Priory Avenue Surgery

Quality Report

2 Priory Avenue
Caversham
Reading
RG4 7SF
Tel: 01189 472431
Website: www.prioryavesurgery.co.uk

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

Ratings

Overall rating for this service

Are services safe?	
Are services effective?	
Are services responsive to people's needs?	
Are services well-led?	

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

Our previous announced comprehensive inspection at Priory Avenue Surgery on 26 January 2017 found breaches of regulations. The overall rating for the practice was inadequate. The practice was placed into special measure and conditions were applied to the registration. The full comprehensive report on the January 2017 inspection can be found by selecting the 'all reports' link for Priory Avenue Surgery on our website at www.cqc.org.uk.

This inspection was an unannounced focused inspection carried out on 1 June 2017 to check that the practice was complying with the conditions imposed upon their registration arising from the breaches in regulations that we identified in our previous inspection on 26 January 2017. This report covers our findings in relation to those conditions and also additional improvements made since our last inspection. Due to the nature of this inspection the ratings have not been reviewed.

Our key findings were as follows:

- Clinical governance systems in place showed improvement but were in early stages of implementation and it was too early to evaluate the sustainability of the structures and systems put in place.
- GP and nursing staffing levels had been increased to provide a wider range of appointments for patients. The evidence indicates that although sufficient staff are rostered to provided clinical services the practice remains reliant upon high cost locum and agency staff to deliver advice and treatment.
- Governance structures had been put in place including daily team huddles and weekly clinical meetings.
- There was a system in place to ensure test results were reviewed and action taken, when required, in a timely manner.
- A system was in place to ensure the timely production of repeat prescriptions.
- A process had been introduced to ensure correspondence from hospitals and other agencies was filed into patient records and reviewed by clinicians in an appropriate timescale.
- There was an open and transparent approach to safety and an effective system in place for reporting and recording significant events.

Summary of findings

- Training needs had been identified but not all mandatory or relevant training had been completed. The timetable for completion of identified training had not been kept up to date.
- Annual reviews for patients with long term conditions had demonstrated improvement. However, reviews of patients on less than four or four or more repeat medicines had been decreased compared to the previous inspection.
- We found additional risks relating to monitoring of fridge temperature checks and disposable curtains were not changed on a regular basis. This demonstrates that whilst improvements have been made the provider has not appropriately monitored, mitigated and taken timely action against the risks and concerns we have identified in this notice.

The areas where the provider must make improvements are:

- Maintain effective and sustainable systems and processes to ensure good governance in accordance with the fundamental standards of care.
- Ensure the monitoring of medicine fridge temperatures is completed in accordance with the practice policy and action taken when required.
- Review and improve the systems in place to ensure the risk of cross infection is minimised.
- Ensure all staff has received training relevant to their role.

In addition the provider should:

- Improve the outcomes for patients with dementia.

Following our previous inspection on 26 January 2017 we applied six conditions upon the practice registration that required urgent action by the practice. The improvements found at this focussed inspection have enabled CQC to remove three of these conditions. However, the practice remains in special measures as further improvement is required and additional breaches of regulation were found. The systems were in their early stages of implementation and their sustainability could not be assessed. Special measures will continue to give patients who use the service the reassurance that the care they get should improve.

The service will be kept under review and if needed could be escalated to further urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service.

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?

- The practice had demonstrated some improvement and ensured timely processing of repeat prescription requests.
- There was an effective system in place for reporting and recording significant events. Staff understood their responsibilities to raise concerns, and to report incidents and near misses.
- Lessons were learnt from significant events and staff we spoke to informed us that significant events were discussed during the team meetings.
- The practice had reviewed and improved clinical staffing levels. However, staff we spoke with on the day of inspection raised concerns regarding poor staffing levels of non-clinical staff.
- We identified some additional risks during this follow up inspection. For example,
- Records showed fridge temperature checks were not carried out daily to ensure medicines were kept at the required temperatures.

Are services effective?

- The practice had demonstrated improvement in monitoring of document management system, referral management system and blood test results.
- The practice had reviewed and improved the systems in place to effectively monitor medicine reviews for patients with long term conditions. However, reviews of patients on less than four or four or more repeat medicines had been decreased compared to the previous inspection.
- In addition, the practice was required to improve the outcomes for patients with dementia. For example, 61% (20 out of 35 patients) structured annual reviews had been undertaken for patients with dementia.
- The practice had conducted a review of the staffing levels and additional clinical staff had been appointed although the majority of these staff were either locums or agency staff.
- Role specific training had not been completed in a timely manner.

Summary of findings

Are services responsive to people's needs?

- The practice had increased the clinical staffing levels and improved the availability of appointments. However, we noticed that the next pre-bookable appointment with GPs were available within three weeks.
- We saw evidence on the rosters that during the two weeks prior to the inspection there were an average of 3.3 GPs whole time equivalent (WTE) and 1 ANP (advanced nurse practitioner) WTE compared to 1.4 GP WTE and 0.8 ANP WTE we found during the previous inspection.
- Information about how to complain was available and easy to understand and evidence showed the practice responded quickly to issues raised.

Are services well-led?

- The practice had reviewed and improved their clinical governance systems, the staffing structures and operating systems. The North and West Reading Clinical Commissioning Group (CCG) had worked alongside the practice in implementing the changes and had withdrawn their input in the last month. It was, therefore, too early to test the sustainability of the practice governance and leadership capabilities into the future.
- We found additional breaches of regulation that had not been identified by the practice prior to inspection, which demonstrated that governance monitoring procedures were not always implemented consistently or effectively.
- The practice was seeking to recruit a permanent practice manager, a salaried GP and two new reception staffs. However, during the inspection we observed a heavy reliance upon agency and locum staffing to provide appropriate levels of clinical input. Whilst some of these staff were committed to work at the practice in the medium term others were not and this did not offer continuity of care to patients.
- The practice had appointed a lead practice nurse whose duties were split with a sister practice.
- The provider was regularly submitting weekly information requested under Section 64 of the Health and Social Care Act 2008. On the day of inspection we verified this information, which was correctly submitted.
- The practice had made improvements in governance and monitoring of an electronic document management system, referral management system and blood test results.

Summary of findings

What people who use the service say

We also spoke with 10 patients and a member of the patient participation group (PPG). They also told us they had noticed some improvements in the last three months. However, some patients raised concerns that they had to wait long time to get through to the practice by telephone and would like to see further improvement in the availability of pre-bookable appointments. All patients we spoke with reported improvement in the turnaround of their prescription requests within 48 to 72 hours.

Prior to the inspection we contacted the local Healthwatch to seek their feedback about their recent enter and view visit (two weeks before this CQC inspection visit) at the Priory Avenue Surgery. They also informed us that some patients said they had noticed some improvement in the waiting time of their repeat prescription requests. However, most patients raised concerns that they were still experiencing issues with the repeat prescriptions (both delays and errors), poor continuity of care due to poor availability of appointment with named GPs and reliant upon locum GPs. They also informed us they found two different notices in the waiting area regarding processing time (48 hours and 72 hours) for repeat prescriptions. We saw both notices on the day of inspection. However, the practice assured us that they were processing repeat prescriptions within 48 hours and removed the 72 hours notice immediately.

As part of our inspection we also asked for CQC comment cards to be completed by patients on the day of inspection. All of the 11 patient CQC comment cards we received were positive about the service experienced. Patients providing positive feedback said staff were helpful, caring and treated them with dignity and respect.

We saw the NHS friends and family test (FFT) results for three months (January to March 2017) and 50% patients were likely or extremely likely recommending this practice. However, we noted an improvement in April 2017 results and 62% patients were likely or extremely likely recommending this practice.

Priory Avenue 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 a CQC GP specialist advisor and a second CQC inspector.

Background to Priory Avenue Surgery

Priory Avenue Surgery provides primary medical services to the Caversham area of Reading from a two-storey converted dwelling, which has undergone several extensions over the last 10 years. There are approximately 6,800 patients registered with the practice. This had reduced from 8,000 when we last inspected. The practice serves a population in an area of mainly average deprivation but with some pockets of low deprivation.

The practice has been through a challenging four years with three changes in provider and a number of GPs and managers leaving, which has caused instability in the practice. One Medicare Ltd took over the contract following a procurement exercise led by the local clinical commissioning group (CCG) in September 2016.

At the time of the inspection the service offers 3.3 whole time equivalent (WTE) GPs, 1 WTE advance nurse practitioner (ANP), 1 WTE practice nurse and 0.4 WTE health care assistant sessions every week. There were male and female GPs available. The practice has an Alternative Provider Medical Services (APMS) contract.

All services are provided from: 2 Priory Avenue, Caversham, Reading, Berkshire, RG4 7SF.

Why we carried out this inspection

We undertook a comprehensive inspection of Priory Avenue Surgery on 26 January 2017 under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The practice was rated as inadequate and was placed into special measure. Conditions were also imposed upon the registration of the practice. The full comprehensive report following the inspection on 26 January 2017 can be found by selecting the 'all reports' link for Priory Avenue Surgery on our website at www.cqc.org.uk.

We undertook a follow up an unannounced focused inspection of Priory Avenue Surgery on 1 June 2017. 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, (Regulated Activities) Regulations 2014, to look at the overall quality of the service under the Care Act 2014. This inspection was carried out to review in detail the actions taken by the practice to improve the quality of care and to confirm that the practice was now meeting legal requirements and complying with the conditions applied to the registration. We did not rate the practice during this focussed inspection.

How we carried out this inspection

Prior to the inspection we contacted the North and West Reading Clinical Commissioning Group (CCG), NHS England area team and local Healthwatch to seek their feedback

Detailed findings

about the service provided by Priory Avenue Surgery. We also spent time reviewing information that we hold about this practice including the data provided by the practice in advance of the inspection.

During our visit we:

- Spoke with two GPs, an advanced nurse practitioner, a practice nurse, a diabetic specialist nurse, a health care assistant and three members of the administration team. We met with the interim practice manager.
- Received and reviewed seven CQC staff questionnaires.
- Also spoke with 10 patients and a member of the patient participation group (PPG).
- Observed how patients were being cared for in the reception area.
- The GP specialist advisor reviewed an anonymised sample of the personal care or treatment records of patients. These were tested to corroborate that reviews of long term conditions and medicine reviews were taking place.
- Reviewed 11 comment cards where patients shared their views and experiences of the service.
- Looked at information the practice used to deliver care and treatment plans.

Are services safe?

Our findings

When we inspected the practice in January 2017, we rated the practice as inadequate and placed it in special measures. We rated provision of safe services inadequate and urgent conditions were applied to the registration of the practice. We found the concerns related to:

- Insufficient numbers of staff on duty to maintain patients safety.
- Ineffective system in place for reporting and recording significant events.
- Ensuring prescriptions were processed, checked and authorised in a timely manner.

At this inspection we found some improvement. We noted that the CCG had worked on site with the practice to support their improvement plan. The CCG had withdrawn their input in the last month and it was too early to assess whether improvements made were sustainable. It was therefore necessary to retain a condition upon the provider to ensure they provided suitably qualified staff in sufficient numbers to maintain safe provision of services. Whilst production of prescriptions had improved we could not test if the improvement could be sustained.

Safe track record and learning

We noted there was an effective system in place for reporting and recording significant events.

- Staff told us they would inform the management of any incidents and there was a recording form available on the practice's computer system. The incident recording form supported the recording of notifiable incidents under the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).
- We saw evidence that when things went wrong with care and treatment, patients were informed of the incident, received reasonable support, truthful information, a written apology and were told about any actions to improve processes to prevent the same thing happening again.
- The practice carried out a thorough analysis of the significant events. Significant events were discussed during clinical meetings.
- We reviewed records of significant events and incidents that had occurred during the last five months. There was evidence that the practice had learned from significant events and communicated widely to support improvement. For example, we saw an analysis of a significant event escalated by a clinical staff regarding poor monitoring of blood test results. The provider had investigated the incident, reviewed clinical staffing, allocated dedicated administration time for regular GP to deal with the back log and review action on test results in a timely manner. We saw an audit sheet was used to monitor this task.

Overview of safety systems and process

- We observed disposable curtains in four clinical rooms had passed their change by date. The curtains were due to be replaced in February 2017 but remained in use.
- Records showed fridge temperature checks were not carried out daily to ensure medicines were kept at the required temperatures. We found significant gaps in fridge temperature monitoring sheet for the last three months. The practice was unable to demonstrate that the temperatures had been checked daily and that the medicines held in fridges were therefore being maintained within relevant temperature ranges. Staff we spoke with informed us there was no spot check system in place. The practice could not be assured that medicines requiring refrigeration were always being kept at appropriate temperatures, that risk to patients had not been identified by the practice prior to inspection, which demonstrated that governance monitoring procedures were not always discharged consistently or effectively.

Monitoring risks to patients

We found that improvement had been achieved in processing requests for repeat prescriptions.

- The practice demonstrated that the previous backlog of repeat prescription requests had been cleared by 1 March 2017.
- Our review of the repeat prescriptions awaiting processing identified that repeat prescriptions were being processed on the day of receipt to await clinician authorisation.
- The prescriptions produced on the day before inspection had been processed and we saw these were authorised by clinicians before we concluded the inspection. GPs were allocated time at the end of their

clinic to check and authorise prescriptions. If they had any concerns relating to the repeat prescription they followed this up with the patient during the protected time at the end of their clinic.

- The 10 patients and a member of the patient participation group (PPG) we spoke with all reported improvement in the turnaround of their prescription requests within 48 to 72 hours or the medicines were available to collect from their chosen pharmacy within a week.
- Staff told us there were usually enough clinical staff to maintain the smooth running of the practice and to keep patients safe. However, most staff raised concerns regarding appropriate staffing levels of non-clinical staff. The practice manager showed us records to demonstrate the actual staffing levels and skill mix. There was evidence of the provider continuing a recruitment campaign to recruit permanent salaried GPs and the interim practice manager (working across sister practice) informed us they were seeking to recruit a permanent practice manager and two reception staff.

Arrangements to deal with emergencies and major incidents

We undertook observations around the practice to assess the capability to deal with an emergency. We found:

- The practice had adequate arrangements in place to respond to emergencies and major incidents.
- The practice had a defibrillator available on the premises and oxygen with adult mask. A first aid kit and accident book were available.
- Emergency medicines were easily accessible to staff in a secure area of the practice.

Are services effective?

(for example, treatment is effective)

Our findings

When we inspected the practice in January 2017, we rated the practice as inadequate and placed it in special measures. We rated provision of effective services inadequate and urgent conditions were applied to the registration of the practice. We found the concerns related to:

- Processing correspondence from other providers of care was not undertaken in a timely manner placing patients at risk.
- A backlog of summarisation of information into medical records.
- Completing medicine reviews for patients with long term conditions and those taking four or more medicines was below average.

At this inspection we found improvements had been made.

Effective needs assessment

The practice had reviewed their systems for dealing with blood test results. Each GP on duty was allocated time during their clinics to review and action incoming test results.

- We found the practice was following up on blood test results and had an effective monitoring system in place to ensure that all pathology results across the practice were managed in a timely manner and saved in the patient records.
- On the day of inspection the results awaiting GP review and action were those that had arrived on 27 May 2017. There had been an improvement in the system to deal with incoming test results. GPs we spoke with told us that the increase in clinical staff time provided them with the opportunity to review and decide action on test results in a timely manner.
- There was a system in place to ensure that when a GP who had requested a blood test was not on duty the result of the test was allocated to a colleague.

Management, monitoring and improving outcomes for people

The practice had cleared the backlog of summarising and correspondence from other providers of health and social care in compliance with the conditions applied in February 2017.

- The practice had acted on correspondence in a timely manner.
- The arrangements for managing and monitoring Docman were effective to ensure patients were kept safe. (Docman is an electronic document management and transfer system which enabled the practice to organise, workflow, track and securely send and receive healthcare documents electronically).
- We checked Docman records of four GPs and found correspondence in all inboxes were managed efficiently; there was a total of 196 items across two of the GPs inboxes dated back to 26 May 2017. There was a dedicated member of staff responsible for monitoring this and we saw an audit or allocation sheet was used to monitor this task.
- All pathology results across the practice were managed in a timely manner and saved in the patient records. The earliest blood test result awaiting action was dated back to 27 May 2017.
- The practice had taken steps to ensure effective monitoring of referral management system. We saw there were 40 outstanding referrals and earliest was dated back to 27 May 2017.
- We noted that all items of correspondence had been scanned and placed into Docman. This included directing the documents to clinicians to review and take action.

The practice had addressed some concerns raised during previous inspection and explained the improvements they had made in the system for reviewing patient medicines. We observed that electronic prescribing prompts were in place and acted on to improve patient's outcomes. We noted that the pharmacist and a diabetic nurse had taken the lead role in carrying out medicine reviews for patients with long term conditions.

- We found that on average 86% structured annual reviews had been undertaken for patients with long term conditions including diabetes, asthma, chronic obstructive pulmonary disease and chronic heart disease.
- Medicine reviews for patients with dementia were 61% (20 out of 35 patients).
- We saw the practice had not shown improvement and repeat medicines reviews had decreased from 56% to 44% of patients on less than four repeat medicines.

Are services effective?

(for example, treatment is effective)

- We saw repeat medicines reviews had decreased from 75% to 68% of patients on four or more repeat medicines.

Effective staffing

- The practice had conducted a review of the staffing levels in accordance with the conditions applied to their registration following their last inspection. Additional clinical staff had been appointed although the majority of these staff were either locums or agency staff. Whilst some of these staff were committed to work at the practice in the medium term others were not and this did not offer continuity of care to patients.
- We noted that appointments to the posts of lead practice nurse and a further practice nurse had been achieved. The practice had a salaried GP, a clinical lead shared between two practices and one of the locum GPs working at the practice had longer term commitment to the practice to improve continuity of care.
- The practice was seeking to recruit a permanent practice manager, a salaried GP and two new reception staffs. The North and West Reading Clinical Commissioning Group (CCG) had worked alongside the practice in implementing the significant changes and had withdrawn their input in the last month. It was, therefore, too early to test the sustainability of the staffing and leadership capabilities into the future.
- We received seven completed CQC staff questionnaires and spoke with two members of the administration team. All reported that they had seen an improvement in clinical staffing. However, all members of staff expressed concerns that the administrative support team remained under pressure due to poor non-clinical staffing levels and that it was difficult to keep up with their work when staff absences occurred.
- The GPs and nursing staff we spoke with told us that their ability to maintain an effective service and cope with medical administration tasks had improved since clinical staffing levels had been increased.
- On the day of inspection the sufficient clinical staffing to maintain a service that protected the health and welfare of patients. However, only one staff was working at the reception in the morning and we observed that answering three telephone calls were missed due to staff shortage. We also noted that emergency staff leave had affected the cover available.
- Staff training had not been completed for all staff and we found significant gaps in the training matrix. This was confirmed on the day of inspection and aligned with the training information supplied in the section 64 information returns supplied up to 19 May 2017 by the provider. However, the practice informed us they were in the process of arranging internal training sessions with workforce development director to complete all role specific training by end of June 2017.

Coordinating patient care and information sharing

- The practice had cleared the backlog of referrals awaiting processing found during the last inspection. There were no referrals outstanding from earlier than 27 May 2017. Data showed that referrals were being made within a week of the decision to refer. There was a system in place to ensure urgent two week wait referrals were processed within a day of the decision to refer.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

When we inspected the practice in January 2017, we rated the practice as inadequate and placed it in special measures. We rated provision of responsive services inadequate and urgent conditions were applied to the registration of the practice. We found the concerns related to:

- The levels of staffing were not adequate to meet the needs of the patient population.
- Patients reported that they were not always able to access appointments. Patients were being referred to the local walk in centre due to a lack of capacity with the nursing staff.

At this inspection we found some improvement. We noted that the CCG had worked on site with the practice to support their improvement plan. The CCG had withdrawn their input in the last month and it was too early to assess whether improvements made were sustainable. It was therefore necessary to retain a condition upon the provider to ensure they provided adequate levels of staffing to meet the needs of the patient population.

Responding to and meeting people's needs

We noted that the practice had undertaken a review of patient demand to determine the correct level of service provision and resource. The demands of the practice population were understood and systems were in place to address identified needs in the way services were delivered.

- We observed clinical staffing levels had increased. We reviewed the rosters for GPs and nurses. These showed us that since 8 May 2017, on every Monday, Wednesday and Friday there had been at least three GPs working and on Tuesday and Thursday there were at least two GPs working. This included one or two GPs offering routine appointments and one duty doctor dealing with telephone triage of patients seeking urgent advice or treatment and seeing those patients requiring face to face consultation on an urgent basis. The rota also included at least one advanced nurse practitioner (ANP) and a practice nurse each morning and afternoon. The ANPs undertaking duties were trained to a level to deal with minor illnesses and were qualified prescribers. Staff we spoke with told us they had seen an increase in clinical staffing levels in the last three months. The practice was providing sufficient clinical input to maintain patient safety.
- All of the 11 patient CQC comment cards we received were positive about the service experienced. Patients providing positive feedback said staff were helpful, caring and treated them with dignity and respect.
- We also spoke with 10 patients and a member of the patient participation group (PPG). They also told us they had noticed some improvements in the last three months. However, some patients raised concerns that they had to wait long time to get through to the practice by telephone and would like to see further improvement in the availability of pre-bookable appointments.
- We saw the NHS friends and family test (FFT) results for three months (January to March 2017) and 50% patients were likely or extremely likely recommending this practice. However, we noted an improvement in April 2017 results and 62% patients were likely or extremely likely recommending this practice.

Access to the service

- The practice had reviewed the availability of appointments. This resulted in an increase in the number of appointments offered since our previous inspection on 26 January 2017.
- The practice offered pre-bookable appointments that could be booked up to four weeks in advance, urgent appointments were also available for patients that needed them.
- We checked the online appointment records of GPs and noticed that the next pre-bookable appointments with GPs were available within three weeks. Urgent appointments with duty GP, ANP or nurses were available the same day. ANP's were qualified to both prescribe and treat minor illnesses.
- Next pre-bookable appointment for cervical screening with a trained practice nurse was available within one week.
- The practice had provided CQC with data relating to the availability of appointments in the last three months. We reviewed the appointments offered since 8 May 2017 and these corresponded with the information the practice had provided.

Are services responsive to people's needs?

(for example, to feedback?)

- We saw evidence on the rosters that during the two weeks prior to the inspection there were an average of 3.3 GPs whole time equivalent (WTE) and 1 ANP WTE compared to 1.4 GP WTE and 0.8 ANP WTE we found during the previous inspection.

The practice had a system in place to assess:

- whether a home visit was clinically necessary; and
- the urgency of the need for medical attention.

The practice operated a triage system for urgent on the day appointments. Patients were offered an urgent appointment, telephone consultation or a home visit where appropriate. In cases where the urgency of need was so great that it would be inappropriate for the patient to wait for a GP home visit, alternative emergency care arrangements were made. Clinical and non-clinical staff were aware of their responsibilities when managing requests for home visits.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. We looked at 12 complaint received in the last four months and found that all written or verbal complaints had been addressed in a timely manner. When an apology was required this had been issued to the patient.

Lessons were learnt from concerns and complaints and action was taken to as a result to improve the quality of care. For example, we observed that most of the complaints were regarding delays in processing the repeat prescriptions. However, we noted that the practice had improved in this area and did not receive any complaints regarding repeat prescriptions during April and May 2017.

Are services well-led?

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

Our findings

When we inspected the practice in January 2017, we rated the practice as inadequate and placed it in special measures. We rated provision of well-led services inadequate and urgent conditions were applied to the registration of the practice. We found the concerns related to:

- a lack of effective and sustainable clinical governance processes and systems to identify, assess and monitor risk, to ensure that all patients were able to access timely, appropriate and safe care.

At this inspection we found some improvements had been made. However, it was too early to assess the sustainability of the improvements made.

Governance arrangements

The practice had reviewed and amended their clinical governance systems to comply with the conditions applied following the inspection on 26 January 2017.

- The lead GP had been allocated administration and management time for one day each week.
- The interim practice manager (working across a sister practice) had reviewed, in conjunction with officers of North and West Reading Clinical Commissioning Group (CCG), the staffing structures and operating systems within the practice. This resulted in an increase in clinical staff on duty and reorganisation of the clinics. However, the CCG had withdrawn their input in the last month. It was, therefore, too early to test the sustainability of the practice governance and leadership capabilities into the future.
- The backlogs in production of prescriptions, summarising, reviewing test results, scanning and clinical correspondence had been cleared. Systems had been established to deal with all the above in a timely manner.
- Most of the gaps in training had either been addressed or were recognised and training sourced to complete them.
- Clinical meetings were held on a weekly schedule and staff huddles continued to be held on a regular basis.
- We saw the provider was regularly submitting weekly information requested under Section 64 of the Health and Social Care Act 2008. On the day of inspection we verified this information, which was correctly submitted.

Whilst there had been improvement in governance capacity and processes these had only been in place since March 2017 and were in early stages of implementation. The North and West Reading Clinical Commissioning Group (CCG) had worked alongside the practice in implementing the changes and had withdrawn their input in the last month. It was, therefore, too early to evaluate whether the changes made would be sustainable and deliver consistent and appropriate governance of the practice.

The practice was seeking to recruit a permanent practice manager, a salaried GP and two new reception staffs. However, staff raised concerns regarding poor non-clinical staffing levels, some training remained outstanding and we found additional breaches of regulation that had not been identified by the practice prior to inspection, which demonstrated that governance monitoring procedures were not always discharged consistently or effectively. It was, therefore necessary to allow the provider a period of time to demonstrate that the systems and processes implemented so far were effective and sustainable.

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:** We found the provider did not have effective and sustainable systems and processes to ensure good governance in accordance with the fundamental standards of care. In particular: Continue to implement a sustainable system to ensure outstanding and future medicines reviews of patients on less than four and four or more repeat medicines are undertaken and fulfil recruitment of permanent clinical and non-clinical staff including a practice manager. Ensure the monitoring of medicine fridge temperatures is carried out and recorded. Review and improve the systems in place to ensure the risk of cross infection is minimised. Regulation 17(1)

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **How the regulation was not being met:** We found the registered person did not operate effective systems to ensure all staff have received training relevant to their role. Regulation 18(2)