Cornwallis Surgery

Quality Report

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

Ratings

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

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

Cornwallis Surgery was placed in to special measures following a comprehensive inspection in July 2015 whilst being run by the previous provider. The current provider took over the running of the practice at the end of July 2015 and inherited the special measures status. In October 2015 the practice merged with another within the same building and the provider also took over three further surgeries in the Hastings area, Little Ridge, Shankill and Essenden Road. These are run as branch surgeries. We carried out an announced comprehensive inspection of Cornwallis Surgery on 9 February 2016. Breaches of legal requirements were found during that inspection within the effective and well-led domains. The practice was rated as requires improvement overall, requires improvement in the effective, caring and well-led domains and good in the safe and responsive domains. The practice was taken out of special measures.

After the comprehensive inspection, the practice sent to us an action plan detailing what they would do to meet the legal requirements in relation to the following:

- Provide opportunities for staff to receive regular supervision and appraisal.
- Seek and act upon feedback from patients in order to continually evaluate and improve services.
- Provide staff with contracts of employment which reflected their current employment status.

Since the last inspection the practice had undergone significant changes in management. On 31 August 2016 the organisation that had been assisting with backroom support withdrew and on 01 September 2016 a new GP joined the current provider GP in the management team and took control of a re-organisation of the delivery of services as clinical lead GP.

At this inspection we found that

- Staff received appraisals and supervision.
- The practice had taken steps to obtain feedback from patients and had acted upon it.
- All staff that had commenced employment since 01 September 2016 had a contract with Cornwallis Surgery. Staff that had commenced employment prior to 01 September 2016 had contracts with the name of their original employer on the contracts but their terms and conditions remained unchanged. Staff were clear who their current employer was and there was a clear staffing structure.

Summary of findings

At this inspection we also focused on concerns raised by patients in the eight months since the last inspection.

Specifically concerns were that:

- There was a lack of clinical staff available.
- Locum GPs had to be available to advise several surgeries at the same time.
- There was a backlog of investigation results to be processed.
- Prescriptions were taken around from surgery to surgery by staff trying to get them signed by the GP.
- Triaging was being carried out by unqualified staff.
- A concern was raised that not all clinical staff were adequately trained for their roles.
- There was poor telephone access for patients.
- If there were no appointments available at their local surgery, patients were being asked to travel to another surgery in the group to receive care.

We found that:

- Since 01 September 2016 the practice had employed two full time paramedic practitioners and two nurse practitioners and decreased the use of locum GPs to improve the continuity of care.
- The new clinical lead GP had put in place several innovations and was working a significant number of additional hours to ensure that they were implemented successfully.
- There was the equivalent of one whole time GP in regular locum cover per week. The practice used locums from a small pool of four locums that the GP felt were tried and trusted.
- Since 01 September 2016 locum GPs were only asked to cover the patients in the surgery that they were working in for that session.
- Investigation result processing was up to date and there was an effective system in place for the processing of investigations.
- The practice had put in place a telephone results clinic for two evenings a week when patients could book a telephone appointment to discuss test results with the clinical lead GP.
- There was a pharmacy technician employed who managed the repeat prescription service. There was an electronic prescription service available.
- A new system of 'on the day' appointment allocation had been introduced referred to as "management streaming and navigation" and managed by a trained member of the administration staff working to a strict protocol. Any issues outside the protocol were referred immediately to the clinical lead GP via the practice on screen messaging service.
- We found that clinical staff were aware of their limitations and worked within their competencies.
- All patients were now registered at the Cornwallis site. Where available patients would be offered an appointment at their nearest branch, if one was not available then they would be offered an appointment at one of the other surgeries in the group if appropriate.

The areas where the provider must make improvement are:

Ensure that there is a risk assessment and sustainable written contingency plan in place to ensure the safe and effective provision of services and meet the needs of the patient population should the clinical lead GP or other key staff be unavailable to do so.

The areas where the provider should make improvement are:

To continue to seek out, and act on, patient and staff feedback in particular in relation to the efficiency of the telephone system, access to appointments and continuity of care.

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?

Good

At our last inspection on 9 February 2016 the practice was rated Good for providing Safe services. The current rating relates to that report. Recent concerns raised by patients were that:

- Prescriptions were taken around from surgery to surgery by staff trying to get them signed by a GP.

During this inspection we also focused on these issues and found that:

- There were now effective systems in place to process repeat prescriptions.

Are services effective?

Good

The practice is rated as good for providing effective services.

At the inspection on 9 February 2016 we found that there was a lack of evidence of appraisals and personal development plans for all staff.

On this occasion we found that almost all staff had had appraisals and had discussed and recorded personal development plans. Those that had not had an appraisal had been booked but cancelled and rearranged for legitimate reasons.

The practice were relying on the clinical lead GP doing the work of two and a half full time GPs per week.

Recent concerns raised by patients were that:

- There was a backlog of investigation results to be processed.
- Not all clinical staff were adequately trained for their roles.

During this inspection we also focused on these issues and found that:

- There were now effective systems in place to process investigation results.
- We found that clinical staff were aware of their limitations and worked within their competencies.

Are services caring?

Requires improvement

The practice is rated as Requires Improvement for providing caring services.

At the previous inspection data from the National GP Patient Survey showed patients rated the practice lower than others for several aspects of care.

Summary of findings

At this inspection we found that the National GP Patient Survey again showed patients rated the practice lower than others for several aspects of care, however the survey data had been collected prior to the 31 March 2016 and changes had taken place in the practice since then.

Patients who we talked to or filled in comment cards, felt that staff were caring and helpful and treated them with dignity and respect and involved them in their care.

Are services responsive to people's needs?

Good

At the inspection on 19 February 2016 the practice was found to be good for providing responsive services. The current rating relates to that report.

Since that time CQC had received complaints in particular with regard to patient access to the practice and appointments via the telephone system and also continuity of care. There were similar complaints on review websites for each branch on the internet. In view of this we also focused on this aspect of care during this inspection. The practice had however listened to patients, identified the issues and had responded positively since 1 September 2016 to try to resolve the concerns.

It was not yet clear whether these actions had been successful as the changes had recently been implemented and are yet to be embedded and sustained to improve patient experiences to improve continuity of care.

Examples of action taken are:

- Two permanent full time paramedic practitioners had been employed with a parallel reduction in the use of GP locums.
- Extended hours surgeries had been introduced from 6pm to 8.30pm on Monday to Thursday evenings.
- A system was introduced whereby any calls for urgent appointments received after appointments had been filled were passed to a trained 'non clinical navigator' who allocated them to a GP, urgent care practitioner (UCP) or Nurse Practitioner depending on their presenting condition and working to a strict written protocol.
- The practice had introduced an 'electronic clinic' whereby patients could email in non-urgent requests such as administrative issues for the clinical lead GP's attention. Any documents for the patient would be ready for collection by the end of the next working day.
- An evening bookable telephone results clinic had been introduced.

Summary of findings

- A GP's personal assistant had been introduced to ensure the smooth running of patient requests including acute prescriptions and to act as a contact for staff and patients when tracking such requests.

Are services well-led?

Requires improvement

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

At the previous inspection we found that :

- There was a clear leadership structure within the practice and staff felt supported by management. However there was a lack of clarity around terms of employment and the organisational structure for staff.
- The practice had not sought feedback from patients on the services provided. The practice had not conducted a patient survey. The patient participation group had been re-launched very recently and was not yet active.
- All staff had received inductions but staff had not received regular performance reviews.

At this inspection we found that:

- A new leadership structure had recently been put in place and a clear diagram describing the structure was available to staff. There had been a practice meeting at which the plans for the future and staffing structure had been discussed. Staff that we talked to understood the new hierarchical structure. All staff employed after 1 September 2016 had a contract of employment with the current provider. Staff that had commenced employment prior to 1 September 2016 had contracts with the name of their original employer on the contracts but their terms and conditions remained unchanged.
- On this occasion we saw that the practice had carried out two patient surveys, one in June 2016 and one in October 2016 and had also produced and acted upon an action plan in response to the June survey and patient complaints. The practice had also produced a recent newsletter for patients explaining the vision and plans for the practice. The patient participation group was active and had had an initial meeting in June and a meeting in September. The next was planned for later in November and was advertised on the website. The practice had met with a community group to discuss the changes that were taking place at their local surgery.
- Staff had received annual appraisals.
- The new clinical lead GP had accepted that they would have a very heavy workload in the short term. However there was no

risk assessment as to the risk to patients, or sustainable written plan in place, to ensure the safe and effective provision of services and cover the breadth of role of the clinical lead GP and other key staff should they be unable to work.	

Summary of findings

What people who use the service say

The national GP patient survey results were published in July 2016 (The survey was run from July to September 2015 and January to March 2016 and pre dates the most recent practice changes which commenced on 01 September 2016. The survey also only related to the Cornwallis Surgery, not the branches. The results showed the practice was performing below local and national averages for some questions. Three hundred and forty four survey forms were distributed and 98 were returned. This represented 1.6% of the practice's patient list attributed to that surgery at the time (approximately 6000 patients).

- 54% of patients found it easy to get through to this practice by phone compared to the clinical commissioning group (CCG) average of 79% and national average of 73%.
- 81% of patients were able to get an appointment to see or speak to someone the last time they tried compared to CCG average of 88% and national average of 85%.
- 81% of patients described the overall experience of this GP practice as good compared to CCG average of 87% and national average of 85%.
- 67% of patients said they would recommend this GP practice to someone who has just moved to the local area compared to CCG average of 79% and national average of 78%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received five comment cards. Four commented on the service and said that staff were helpful, listened, concerns were taken seriously and the service was good. One said that they had no problem in making an appointment and booking another. The fifth commented that phoning in the morning was 'not good.'

We spoke to 13 patients across all four surgeries. Ten of the patients felt that once they saw a clinician they were felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them. One patient had felt a bit rushed, but had been involved in the decision 'to a degree' and that the clinician was good and helpful. The other two patients were concerned that there was a lack of continuity of care. Ten of the patients said that it had been very difficult to access the practice via the telephone system.

Patient feedback from the comment cards we received was also positive and aligned with these views.

Cornwallis Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector**.** The team included two GP specialist advisers, two additional CQC inspectors, a practice nurse specialist adviser and a practice manager specialist adviser.

Background to Cornwallis Surgery

This recent background should be read in conjunction with that in the last report from the inspection dated 9 February 2016.

The Cornwallis Surgery was taken over by a single GP in July 2015 at the time the location was in special measures. At the time the practice engaged with a consultant firm who provided some managerial support. In October 2015 the practice merged with another within the same building and the provider also took over three further surgeries in the Hastings area, Little Ridge, Shankill and Essenden Road. These are run as branch surgeries. The practice is still accepting new patients and currently has approximately 19,000 patients registered. In February 2015 CQC carried out a comprehensive inspection after which the practice was rated requires improvement overall, requires improvement in the effective, caring and well-led domains and good in the safe and responsive domains. The practice was taken out of special measures.

On 1 September 2016 the consultancy organisation assisting with back office support withdrew and a second GP joined the practice and took over the role of clinical lead GP (male). The newly recruited GP is the only permanent GP currently available. The registered provider (GP provider) is currently unavailable as he is on a sabbatical.

The clinical lead GP is supported by a long term locum (who until recently had been a salaried GP) for eight sessions a week (male) and a long term locum for two sessions a week (female), two Paramedic Practitioners (male) work as urgent care practitioners (UCPs). Two further posts are currently being advertised. The practice also employs two nurse prescribers (both female), one of whom is a community nurse practitioner and triages and carries out home visits. The other is a nurse practitioner who can treat patients with minor illnesses. All non GP clinicians' work is governed by strict protocols as to what conditions they are able to treat and the clinical lead GP is available in person, on the practice internal instant messaging service or by phone for support when required. There are four practice nurses (female) and two health care assistants (female) who work across the four sites. There is also a practice clinician who had been trained to check blood pressures, and measure and weigh patients. The organisational structure was also revised and a net total of seven extra receptionist/administrators have already started or are due to start by the end of November 2016 to help deal with patient access to appointments.

We were told that a further GP (male) was identified and it is hoped will be recruited as a potential partner and is due to start work in May 2017 although the practice hopes to bring the date forward.

Practice opening hours are:

Monday :

Cornwallis Surgery 8.00am to 6.30pm

Essenden Road 8.00am to 6.30pm

Detailed findings

Little Ridge 8.00am to 8pm (8pm to 9 pm telephone results surgery)

Shankill 8.00am to 5.30pm

Tuesday:

Cornwallis Surgery 8.00am to 6.30pm

Essenden Road 1.00pm to 6.30pm

Little Ridge 8.00am to 1.00pm

Shankill 8.00am to 8.00pm

Wednesday:

Cornwallis Surgery 8.00am to 8.00pm

Essenden Road 8.00am to 1.00pm

Little Ridge 8.00am to 6.30pm (8pm to 9pm telephone results surgery)

Shankill 8.00am to 1.00pm

Thursday:

Cornwallis Surgery 8.00am to 6.30pm

Essenden Road 8.00am to 8.00pm

Little Ridge 8.00am to 1.00pm

Shankill 8.00am to 1.00pm

Friday:

Cornwallis Surgery 8.00am to 6.30pm

Essenden Road 8.00am to 6.30pm

Little Ridge 8.00am to 6.30pm

Shankill 8.00am to 5.30pm

Saturday and Sunday: All surgeries are closed.

When the surgeries are closed patients can access the out of hours service by phoning 111.

Services are provided at:

Cornwallis Surgery, Station Plaza Health Centre, Station Approach, Hastings East Sussex. TN34 1BA.

Essenden Road Surgery, 49 Essenden Road, St Leonards-on-Sea, East Sussex , TN38 0NN.

Little Ridge Surgery, 38 Little Ridge Avenue, St Leonards-on-Sea, East Sussex , TN37 7LS.

Shankill Surgery, 21 Fairlight Road, Hastings, East Sussex, TN35 5ED.

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 on 09 February 2016 as part of our regulatory functions. This inspection was planned to check whether the provider was 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.

Breaches of legal requirements were found. As a result, we undertook a focused inspection on 01 November 2016 to follow up on whether action had been taken to deal with the breaches. Additionally we had received information of concern from members of the public regarding some aspects of the practice and we also focused on these concerns raised. As the concerns involved all of the surgeries in the group, we also inspected the branch surgeries as well as the main surgery.

Previously the practice had been owned by another provider and put in to special measures. The current provider took over the running of the practice at the end of July 2015 and inherited the special measures status. In October 2015 the practice merged with another within the same building and the provider also took over three further surgeries in the Hastings area, Little Ridge, Shankill and Essenden Road. These were run as branch surgeries. We carried out an announced comprehensive inspection of Cornwallis Surgery on 9 February 2016. Breaches of legal requirements were found during that inspection within the effective and well-led domains. The practice was rated as requires improvement overall, requires improvement in the effective, caring and well-led domains and good in the safe and responsive domains. The practice was taken out of special measures.

Good

Are services safe?

Our findings

Overview of safety systems and processes

We had received complaints that repeat prescriptions were not being dealt with effectively and in a timely manner. We found that since the new clinical lead GP had commenced, new systems had been put in place to resolve these issues. There was a pharmacy technician who managed the repeat prescriptions across the four surgeries. A GP's personal assistant ensured that acute prescriptions were transported to the correct destination. We saw that processes were in place for handling repeat prescriptions. This included the review of high risk medicines. Two of the nurses had qualified as an Independent Prescriber and could therefore prescribe medicines for specific clinical conditions. They received support from the clinical lead GP for this extended role. Patient Group Directions had been adopted by the practice to allow nurses to administer medicines in line with legislation.

Good

Are services effective?

(for example, treatment is effective)

Our findings

At our inspection in February it had been found that staff were not being provided with regular supervision and regular annual appraisals.

On this occasion we saw that all staff had either received an annual appraisal or in the case of one staff member it had been cancelled for legitimate reasons and a new date set. Staff told us that learning needs were identified and personal development addressed at their appraisal meetings. Almost all staff felt that they received very good supervision. Clinical staff could instant message the clinical lead GP through the practice computer system or by phone and commented that they always received a very prompt response. There were monthly clinical meetings that all clinical staff were invited to and included an opportunity to discuss interesting clinical issues.

We had also received letters of concern from patients since our last inspection that on occasions locums had been asked to cover several surgeries in the absence of other clinical cover. There was also concern from patients that there was a lack of clinical staff available. We saw that the practice had recently written to patients explaining their clinical arrangements and their intention to keep all of the branch surgeries open. We saw that the current rota required that a GP was present at each branch surgery each morning and afternoon that it was open. We saw that there was a GP clinic for a period of at least an hour every morning and afternoon at each branch surgery when they were open. There was additionally a full time Urgent Care Practitioner (UCP) based at the Shankill branch every session that it was open (eight half day sessions a week).

There was a full time (regular) locum GP surgery six sessions a week at Essenden Surgery, with two shorter GP surgeries on Friday mornings and afternoons. Little Ridge had two full (regular) GP locum sessions a week, three shorter GP sessions a week, one UCP session a week and was closed for two sessions a week. The main Cornwallis Surgery had nine shorter GP sessions per week as well as three full GP sessions (including two by a female long term GP locum). Additionally there were seven full nurse practitioner sessions per week and nine full UCP sessions per week. The practice was now providing an extended hours service from 6.30pm until 8pm from Monday to Thursday which rotated around each of the surgeries. Patients could book at whichever surgery they wished and if they could not be offered an appointment at their preferred surgery, they would be offered an appointment at one of the alternative surgeries in the group. The locum that we spoke to said that they were not asked to cover more than one surgery at the time.

Since our inspection of February 2016, there had been concerns raised that test results were not being dealt with promptly and that in the past backlogs had built up. At this inspection we were told that the clinical lead GP had made it a priority to clear the backlog of results when they took over the clinical management role in September 2016. We saw that there was no backlog of results and that there was an effective system in place for the processing and managing of results and investigations.

Concerns had also been raised by patients that not all clinical staff were adequately trained for their roles. At this inspection we found that clinical staff were aware of their limitations and worked within their competencies.

Requires improvement

Are services caring?

Our findings

Kindness, dignity, respect and compassion

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

We received five comment cards. Four commented on the service and said that staff were helpful, listened, concerns were taken seriously and the service was good. One said that they had no problem in making an appointment and booking another. The fifth commented that phoning in the morning was 'not good.'

We spoke with one member of the patient participation group (PPG). They also told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

At the previous inspection in February 2016 The practice was below average for its satisfaction scores on consultations with GPs and nurses. The practice had taken some steps to make improvements, but had continued to be very reliant on the use of locums. Results from the most recent national GP patient survey showed that the practice was still generally below average for its satisfaction scores on consultations with GPs and nurses. However the most recent results were published in July 2016 (The survey was run from July to September 2015 and January to March 2016 and pre dates the most recent practice changes which commenced on 01 September 2016. The survey also only related to the Cornwallis Surgery, not the branches.)

For example:

- 71% of patients said the GP was good at listening to them compared to the clinical commissioning group (CCG) average of 89% and the national average of 89%.
- 72% of patients said the GP gave them enough time compared to the CCG average of 87% and the national average of 87%).
- 93% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 95% and the national average of 95%)
- 72% of patients said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 86% and the national average of 85%).
- 76% of patients said the last nurse they spoke to was good at treating them with care and concern compared to compared to the CCG average of 86% and the national average of 91%.
- 86% of patients said they found the receptionists at the practice helpful compared to the CCG average of 90% and the national average of 87%.

Care planning and involvement in decisions about care and treatment

We spoke to 13 patients across all four surgeries. Ten of the patients felt that once they saw a clinician they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them. One patient had felt a bit rushed, but had been involved in the decision to a degree and that the clinician was good and helpful. The other two patients were concerned that there was a lack of continuity of care. Ten of the patients said that it had been very difficult to access the practice via the telephone system.

Results from the same national GP patient survey showed patients responses to questions about their involvement in planning and making decisions about their care and treatment were lower than local and national averages. For example:

- 75% of patients said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 87% and the national average of 86%.
- 66% of patients said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 83% and the national average of 82%.
- 71% of patients said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average of 87% and the national average of 85%.

The practice were aware of these results and had carried out a detailed analysis of the reasons for low patient satisfaction in their initial presentation to the CQC inspection team and produced an explanation and the actions that they were taking to improve.

Requires improvement

Are services caring?

The practice identified reasons for the low satisfaction rate in caring which included:

- A lack of continuity of care due to an over reliance on locum GPs.
- What was now one practice had been working as four separate surgeries in isolation.
- A lack of engagement with the local community and no active PPG.

In response they:

- Decreased the use of locum GPs.
- No longer used locums who under-performed or received poor patient feedback and used locums from a pool of four trusted locums.
- Removed the limit of one problem per consultation.
- Encouraged the integration of staff between surgeries and engaging staff in the new plans.
- Engaged with patients via surveys, meeting with a community group and restarted and encouraging the patient participation group.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

Since the last inspection in February 2016 we had received letters of concern from patients about access to the practice via the telephone and also access to appointments. Many of the complaints were received in September. On the day of the inspection we spoke to 13 patients. The majority of patients (ten) found the practice very difficult to access by telephone and had often had to ring many times to get through. Patients also felt that there were not enough appointments available and that there was a lack of continuity of care because they saw different locums each time. The practice were aware of the issues, and had tried a number of changes to the call system, however, at the time of the inspection patients were still having problems. The practice had also employed additional reception and administration staff across the four surgeries. By the end of November a net total of seven extra staff will have commenced work to ensure that there were three staff to answer the phones at each surgery. Lines remained open at all surgeries from 8am to 6.30pm even when branch surgeries were closed to appointments.

Other steps that the practice had taken to try to improve patient access since 01 September 2016 included:

- The introduction of extended hours surgeries from 6pm to 8.30pm on Monday to Thursday evenings.
- Introducing a system whereby any calls for appointments received after appointments had been filled were passed to a 'non clinical navigator' who was a trained member of administrative staff who allocated them to a GP, UCP or Nurse Practitioner depending on their presenting condition and working to a strict written protocol. If a patient has a medical problem not included in the protocol, the senior GP was sent an urgent screen message. Several members of staff confirmed that he would reply very promptly to advice on the course of action.
- Introducing an electronic clinic whereby patients could email in non-urgent requests such as administrative issues for the GPs attention. Documents for collection by patients would be ready by the end of the next working day.
- An increase in the number of 'permanent' GP appointments, although the majority of these were with the new GP.
- The clinical lead GP also ran a results clinic between 8pm and 9pm two evenings a week whereby patients could book telephone appointments to discuss the results of tests.
- These innovations were aided by the practice employing a GPs personal assistant. This role was created following feedback from staff. She was responsible for transferring paperwork, prescriptions and fit notes to a patient's chosen destination. She was also a point of contact for staff and patients wishing to track the progress of a request.
- The practice figures showed that these innovations had led to an increase in patient appointments per week (with GPs, nurse practitioners, and urgent care practitioners, including telephone, electronic clinic, results clinic and navigator's clinic appointments) from just over 900 in August 2016 to just under 1300 in October 2016. The figures also showed that the proportion of appointments that were with a permanent GP had risen significantly.

The practice could not demonstrate that the changes had embedded significantly to improve services and more time was required to determine impact, although staff felt that the system worked better and that there had been fewer complaints recently.

Are services well-led?

Requires improvement

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

Our findings

Governance arrangements

At the previous inspection it was found that the level of staff understanding and awareness surrounding the organisational structure was inconsistent. Some staff were uncertain who their employer was. We found there was a lack of clarity and openness surrounding organisational and employer lines of responsibility. It was also found that staff roles were not clearly defined.

On this inspection we found that there was a clear staffing structure which had been described to staff in a recent staff newsletter. There had also been a full staff meeting at which the vision and aims for the practice as well as the staffing hierarchy had been discussed. Staff told us that the meeting was very useful and encouraging. All staff were aware of the new structure, their roles within the practice and who they were employed by. All staff employed since the 1 September 2016 had received a contract with Cornwallis Plaza Surgery. Staff that had commenced employment prior to 1 September 2016 had contracts with the name of their original employer on the contracts but their terms and conditions remained unchanged. The practice told us that they would be issuing an updated notice to clarify this.

At the time of the inspection there were two GPs. The registered provider was on a sabbatical and we were not informed of any plans at the time for him to carry out any clinical work at the practice. Significant changes in practice infrastructure had taken place in the two months previous to the inspection in response to patient (and practice) concerns about telephone access, patient access to appointments and continuity of care. The new GP had introduced several innovations to maximise the efficient use of GP time and thus reduce the demand for unnecessary face to face appointments and effectively increase the number available for consultations that needed to be face to face rather than by telephone. However this meant that they were working the hours of more than two and a half full time GPs, starting at 8am and working to 8pm or 9pm on Monday to Thursday (6.30 pm on a Friday) and the arrangements involved them driving between three or four surgeries each day holding surgeries and supporting staff at each. They told us that this was a situation that they had planned for and was going to continue for a total of six months whilst the changes became embedded and until a new GP partner arrived to share the workload. They were supported by a salaried GP who had just changed roles to that of a locum, but was continuing to work the same eight sessions a week. There were also two sessions covered by other regularly used GP locums. Most non-medical clinical staff (UCPs and nurse practitioners) said that they felt well supported by the lead GP and that he was quickly accessible in person, by phone or by the internal messaging service if needed. One clinical staff member found it more difficult to obtain advice from locums. There was a monthly clinical meeting which all clinicians were expected to attend. One member of staff felt they would like more general supervision.

However at the time of the inspection there had not been time for the new systems to become embedded or evidence as yet that the changes had been successful in their aims. Additionally the employment of paramedic and nurse practitioners required GP support in addition to the GP's general workload and currently there was only one permanent GP covering that role in a practice of 19,000 patients. They were supported by locum GPs working the equivalent of one whole time equivalent GP a week between them. Currently the practice was relying very heavily on the presence of the lead GP. They told us that they were not expecting to take time off, but if they were forced to do so due to unforeseen circumstances, they felt that the locums that they used would help in the short term and that their partner, the current practice provider, (who was currently absent) would return to cover their role in the medium to long term. There was however no written business continuity plan detailing this to ensure that the practice would continue to run safely and effectively in the event that they were unable to carry out their role. The second GP who was the registered provider was currently on a sabbatical.

Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system in place which was devised three months in advance for all the different staffing groups to ensure enough staff were on duty. The practice had identified a need to increase the number of administrative/reception staff at each branch to improve telephone access for patients. A net total increase of seven staff had been employed. Some had already started and the remainder were to commence work by the end of November 2016. One member of the clinical staff felt that

Are services well-led?

Requires improvement

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

the practice would benefit from additional nurse cover to help with cover should a staff member be unavailable and other staff members felt that the practice would benefit from more GPs or emergency clinicians.

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

At the previous inspection it was found that the registered provider did not always seek and act on feedback from relevant persons and other persons on services provided in the carrying on of the regulated activity, for the purposes of continually evaluating and improving such services.

On this occasion we saw that the practice had carried out two patient surveys, one in June 2016 and one in October 2016 and had also produced and acted upon an action plan in response to the June survey and patient complaints. The recent survey showed that there was improvement in patient satisfaction since June in a number of key areas. Most notably these were opening hours, online bookings and prescription requests, same day and pre-bookable appointments, although there was still some room for improvement. There was also an improvement in satisfaction with the clinician that they saw and the overall satisfaction with the appointment. There was however a decrease in satisfaction with the reception and waiting room appearance. The practice had also produced a recent newsletter for patients explaining the vision and plans for the practice. This was available on the website, in the surgeries and had been emailed to patients that had registered their email address. The patient participation group was active and had had an initial meeting in June and a meeting in September. The next was planned for later in November and advertised on the website. The practice had also had a meeting with a community group local to one of the branch surgeries to discuss their concerns and explain the plans for the future.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **How the regulation was not being met:** The provider was not assessing, monitoring and mitigating risks relating to the health safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity. The provider did not a have risk assessment and sustainable written contingency plan in place to ensure the safe and effective provision of services and meet the needs of the patient population should the clinical lead GP or other key staff be unavailable to do so. This was in breach of regulation 17 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014