Priory Avenue Surgery

Quality Report

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Caversham
Reading
Berkshire
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Date of inspection visit: 27 November 2014
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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We undertook a comprehensive inspection of Priory Avenue Surgery on 27 November 2014. The practice was rated inadequate in the safe, effective and well led domains. The practice was rated requires improvement in the caring and responsive domains.

Our overall rating for the practice was inadequate.

On the basis of the ratings given to this practice at this inspection I am placing the provider into special measures.

Our key findings were as follows:

Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. We saw staff treated patients with kindness and respect, and maintained confidentiality.

Some patients reported considerable difficulty in accessing a named GP and they experienced a poor continuity of care. However, all patients told us urgent appointments were usually available the same day.

Patients were at risk of harm because systems and processes were not in place in a way to keep them safe. The practice was going through a significant staffing crisis and there had been severe staff disruption in recent months. The practice was working closely with the NHS England area team to ensure they took immediate corrective action, which would enable them to fulfil their basic functions safely. The North and West Reading Clinical Commissioning Group were also monitoring the concerns and issues within the practice.

We saw no evidence that audit was driving improvement in performance to improve patient outcomes. We found, the recent staff shortages had an adverse impact on patient records. This posed a significant risk to patient

Summary of findings

safety as their patient records were not up to date with recent test results and discharge information from hospital. Therefore, patients may not have received appropriate follow up treatment or care.

There was no formalised induction programme for new administration and reception staff. However, training had taken place and staff felt supported by their immediate team and manager.

The practice did not have a clear vision and strategy. Staff we spoke with were not clear about their responsibilities in relation to the vision or strategy. There was no clear leadership structure and staff did not feel supported by the directors.

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

Importantly, the provider must :

- Document all recruitment and employment information required by the regulations in all staff members' personnel files.
- Ensure all staff identified as requiring a criminal records check through the Disclosure and Barring Service (DBS) have one undertaken as soon as possible.
- Carry out risk assessments and document these to inform which members of staff required a DBS check and which staff did not.
- Take immediate corrective action to address current staffing issues to ensure safe minimum levels are reached.
- Implement a system to ensure all staff members receive regular supervision and appraisal.
- Provide clinical leadership and management to all practice staff.
- Develop a clinical audit process and implement findings from audits.
- Develop and maintain a system to identify risks and improve quality in relation to patient safety.
- Implement a process to disseminate learning from significant events, clinical audits, complaints and referral, to practice staff members.
- Take immediate action to ensure all patients' records are updated with appropriate information and documents in relation to the care and treatment they have received.
- Undertake and record all relevant risk assessments.
- Undertake regular infection control audits that are documented and introduce a cleaning schedule for practice equipment.

Action the provider SHOULD take to improve:

In addition the provider should:

- Introduce a legionella risk assessment and related management schedule.
- Organise an induction programme for all new starters.

On the basis of this inspection and the ratings given to this practice the provider has been placed into special measures. This will be for a period of six months when we will inspect the provider again.

Special measures is designed to ensure a timely and coordinated response to practices found to be providing inadequate care.

We are currently piloting our approach to special measures, working closely with NHS England. The proposals we are piloting are that GP practices rated as inadequate for one or more of the five key questions or six population groups will be inspected no longer than six months after the initial rating is confirmed. If, after re-inspection, they have failed to make sufficient improvement, and are still rated as inadequate for a key question or population group, we will place them into special measures. In a small number of cases, a GP practice will have such significant problems that people who use services are at risk or there may be sufficiently little confidence in the practice's capacity to improve on its own. In these instances the practice will be placed straight into special measures.

Being placed into special measures represents a decision by CQC that a practice has to improve within six months to avoid having its registration cancelled.

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. Although the practice reviewed when things went wrong, lessons learned were not communicated and so safety was not improved. Patients were at risk of harm because systems and processes were not in place to keep them safe. For example, the practice was going through a staffing crisis and there had been severe staff disruption in recent months. This posed a significant risk to patient safety. We found no evidence of any completed infection control audits. The practice did not have a policy for the management, testing and investigation of legionella (a germ found in the environment which can contaminate water systems in buildings). There was no risk assessment to determine if action was required to reduce the risk of legionella infection to staff and patients. We found all recruitment and employment information required by the regulations was not documented in all staff members' personnel files.

Are services effective?

Inadequate

The practice is rated as inadequate for providing effective services. There were limited completed audits of patient outcomes. We saw no evidence that audit was driving improvement in performance to improve patient outcomes. Some multidisciplinary working was taking place but was generally informal and record keeping was limited or absent. We found the recent staff shortages had an adverse impact on patient records. We saw a sizeable backlog had built up in the recent months. For example, new patients records were awaiting to be processed by a GP, repeat prescriptions were delayed and medical reports were not up to date. There was no formalised induction programme for new administration and reception staff.

Are services caring?

Requires improvement

The practice is rated as requires improvement for providing caring services. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information to help patients understand the services was available. We also saw that staff treated patients with kindness and respect, and maintained confidentiality. However patient survey results showed that patients rated the practice much lower than others for some aspects of care. For example, 57% of patients described their experience of making an appointment as good. Forty

Summary of findings

five per cent of patients said they do not normally have to wait too long to be seen. These percentages were much lower when compared to national and clinical commissioning group (CCG) averages.

Are services responsive to people's needs?

Requires improvement

The practice is rated as requires improvement for providing responsive services. Services were not always planned to meet the needs of the local population. Some patients we spoke with reported considerable difficulty in accessing a named GP and poor continuity of care. All patients told us urgent appointments were usually available the same day. The practice was equipped to treat patients and meet their needs. Patients could access information about how to complain in a format they understood. However, there was no evidence that learning from complaints had been shared with staff.Patients we spoke with on the day gave us mixed responses about the booking of appointments and their continuity of care.

Are services well-led?

Inadequate

The practice is rated as inadequate for being well-led. It did not have a vision and strategy. Staff we spoke with were not clear about their responsibilities in relation to the vision or strategy. There was no leadership structure and staff did not feel supported. Administration staff and nurses worked well in their roles but told us they did not always feel supported by the management team, directors and the GPs. Governance meetings were not held regularly and had not been held at all for a number of months. The GPs and nursing staff told us they had not received regular supervision.

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

Requires improvement

Patients over 75 years of age had a named GP. However, due to staff shortages this was not being maintained. Patients reported that they were unable to see the same GP and this had impacted upon the continuity of their care. Home visits were arranged for housebound patients. The practice provided medical services to two local nursing homes. The practice ran various clinics to support elderly patients. These included specialist wound care, minor operations and Doppler clinics.Flu immunisations were offered to patients over 75 years. The practice data showed 79% of older patients had been vaccinated. The practice also ran vaccination clinics for shingles and pneumonia for older people. The practice provided community enhanced services to all over 75 years of age patients.

People with long term conditions

Requires improvement

Flu immunisations were offered to 'at risk' patients. This group of patients, were invited for regular reviews. Patients with long term conditions had a care plan in place to prevent unplanned admissions. Diabetic eye screening appointments were offered at the practice. The practice held dedicated clinics for patients diagnosed with conditions such as diabetes, respiratory and cardiovascular disease. The practice had robust recall systems in place to ensure patients with long term conditions received appropriate monitoring and support.Patients had an annual review of their condition and their medication needs were checked at this time. However, patient records and test results were not always being processed and reviewed in a timely way. Therefore this increased the risk of patients receiving delayed treatment and care.

Families, children and young people

Requires improvement

Childhood immunisations were carried out at the practice. Antenatal, baby checks and family planning clinics with a GP were available. Cervical screening was offered at the practice. We saw that the waiting area and treatment rooms were able to accommodate patients with prams and buggies. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities. Chlamydia testing was offered to 15 to 24 year old patients. The salaried GPs of the practice told us that they were unable to attend to their full range of duties due to the staff shortages. This included the review of safeguarding action plans and risks to individual patients.

Summary of findings

Working age people (including those recently retired and students)

Requires improvement 

The practice provided a range of appointments between 8am to 8pm. The practice was also open two Saturdays each month. At the time of the inspection the extended hours appointments had been reduced due to the staff shortages. This reduced the availability of access to patients who worked and we unable to visit the practice during working hours. Telephone calls to patients who were at work were made at times convenient to them. There was an online appointment booking system and repeat prescription service. The practice also offered NHS Health Checks to all its patients aged 40-75, in line with national guidelines.

People whose circumstances may make them vulnerable

Requires improvement 

The practice held a register of patients with learning disabilities. We saw 36 patients were recorded on the register, of which eight patients had received a health review. A GP carried out ward rounds for all patients with learning disability in a local care home. All vulnerable patients were prioritised, and given same day appointments. The practice provided medical services to homeless patients and temporary residents. Interpreters were used for patients whose first language was not English. Patients in vulnerable circumstances were at risk of delayed care and treatment, due to the shortage of GPs in the practice. The practice systems to review the care and support of those in vulnerable circumstances were not effective. The lack of leadership in the practice meant there was limited oversight and review of the patient population. This included changes to tailor the practice services to the needs of their population.

People experiencing poor mental health (including people with dementia)

Requires improvement 

Longer appointments were available for people who needed them, such as those suffering from poor mental health. A drug counsellor held a monthly session at the practice and appointments were offered to patients for this. The practice referred patients to appropriate mental health services. The referrals to other NHS services had not always been monitored or reviewed by the practice within their clinical governance processes. Practice data identified that the overall referral rates had increased recently. We were unable to evidence how the practice ensured their appropriateness and whether they were in line within current local and national referral guidance.

Summary of findings

What people who use the service say

We spoke with nine patients which also included the patient participation group (PPG) chairperson. A PPG is made up of a group of volunteer patients and practice staff who meet regularly to discuss the services on offer and how improvements could be made. We received further feedback from two patients via comment cards. The feedback from the patients we spoke with was mixed. Some patients told us it was very difficult to get a routine appointment. They told us that they often had to wait for over four weeks to get a routine appointment. Some patients were concerned about the lack of continuity of care they received. This was due to seeing different nurses or GPs at subsequent appointments for on going treatment or care. All the patients we spoke with told us if needed to be seen urgently, then they were offered same-day appointments. Patients were mostly positive about the care they received from GPs and nurses. Patients told us staff were usually very caring and supportive.

Patients told us the GP and nurses involved them with decisions about their treatment and care. Some patients told us they were provided with printed information when this was appropriate. Patients commented the practice was safe and clean.

We reviewed patient feedback from the national GP survey from 2014 which had 51 responses. The results from the national GP survey showed, 76% of patients said they found it easy to get through to the surgery by phone. Fifty seven per cent of patients said they were able to see their preferred GP and 57% of patients described their experience of making an appointment as good. Forty five per cent of patients said they do not normally have to wait too long to be seen. These percentages are very low when compared to national and clinical commissioning group (CCG) averages.

Areas for improvement

Action the service MUST take to improve

Importantly, the provider must :

- Document all recruitment and employment information required by the regulations in all staff members' personnel files.
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- Carry out risk assessments and document these to inform which members of staff required a DBS check and which staff did not.
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Action the service SHOULD take to improve

In addition the provider should:

- Introduce a legionella risk assessment and related management schedule.
- Organise a formalised induction programme for all new starters.

Priory Avenue Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC lead inspector, and two GP specialist advisors. The team also included a practice nurse and practice manager advisor.

Background to Priory Avenue Surgery

The practice provides personal medical services to over 8,050 patients in Caversham, Berkshire. There was an older than average practice population, with a high proportion of patients aged over 65, and low deprivation scores.

The practice occupies a victorian building in a prominent location on the main road through Caversham. The building was converted for general practice usage and had been extended several times in the last 10 years to meet patient needs. Consultation and treatment rooms are spread over the ground and first floors. The practice does not have onsite parking facility for patients. Limited disabled parking was available for patients with restricted mobility.

Care and treatment is delivered by a number of GPs, practice nurses and health care assistants. Outside normal surgery hours patients were able to access emergency care from an Out of Hours (OOH) provider. Information on how to access medical care outside surgery hours was available on the practice leaflet, website and in the waiting area.

The practice had undergone significant management changes in the last two years and included partnership changes in 2012. The former partnership dissolved and the practice was handed over to NHS Berkshire West Primary Care Trust (PCT) in September 2012. The current management, Specialist Health Service Ltd (SHS) tendered for and took over the practice. They have been running the practice since August 2013 and have an eight year contract with NHS England. The practice is now part of the North and West Reading Clinical Commissioning Group.

The current management team comprises of four directors. Two of the directors are GPs, but do not practise at the Priory Avenue Surgery. The third director is a retired GP and the fourth director is a business/practice manager at Priory Avenue Surgery. GP consultations are solely delivered by salaried and locum GPs and have been since the new practice was formed in August 2013.

A team of salaried doctors were recruited in 2013 and after some initial issues and changes, the medical service provision appeared to be stabilising. However, due to the increasing management and leadership concerns there have been a series of resignations in July and August 2014 from many of the salaried GPs. As a result management at the practice has become a major challenge and the practice experienced significant difficulties in recruiting new salaried GPs.

NHS England has received an action plan from the practice outlining the action they are planning to take to resolve the staffing and management issues identified in the previous eight weeks. This was agreed in November 2014 and the actions required are currently in progress. The action plan will be reviewed by NHS England. The clinical commissioning group are also involved in the recovery plan and supporting the practice.

The practice has a Alternative Personal Medical Services (APMS) contract. APMS agreements are locally agreed contracts between NHS England and a GP practice. This was a comprehensive inspection.

Detailed findings

The practice provides services from

Priory Avenue Surgery, 2 Priory Avenue, Caversham, Reading, Berkshire, RG4 7SF.

Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This provider had not been inspected before and that was why we included them.

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.

How we carried out this inspection

Prior to the inspection, we reviewed wide range of intelligence we hold about the practice. Organisations such as local Healthwatch, NHS England and the clinical commissioning group (CCG) provided us with any information they had. We carried out an announced visit on 27 November 2014. During our visit we spoke with the practice staff team, which included GPs, practice nurses, and the administration team. We spoke with nine patients including the Patient Participation Group (PPG) chairperson who used the service and reviewed two completed patient comment cards. We observed interactions between patients and staff in the waiting and reception area and in the office where staff received incoming calls. We reviewed policies and procedures the practice had in place.

To get to the heart of patients experiences of care, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

We also looked at how well services are provided for specific groups of people and what good care looks like for them. The population groups are:

- Older people
- People with long-term conditions
- Mothers, babies, children and young people
- The working-age population and those recently retired
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing a mental health problems

Inadequate

Are services safe?

Our findings

Safe track record

The practice had not raised any safeguarding alerts within the last year. We reviewed some recent Medicines and Health Regulatory Agency (MHRA) alerts and saw these had been appropriately dealt with. The practice had a 'Handling of Medical Safety Alert' policy in place and staff were familiar with these.

Individual GPs were responsible for safety alerts, in line with the national guidelines. GPs told us safety alerts were not being discussed routinely at meetings or being recorded. We were unable to review all safety records and minutes of meetings in the previous six months because they had not been held or recorded. This showed the practice was not routinely managing safety and risk consistently overtime and therefore were unable to demonstrate a safe track record.

Learning and improvement from safety incidents

We saw some evidence of some reporting, recording, and monitoring of significant events. The practice manager recorded significant events on a register. However, we found no evidence of action being taken. The events had not been discussed or reviewed for identification of trends and learning was not being shared. The salaried GPs told us, meetings to discuss significant events should be taking place every two months, however these had not taken place recently.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. All staff had received safeguarding training, appropriate to their roles. We asked members of medical, nursing and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies. The contact details of these agencies were easily accessible to staff.

A safeguarding lead had been appointed and had undertaken appropriate safeguarding training. The safeguarding lead was long term sick leave, and a deputy lead had been appointed.

All staff we spoke to were aware who these leads were and who to speak with in the practice if they had a safeguarding concern.

The practice had a chaperone policy in place. The administration and reception staff members had acted as a chaperone. The administrative staff we spoke with told us patients were informed they were part of the non-clinical team and sought their consent before supporting as chaperone. We saw evidence all chaperones had a Disclosure and Barring Service (DBS) check in place. We found no evidence which confirmed staff had received appropriate chaperone training. We saw notices in the waiting area and next to examination couches in the surgeries informing patients that they could request a chaperone. Some patients we spoke with told us they had been offered a chaperone if they required an intimate examination.

Medicines management

The practice had management of medicines policies and procedures and staff knew how to access these. The vaccines and medicines were monitored by the Health Care Assistant (HCA).

We found all medicines and vaccines stored were within expiry date and there were appropriate stock levels. Vaccines were stored appropriately in dedicated vaccine fridges and they were transported safely. These fridges were subject to daily temperature checks to ensure the vaccines were stored at the correct temperatures. This was supported by the fridge temperature logs made available to us. Medicines kept in one of the nurses rooms were being monitored by the HCA on a monthly basis. However, there were no written records of these checks.

The practice had procedures for repeat prescriptions, and protocols for how to handle repeat prescription requests. Staff we spoke with knew how to access this information. We found the prescription pads were stored safely and securely. All prescriptions were required to be signed by the GP before they were issued to the patient. The practice had systems in place for safe disposal of medicines.

Inadequate

Are services safe?

Patient Group Directions (PGDs) were available at the practice. PGDs are specific written instructions for the supply and administration of a licensed named medicine. There is a requirement that all PGDs should be signed at the time of issue. We reviewed a sample of PGDs issued in February and July 2014. We found these PGDs had been completed and signed by a GP. However, we noted that these had not been signed until November 2014.

Cleanliness and infection control

During our inspection we looked at all areas of the practice, including the GP surgeries, nurses' treatment rooms, patients' toilets and waiting areas. All appeared visibly clean and dust free. The patients we spoke with commented the practice was clean and appeared hygienic. We noted during our interview with one of the GPs, their room was cluttered. For example, we saw notes and letters scattered on the floor and on the desk. The GP told us they had been in the process of catching up on some administration work. Other rooms appeared to be tidy and clutter free.

The practice had a comprehensive infection control policy. This provided staff with guidance on hand hygiene, importance of personal protective equipment, handling of blood samples and how to deal with microbiological swabs. The staff we spoke with were familiar with these. The Health Care Assistant (HCA) was the lead for infection control, they were not available on the day of the inspection.

The practice had employed a cleaning company, who came in daily. Cleaning schedules were in place and these confirmed the areas the cleaners were required to clean and how frequently. This was monitored by the infection control lead. We found appropriate arrangements were in place to enable the safe removal and disposal of any waste from the practice.

We found no evidence of any completed infection control audits. This was supported by the staff we spoke with told us they were not aware such audits and this had not been shared with them. A blank 'Infection control audit' document was made available to us. There was no cleaning rota for the practice equipment, such as telephones, spirometry, keyboards and BP cliffs. The cleaning of these items was not being monitored.

The practice did not have a policy for the management, testing and investigation of legionella (a germ found in the environment which can contaminate water systems in buildings). There was no risk assessment to determine if action was required to reduce the risk of legionella infection to staff and patients.

Equipment

Staff had access to a defibrillator and oxygen. Staff knew the location of the resuscitation equipment. We saw servicing records for medical equipment were up to date and within their expiry date. A schedule of testing was in place. Electrical appliances were tested to ensure they were safe. We saw a log of calibration testing for the practice and all equipment was calibrated in February 2014. Disposable medical instruments were stored in clinical treatment rooms in hygienic containers ready for use.

Staff told us they had received training in fire safety and health and safety. The GPs and nursing team had received training in basic life support (BLS) this year. The administration team had not received BLS training. The practice had health and safety protocols and staff knew how to access these should the need arise. Health, safety and welfare procedures were also available in the staff handbook.

Staffing and recruitment

Recruitment policies and procedures were in place. We reviewed the personnel files of six staff members who had been recruited in the last two years. These included two GPs, a nurse, an HCA and two members of the administration team. We found not of all the information required by the regulation was recorded in the individual staff files.

We saw one of the administration members file only included an employment contract. There was no evidence of application form or CV, references, identity checks, or recent photograph. In another file, there was evidence of application form, references had been requested but not received and employment contract was in place. There was no evidence of criminal records check through the Disclosure and Barring Service (DBS), for both staff members.

We noted in the health care assistant's file, references had been sought and received and a contract of employment was in place. However there was no application form,

identity checks, a recent photograph and criminal records check contained in the file. The nurse practitioner file did not include any of the information required under the regulation.

We reviewed two GP personnel files. In one GP file there was evidence of identity checks, and professional registration. However there was no evidence of an application form or CV, a recent photograph, no employment contract or evidence of relevant qualifications for the member of staff. In the other GP personnel file we saw evidence of a CV and employment contact. However there was no evidence of confirmation of professional registration or if they were part of the NHS England performers list. There was no evidence of a criminal records check through the Disclosure and Barring Service (DBS) for one of the GPs.

The practice had not obtained evidence for staff to ensure they were physically and mentally fit to carry out their roles. We found a documented risk assessment to determine which staff required a DBS check and the risks this posed to patients, was not in place. This meant, the practice did not have suitable recruitment systems in place, to ensure patients were treated by skilled and qualified staff.

The practice provided medical services to over 8,050 registered patients. The practice had identified that the ideal number of clinical sessions required to support and manage an 8,050 patient list should be approximately 43 sessions per week. At the time of the inspection, the practice had four salaried GPs who were providing 19 clinical sessions between them and the nursing team provided 10 sessions. Patient safety may be at risk because the practice would not be able to fulfil its basic functions safely.

We found the practice did not have sufficient regular clinical staff on duty to support the needs of the patient population safely. A full time salaried GP had left the practice in October 2014. A long term locum had been appointed to cover these GPs clinical sessions. One salaried GP was on long term sick leave, and had recently resigned.

A number of current working salaried GPs had resigned and were serving their notice period. The loss of these GPs would then leave a total of just nine regular clinical GP sessions per week between the two remaining salaried GPs, who delivered four and five sessions per week respectively. If the practice did not make immediate improvements to staffing levels, the practice may be at more significant risk of not being able to ensure patient safety.

One of the directors, who was also the business manager had resigned from the company and was due to leave in December 2014. The management team told us a recruitment programme was in place to look for a new experienced practice manager. This person would provide management support and be a lead to the administration and reception team.

The staffing shortages had an adverse impact on practice staff, the running of the practice and the clinical and non-clinical workload. A salaried GP told us at present they were only seeing patients and were unable to complete necessary paperwork. They said there had been occasions when only one GP turned up for work and the practice was unable to get cover for urgent matters. Salaried GPs told us previously a 'Buddy system' was in place to cross cover when GPs were on annual leave. However this system had completely collapsed, due to the recent staffing disruptions.

The administrative team we spoke with told us there was not enough clinical staff to support the practice population. In particular difficulties arose, when a salaried GP was sick. They told us on occasions many appointments had to be rescheduled or cancelled. This had left the patients unhappy and the staff in a difficult position. Another staff member told us, they were concerned about the on going clinical staffing issues. They said on one occasion, there was only one salaried GP working (who left midday) and there was no duty GP. There was no nurse working on the day and the two locum GPs worked until 5pm. The staff member said the practice manager was unable to sort out these issues. They were worried this could impact patient safety, because of increased workload and pressure on the existing staff.

The administration team told us there were also staff shortages in their team. For example, when the medical secretary, clinical data manager and the person responsible for scanning documents were on leave, there were no cover arrangements in place. They told us this work was not actioned and left for the staff members return.

Inadequate

Are services safe?

The senior management told us about the serious staffing challenges they faced due to the delays in recruitment, staff sickness and the recent resignations. As a result, a recruitment programme had been commenced and the management team had been working closely with several medical recruitment consultants to appoint new salaried GPs and a medical partner. This had proven to be challenging due to the present national shortages of GPs. The practice manager told us the practice was trying to recruit full time GPs but this was proving difficult due to a lack of qualified staff applying for the vacant roles. The practice was using locums regularly.

The management team were aware the usage of locum GPs was not sustainable long term. The use of locums had adverse effect on the practice. Some issues identified included a patient dissatisfaction with the lack of continuity of care, increased referral rates, increased prescribing costs and difficulty in ensuring clinical governance was effective. However, the management team told us they had no choice but to use locums until full complement of full time staff were in place.

We saw some evidence that efforts had been made to ensure a continuity of staffing in the nursing team. Initially the practice had employed a nurse practitioner with specific responsibility to lead the nursing team. However, the nurse practitioner's employment was ceased as the salaried GPs and the nursing team did not feel the person was appropriate for the role. A new nurse practitioner had since been employed who had meetings with the nursing team and planned to carry out appraisals for them. A Health Care Assistant (HCA) had been appointed to reduce the routine tasks that were being completed by a nurse, which could be done by a HCA.

We found the general work availability was operated to cater for the needs of the GPs and not for the needs and requirements of the patient population.

Monitoring safety and responding to risk

The business continuity plan identified the range of risks the practice could face that would prevent the delivery of care and treatment. The plan identified how these risks would be mitigated and actions needed to restore services to patients. However, they had failed to identify the risks associated with the staffing problems when they began to arise earlier in 2014. We were unable to evidence how the practice management and leadership team had identified this risk and had taken immediate and corrective action to minimise the impact for patients and the practice.

We found no evidence of relevant risk assessments. For example, risk assessments in fire safety, a control of substances hazardous to health (COSHH) risk assessment and there was no overall health and safety risk assessment in place.

Arrangements to deal with emergencies and major incidents

The practice had a system and procedures in place to deal with most emergencies. The practice had a 'Disaster Handling and Business Continuity Plan' to deal with most emergencies that could interrupt the smooth running of the practice. This plan outlined protocols for staff to follow in the event of, losing computer system/essential data, loss of telephone system and loss of the main building. The practice manager told us the document was available to staff on the computer system. Some of the staff we spoke with were not familiar with the business continuity plan. The practice manager kept copies of the document and other insurance policies off site.

The practice had alarm buttons to alert staff in the event of emergencies. Staff had access to emergency medicines and medical equipment. We found the medicines were within their expiry date. The practice nurse was responsible for checking resuscitation equipment and medicines and recorded this information weekly.

Inadequate

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing team we spoke with were able to describe and demonstrate how they access both guidelines from the National Institute for Health and Care Excellence and from local commissioners. All the GPs and nurses we interviewed were aware of their professional responsibilities to maintain their knowledge.

Patients had their needs assessed and care planned in accordance with best practice. The CQC specialist GP advisor sampled some patient records. They found all patients were well managed and patients were on appropriate treatments. We saw patient records were computerised. Medical notes included information such as laboratory, X-ray and scan results, correspondence with secondary providers and prescribing information was recorded accurately until September 2014.

The provider did not maintain an accurate record in respect of each patient which shall include appropriate information and documents in relation care and treatment provided to the patient. We found, the recent staff shortages had an adverse impact on patient records. We saw a sizeable backlog had been built up over the last two months. For example, new patients records were awaiting to be processed by a GP, repeat prescriptions were delayed, medical reports were not up to date and there was a backlog of hospital letters and reports that needed to be processed. The salaried GPs we spoke with told us in the last couple of months they were only seeing patients and did not have time to complete the necessary paperwork. Locum GPs did not complete administration tasks and other necessary paperwork. This increased the salaried GPs workload and further increased the backlog.

Referrals were made using the Choose and Book service. The process involved GPs completing a referral form, the administration team then processed the referral and documented this on patient record and patient was contacted. We found the referrals were dealt with appropriately and in timely manner. We saw evidence of appropriate use of Two Week Wait referrals. Salaried GPs told us due to lack of regular clinical meetings, recent referrals were no longer discussed and learning opportunities were not available. There had been an increase in the number of referrals from the practice as a consequence. Audits had not been undertaken to measure the referral rates per GP and the reasons to confirm the appropriateness.

Management, monitoring and improving outcomes for people

The practice routinely collected information about patients care and outcomes. The practice used the Quality and Outcomes Framework (QOF) which is a voluntary system for the performance management and payment of GPs in the National Health Service. This enables GP practices to monitor their performance across a range of indicators including how they manage medical conditions. The 2014 QOF data made available to CQC showed the practice had either met QOF targets or exceeded them. The practice had done well in all clinical and public health areas. A specialist diabetes nurse had been employed in June 2014, and practice anticipated improved QOF scores in diabetes.

We found no evidence of completed clinical audit cycles in the last two years. A clinical audit is a process or cycle of events that help ensure patients receive the right care and the right treatment. This is done by measuring the care and services provided against evidence base standards, changes are implemented to narrow the gap between existing practice and what is known to be best practice. The audit documents made available to us did not reflect this definition.

During our visit we were provided with a loose leaf folder of practice audits, which included five documents. For example, one document had identified the number of home visits made in the local care home and it was acknowledged that this was not an audit. Another document was named 'Audit' for patients receiving, medicines to reduce cholesterol levels and to control blood pressure. This appeared to be results of a straightforward computer search and was not a complete audit. We found no evidence of a topic for clinical audit being selected and a detailed methodology and data collection process being tested for the audit. There was no evidence of the results then being shared with practice staff, an action plan devised to monitor changes and evidence of repeat audit planned, in the audit documents made available to us.

Inadequate

Are services effective?

(for example, treatment is effective)

The salaried GPs we spoke with told us clinical audits had lapsed. The nursing team had not been involved in any clinical audits, in the last two years. The meeting minutes made available to us, showed there was no discussion of any recently completed clinical audits.

Effective staffing

All GPs were up to date with their yearly continuing professional development requirements and all either have been revalidated or had a date for revalidation. (Every GP is appraised annually and every five years undertakes a fuller assessment called revalidation. Only when revalidation has been confirmed by NHS England can the GP continue to practice and remain on the performers list with the General Medical Council).

The nursing team told us they had regular training and new members of staff were provided with structured induction programme. Some of the recent training included, information governance, children and adult safeguarding and resuscitation. One nurse we spoke with told us they had been offered a lot of support from the IT team to understand the practice IT systems. However, there was no formalised induction programme for new administration and reception staff. Staff we spoke with told us the nature of their roles was discussed. However, their competence was not checked before being allowed to work unsupervised.

Working with colleagues and other services

The practice had a strong working relationship with the district nurse team and the community matron, who were based within the premises. They were called into the practice when information needed to be shared. The practice also worked closely with midwife and health visitor who visited the practice regularly and ran clinics from practice.

The practice held multi-disciplinary meetings which were attended by district nurses, midwives, a community matron and palliative care nurses. We reviewed minutes of a recent palliative care meeting, dated August 2014 and we saw there was discussion on all patients receiving palliative care and how they could be best supported. The detail evidenced good information sharing and integrated care for those patients at the end of their lives.

The practice maintained a register for children at risk. The practice worked closely with the multi-agency safeguarding hub (MASH). The MASH process was operating effectively to ensure early notification of referrals across agencies, information was shared and appropriate action secured by relevant parties to promote early help as well as preventative work. The salaried GPs were clear about the role of and referral processes to the MASH. We saw a recent example of referral to MASH and saw this had been appropriately deal with.

Information sharing

Blood results, X-ray results, letters from hospital accident and emergency and outpatients and discharge summaries, and the 111 service were received electronically and by post. The process of information sharing had been severely compromised. We found there was a backlog of letters from hospital, A&E reports, and reports from out of hours services which needed to be processed and actioned by a GP. This information had not been dealt with in timely manner.

We saw evidence of special notes that had been used to share information with the Out of Hours (OOH) service.

Consent to care and treatment

The GPs we spoke with had a sound knowledge of the Mental Capacity Act 2005 (MCA) and its relevance to general practice. The GPs and nurses we spoke with understood the principles of the legislation and described how they implemented it. Staff were able to describe the action they would take if they thought a patient did not understand any aspect of their consultation or diagnosis. They were aware of how to access advocacy services. The GPs we spoke with told us they maintained their own knowledge on these areas, and had no support from the practice. For example, there was no collaboration or communication between them and the practice (i.e. through team meetings) on these issues.

The GPs we spoke with gave examples of how a patient's best interests were taken into account if a patient did not have capacity to consent. GPs and nurses demonstrated a clear understanding of Gillick competencies, used to identify children under the age of 16 who have the legal capacity to consent to medical examination or treatment.

Health promotion and prevention

GPs and nurses referred patients to appropriate organisation for further help and support with their

Inadequate

Are services effective?

(for example, treatment is effective)

treatment and care. The nurses we spoke with told us they had referred patients to smoking cessation groups, provided information on eating healthy and advised on appropriate healthy living pathways.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance for all immunisations was above average for the CCG, and the practice had a recall system in place to follow up non-attenders.

The practice website and surgery waiting areas provided various up to date information on a range of topics and health promotion literature was readily available to support people considering any change in their lifestyle. These included information on, diabetes, asthma, cancer and carer's support.

Requires improvement

Are services caring?

Our findings

Respect, dignity, compassion and empathy

Staff took steps to protect patients' privacy and dignity. Patients we spoke with told us they were treated with privacy and dignity. Curtains were provided in treatment and consultation rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

Receptionists closed a glass screen on the reception desk when speaking to patients on the phone. Staff told us all computers were password protected and only the practice staff had access to the systems. We saw a self-check in facility was available. This ensured long queues were avoided at reception, which reduced conversations being overheard.

The practice confidentiality policy highlighted the importance of patient confidentiality and staff responsibility to ensure patient medical records were not moved from the premises. The design and layout of the reception area meant patient records could not be viewed by those attending the practice, and records were maintained securely and confidentially. The practice complied with data protection and confidentiality legislation and guidance.

We reviewed the recent data available for the practice on patient satisfaction. This included information from the national patient survey and a practice survey completed by of 89 patients, in November 2013. The 2014 GP national survey showed that 85% of patients said the last GP they saw was good at treating them with care and concern. Fifty six per cent (61% CCG average) of patients were satisfied with the level of privacy when speaking to receptionist at the practice and 86% of patients found the receptionists at the practice helpful. Seventy six per cent of patients described their overall experience of the surgery as good and 68% (85% CCG average) of patients said they would recommend this practice. Some of these percentages were low when compared to national and CCG averages.

We saw the November 2013 practice survey showed 51% of patients rated their GPs as very good for treating them with care and concern and 39% of patients rated it as good. Thirty seven per cent (46% CCG average) of patients rated their experience as very good and 40% (43% CCG average) as good.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example, data from the 2014 national GP survey showed, 89% of patients said the last GP they saw was good at listening to them and 90% of patients said their GP was good at giving them enough time. Seventy six patients said their GP was good at involving them in decisions about their care and 76% (83% CCG average) of patients said the GPs they saw were good at explaining tests and treatment.

Patients we spoke with told us they felt that they had been involved in decisions about their own treatment and that the GPs and nurses gave them plenty of time to ask questions and had not been rushed. Patients were satisfied with the level of information they had been given and said that any next steps in their treatment plan had been explained to them.

Patient/carer support to cope emotionally with care and treatment

Notices in the patient waiting room and practice website also signposted people to a number of support groups and organisations, such as carer support, counselling, dealing with loneliness for older people, memory loss and bereavement support. The practice website had information about family health, long term conditions and minor illness.

The practice website had online resources, which included information about health advice for young people and online talking therapies and support clinics. The online clinics covered a wide range of health conditions.

The survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. The patients we spoke with on the day of our inspection told us GPs and nurses were supportive.

Requires improvement

Are services caring?

The practice maintained a register for patients with depression and provided these patients with appropriate care and support.

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The current staffing crisis had impacted the practice function of responding to meet patient's needs. For example, the change in GP staffing levels had meant the principle of 'personal list' had ceased. All the over 75 year old patients had a named GP. However this was no longer supported or possible due to the low numbers of GPs in the practice.

Longer appointments were available for people who needed them, such as those suffering from poor mental health and patients with long term conditions. This also included appointments with a specialist nurse, such as appointments for diabetes checks. The practice provided medical services to a local care home. One of the GPs visited one morning each week to carry out a ward round to see patients. Home visits were provided at the discretion of GPs and according to clinical need. The practice reserved these for older patients, disabled and terminally ill patients or for emergencies. One of the GPs undertook monthly visits to local residential care home and provided treatment and care to many of the autistic patients.

The practice had patient registers including learning disability, long term conditions and palliative care registers. For long term conditions, the practice held registers for diabetes, asthma, arthritis and chronic obstructive pulmonary disease (COPD). We found there was a recall and annual review system in place for patients with diabetes and respiratory disease, and this process was nurse led. The practice held an unplanned admissions register, however in recent months this was not being maintained or completed by the GPs. No meetings had been held to discuss unplanned admissions and to share learning with staff

There was an online repeat prescription service for patients. This enabled patients who worked full time to access and order their prescriptions easily. Patients could also drop in repeat prescription forms to the surgery to get their medications. Some patients we spoke with told us that the repeat prescription service worked well at the practice. However, we found a back log of repeat prescription requests on the day of inspection.

Tackling inequity and promoting equality

The premises and services had been adapted to meet the needs of people with mobility problems. The doorways were wide and there was space for wheelchairs and mobility scooters to turn. All elderly and frail patients and those with limited mobility were seen in the ground floor consultations rooms. If patients needed help with access, they were able to ring the doorbell at the patients' entrance and a receptionist staff member would assist them accordingly. The practice had limited reserved car spaces for patients with disabilities. Adapted toilet and washroom facilities were available for patients.

Staff told us that translation services were available for patients who did not have English as a first language. They said it was rare that this service was required. The practice also utilised language skills within the practice team, to support patients who did not understand English. We saw the self-check in service available in several other languages. The practice website could be translated into over 50 languages. These included Urdu, Spanish, Polish and Arabic.

Access to the service

Patients were able to book an appointment to see a GP or nurse by text, telephone, online and in person. The practice were contracted to offer a range of appointments available to patients every weekday between the hours of 8am and 8pm. The practice also offered Saturday and Sunday appointments. This improved access to patients who worked full time. However, at the time of inspection the directors had withdrawn the extended hours service, and had decided to concentrate on normal hours until the practice was fully staffed.

The patient feedback on access was mixed. Some patients we spoke with reported considerable difficulty in accessing a named GP and poor continuity of care. Patients told us there had been a significant change of locum GPs in the last two months and this affected their continuity of care. One patient told us they saw a different GP each time they had come in the last month. Patients said access to a preferred GP was poor and at times had to wait for a routine appointment with preferred GP for over four weeks. Other patients said they were happy to see any GP and

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

were able to make an appointment fairly easily and did not have wait too long to be seen. Patients were generally happy with the opening hours. All patients told us urgent appointments were available on the day.

We reviewed the results of the 2014 national GP survey. We saw the practice had scored below the CCG average, on service access. For example, 57% of patients said they were able to see their preferred GP and 57% (76% CCG average) of patients described their experience of making an appointment good. Sixty per cent of patients said they usually had to wait 15 minutes or less after their appointment time to be seen. Forty five per cent of patients said they did not have to wait too long to be seen. Seventy six per cent of patients found it easy to get through to surgery by phone.

Listening and learning from concerns and complaints

Patient's comments and complaints were listened to and acted upon. Information on how to make a complaint was provided on the practice website and leaflet. The complaints procedure provided further information on how to make complaint and who at the practice would deal with the complaint. The practice had a complaints and procedure and this was displayed in the waiting area. The practice manager was the complaints lead and would in the first instance speak to patients face to face to diffuse the situation and provide patients with immediate resolution. Patients were provided with a complaints form to raise a complaint and were advised of the timescales of when they would be responded to.

The practice manager kept a record of all written complaints received. The complaints we reviewed had been investigated by the practice manager and responded to, where possible, to the patient's satisfaction.

We found patients' comments made on the NHS Choices website were not always monitored. We noted some comments on the NHS website were positive and others were negative. We saw the practice had not responded to any of the comments.

Some patients we spoke with told us they would be comfortable making a complaint if required. Others said they would not raise a formal complaint, as they were worried there would be repercussions and this would affect the care and treatment they would receive. In particular they feared that they would be removed from the practice list.

Are services well-led?

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

Our findings

Vision and strategy

Priory Avenue Surgery was formerly a group general practice. In 2012 the partnership was dissolved and the practice was handed back to NHS Berkshire West Primary Care Trust (PCT). In April 2013, a new provider was found, Specialist Health Services Limited (SHS), who had put in a successful bid and were offered an eight year APMS contract.

The SHS management structure comprised of four directors. Two of the directors were GPs, but did not practise at Priory Avenue Surgery. The third director was a retired GP and the fourth director a business/practice manager at Priory Avenue Surgery. We spoke with all four directors during our inspection. The directors told us the aim and vision of the practice was to let the salaried GPs run and manage the practice and the directors would be responsible for the running of the premises. This had not been well received by the salaried GPs, who had expected and had asked for clinical management support from the management team and directors.

The staff we spoke with did not know what the practice vision or strategy was. Staff told us they did not know who was responsible for what area or who had lead roles in clinical matters. For example, during our inspection we were told a salaried GP was the lead in cancer, thyroid and epilepsy for the practice. However, the staff member was not aware they were the lead for these clinical areas.

We found the practice had not developed a business or strategic plan for the future. There was no evidence of succession planning for the salaried GPs who were due to leave soon. The practice had not identified or developed internal staff to fulfil leadership positions within the practice. Staff told us the practice did not have regular team meetings and there was no discussion on practice visions and values.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the practice computer system. These included policies in safeguarding children and vulnerable adults, complaints, whistle blowing, clinical waste management, recruitment and repeat prescribing. All of these policies were updated to reflect new legislation and guidance and future review dates were also in place.

The practice used the Quality and Outcomes Framework (QOF) to measure their performance. The 2014 QOF data for this practice showed they were performing in line with national standards. We saw the practice had performed well in areas such as, coronary disease, stroke, and diabetes.

The practice did not hold governance meetings to discuss performance, quality and risks and this was confirmed by the GPs and nurses we spoke with. Salaried GPs told us that previously meetings took place regularly, where QOF, unplanned admissions, referrals and prescribing initiatives were discussed. However, in the last 18 months, these meetings had become less frequent and were inconsistent. The nurses told us they had never been invited to any previous clinical meetings and would welcome involvement in these.

Nursing team meetings had recently commenced, and these were chaired by the new nurse practitioner. The administration and reception team also had their own meetings and issues were discussed and learning was shared regarding incidents and topics in relation to their area of the practice.

The practice did not have systems in place to monitor all aspects of the service such as complaints, incidents, safeguarding, risk management, and clinical audit. The recent staffing crisis had an adverse impact on these processes and systems, and as a result this work had lapsed.

Clinical audits had not being undertaken in the previous two years to drive improvement and change. We found evidence which identified how recent clinical audits were not effective. For example, during our inspection we were presented with a copy of an audit which looked at patients receiving pain management medication and without proton pump inhibitor (PPI) cover. This audit was completed in April 2014. The audit included a data table section and the information and results had not been recorded. The results of the audit concluded there was no change in the treatment and care of patients or the usage of pain management medications. It was not clear from the records which GP undertook the audit. These results were

Are services well-led?

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

shared with the salaried GPs. Later on the inspection day we were provided with another audit document by the same GP, which had the same title, the same front page and the same date of data collection, as first audit reviewed. However, now the data collection showed that 1000 patients (out of 8000) were receiving specific pain management medication and no patients were receiving antiplatelet drugs without proton pump inhibitor (PPI) cover. The results of this audit concluded 'It was heartening that we found no patients in the warning group'. We were unable to confirm which audit accurately and correctly represented the practice or what changes and actions were taken following this.

Leadership, openness and transparency

At the time of the inspection, there was no clear leadership structure at the practice. Staff were not clear about their own roles and responsibilities, and this had been affected by the constant changes in staffing. The practice had gone through a period of change in the last two years. We found that no formal leadership team or processes were in place or in development to manage and implement the significant change. There had been constant failures in communication between the current directors and salaried GPs, which had led to a breakdown in relationships and the failing of any leadership in the practice. The environment had left the practice staff demotivated, demoralised and disillusioned with the lack of management support. The departure of salaried GPs and other staff in the recent months further de-stabilised the practice team.

All the salaried GPs, nurses and the administration team told us there was no leadership at the practice and that this was something they had asked for constantly from the directors since August 2013. All staff we spoke with told us the current directors were rarely seen at the practice. One salaried GP had never met all of the directors of the organisation until the day of inspection. Another member of staff told us, there was no leadership within the medical team. They said they did not have a lead or partner to go to discuss issues or concerns.

During our visit the directors told us the about the issues that had been escalated by the salaried GPs behaviour. They felt the salaried GPs had shown constant resentment to any possibility of leadership emerging from their team. There was no unity between the salaried GPs and directors.

The management team recognised and understood the issues at the practice. The directors accepted that they should have been more proactively involved and should have overseen the clinical management and leadership until full complement of staff were in place.

The directors told us, following initial difficulties the practice had begun to run in stable fashion and they did have a full complement of staff. However, the recent resignations and communications from salaried GPs had precipitated the staffing crisis and a number of other issues causing an adverse impact. This had only recently been identified. These included a lack of cohesion amongst salaried GPs, lack of team meetings, lack of leadership and management failures.

The directors had taken some action to address these issues. This included, a recruitment drive which had been launched to employ new GPs. A decision was made to recruit a medical partner, who would be the clinical management lead for all staff, and to increase pay and improve working conditions to retain and attract staff. The directors had decided they would be present in clinical and practice meetings, and we saw evidence a team building session had been organised. The practice was looking to recruit a new practice manager, with the relevant experience and skills. The practice was in discussions with the NHS England and an action plan had been produced confirming the actions that will be taken to address the ongoing issues.

The directors were aware of severity of the issues and the potential significant risks these posed to patients. They were working hard to address these concerns, but at the same time were realistic of what could be achieved. The November 2014 action plan submitted to NHS England, stated if they were unable to recruit the GPs to fulfil patient requirement, they would hand over the contract and cease the business, which could lead to immediate closure of the practice.

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

The practice had a patient participation group (PPG), where six members attended. The PPG chairperson told us they met every month and the meetings were attended by the practice manager and one of the directors. The present PPG group comprised of predominately retired patients. The PPG had identified it was difficult to get teenagers and

Are services well-led?

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

working age people involved and had they tried different ways to attract these patients, but were unsuccessful. We saw evidence that the PPG had advertised information on how to join the group on the practice website and in the waiting area.

We spoke with the PPG chairperson who told us they felt valued and thought their views were listened to. We were given examples of where the PPG had highlighted areas and the feedback was acted on and changes were made. For example, the PPG had suggested arm chairs were required in the waiting area, for patients with arthritis to ensure they were comfortable. This was reviewed and new arm chairs were put in place. The PPG had suggested that a greeting message should be introduced to inform patients to call for test results after 11am. This would reduce the telephone traffic in the early morning and make it easier for patients calling for an appointment to get through to staff. The practice had actioned this and had also introduced online appointment system.

Staff were aware there was a whistleblowing policy. They knew who they should approach if they had any concerns within the practice. All staff we spoke with told us they were comfortable to whistle blow, should the need arise. Staff were also aware of the external organisations should they have any concerns that needed to be escalated outside the practice. This included, the local clinical commission group (CCG), NHS England and the Care Quality Commission (CQC).

Management lead through learning and improvement

The practice did not have systems to learn from incidents which potentially impacted on the safety and effectiveness of patient care and the welfare of staff. Staff told us regular clinical meetings were not taking place. As a result, topics such as referrals, prescribing methods/errors and significant event analysis were not being discussed or shared. Staff said learning from complaints or audits were also not being shared or discussed. Limited team meetings took place for administration and reception team. The administration team told us the practice did not hold away days or meetings for all the staff and that they had not been invited to join the recent one held away day held.

The practice manager and administration and receptionist team had regular annual appraisals, to discuss individual support needed to develop their knowledge and skills. The administration team told us although they did not have regular supervision; they were supported by the practice manager and would go to them if they had any concerns.

GPs and nurses told us they maintained their own continual professional development (CPD). They said it was their responsibility and that they had not been supported by the management team with this.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers **Regulation 21 Health & Social Care Act 2008 (Regulated Activities) Regulations 2010. Requirement relating to workers** **The registered person must ensure all information specified in Schedule 3 is available in respect of staff employed for the purpose of carrying on the regulated activity. Regulation 21 (a) & (b).**

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 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control **Regulation 12 Health & Social Care Act 2008 (Regulated Activities) Regulations 2010. Cleanliness and infection control** **The registered person must ensure an effective operation of systems designed to assess the risk of and prevent, detect and control the spread of a health care associated infection. Regulation 12 (2) (a).**

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers **Regulation 10 Health & Social Care Act 2008 (Regulated Activities) Regulations 2010. Assessing and monitoring the quality of service provision.** **The registered person must regularly assess and monitor the quality of the services provided. And identify, assess and manage risks relating to health, welfare and safety of patients. Regulation 10 (1)(a) and (b), (2) (b)(i) and (c)(I)**

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records **Regulation 20 Health & Social Care Act 2008 (Regulated Activities) Regulations 2010. Records** **The registered person must ensure an accurate record in respect of each patient which shall include appropriate information and documents in relation to the care and treatment provided to each patient. Regulation 20 (1) (a).**