to develop and promote the group.
- There had not been a further in house patient survey performed. We asked for the results of the friends and family test and were given ten results collected since April 2016. All ten were extremely likely to recommend the practice.
- Staff told us the morale at the practice was improving and communication was better and done both informally and formally through an increased number of meetings. We were told there was not yet a formal programme of meetings.

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 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment There were not proper and safe management of medicines. Controlled drugs and the prescribing of medicines were not managed in accordance with national guidance or advice.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed There was no evidence to demonstrate competence of how the management of the two locations, considering the geography of the locations coupled with the clinical commitments of the partners, provide safe, effective, caring, responsive and well led services.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Systems or processes in regard of governance arrangements were not fully or effectively established or operated to ensure an effective oversight of Introduce governance systems to monitor and ensure that: • New staff receive appropriate training to enable them to carry on their duties they are employed to perform. • Information for patients, risk assessments and policies do not contain conflicting information

This section is primarily information for the provider

Requirement notices

- Evidence of recruitment has taken place on transfer to more permanent employment at the practice.
- Assessment of risk takes place to ensure the premises are safe.
- Processes are in place to ensure prescribing is performed in a safe and proper manner.

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.