

# Wake Green 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

Inadequate



Are services safe?

Inadequate



Are services effective?

Inadequate



Are services caring?

Good



Are services responsive to people's needs?

Requires improvement



Are services well-led?

Inadequate



# Summary of findings

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## Overall summary

### Letter from the Chief Inspector of General Practice

We previously carried out an announced comprehensive inspection at Wake Green Surgery on 17 August 2015. The overall rating for the practice at the time was requires improvement. We found breaches in relation to regulation 12 (safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The full comprehensive report on the Wake Green Surgery inspection can be found by selecting the 'all reports' link for Wake Green Surgery on our website at [www.cqc.org.uk](http://www.cqc.org.uk).

This inspection was undertaken to follow up progress made by the practice since the inspection on 17 August 2015. It was an announced comprehensive inspection on 16 December 2016. Overall the practice is now rated as inadequate.

Our key findings were as follows:

- Although the practice had taken some action since our previous inspection we continued to identify issues

relating to the provision of safe services. This included prescription safety and security, staffing arrangements and support and with the effective monitoring of safety arrangements.

- There had been some improvements in the management of risks to patients although there was a lack of consistency in the effective assessment and monitoring of those risks.
- Significant events and incidents were generally well managed but there was little evidence of shared learning with all staff and we saw evidence of opportunities for learning missed.
- Staff made use of current evidence based guidance in the provision of care and had the skills, knowledge and experience to deliver effective care and treatment. However, it was difficult to ascertain the level of supervision and support that all staff had received as there was no formal system in place to monitor this and records seen were incomplete.
- The practice did not always respond in a timely way to patient information received or when making referrals leading to potential delays in patients care and treatment.

# Summary of findings

- Working relationships with health and social care professionals were in place to understand and meet the range and complexity of patients' needs. However, health and social care professionals experienced a range of difficulties when working with the practice which impacted on patient care.
- Patients said they were treated with compassion, dignity and respect. Results from the national GP patient survey showed patients rated the quality of consultations in line with others but slightly lower than others in relation to involvement in decisions about their care and treatment.
- Information about services and how to complain was available and easy to understand. The practice responded to complaints in an open and honest way. However, we saw trends in the complaints that had not reviewed to identify where systems and processes may be improved.
- Not all patients said they found it easy to make an appointment. The practice was taking action to try and improve access for patients.
- The practice was equipped to treat patients and meet their needs.
- The practice had no clear leadership structure and the practice was unable to demonstrate effective team working.
- Systems in place for responding to feedback from staff and patients were not always effective.
- The provider was aware of the requirements of the duty of candour.

The areas where the provider must make improvement are:

- Ensure the safety and security of prescription stationery in the practice and the management of uncollected prescriptions.
- Ensure effective systems are in place for the timely management of patient information and referrals.
- Ensure effective working arrangements with health and social care professionals.
- Ensure effective governance arrangements to ensure risks are effectively assessed and monitored such as the cleaning of clinical equipment, carpets and curtains and for checking of defibrillator and the availability of safety information for the control of substances hazardous to health.

- Ensure effective systems for managing incidents and significant events to ensure learning and to support safety improvements.
- Ensure effective system are put place to respond to trends in incidents and complaints to support safety improvements and ensure learning.
- Ensure appropriate information is available to verify the fitness of staff to work with vulnerable patients and others.

The areas where the provider should make improvement are:

- Ensure all patients with a learning disability are offered an annual health review.
- Review and take action to improve the induction and appraisal process for newly recruited staff.
- Review how patient involvement in their care and treatment may be improved.
- Continue to review and take action to improve patients access to appointments.
- Ensure the practice website is updated to ensure accurate information about the complaints process is available.

I am placing this service in special measures. Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate for any population group, key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

The service will be kept under review and if needed could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service by adopting our proposal to remove this location or cancel the provider's registration.

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

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

# Summary of findings

## The five questions we ask and what we found

We always ask the following five questions of services.

### Are services safe?

The practice continues to be rated as inadequate for providing safe services.

- Although the practice had taken action since our previous inspection we continued to identify issues relating to the provision of safe services.
- Systems processes and practices to keep patients safe were not always clear or well embedded. For example, we found weaknesses in the monitoring of uncollected prescriptions and prescription safety, staff records, monitoring of all emergency equipment and cleaning of clinical equipment, carpets and curtains.
- Significant events and incidents were generally well managed but there was little evidence of shared learning with all staff and we saw evidence of opportunities for learning missed.
- Safety alerts were well managed and acted upon.
- We saw improvements had been made to the management of risks relating to the premises including fire safety and legionella. There were however areas for improvement such as ensuring safety information for the control of substances hazardous to health were readily available.
- The practice did not always respond in a timely manner to test results received and monitoring arrangements had not been effective.

Inadequate



### Are services effective?

The practice is rated as inadequate for providing effective services.

- Data from the Quality and Outcomes Framework (QOF) showed patient outcomes were comparable to CCG and national averages.
- Staff had knowledge of and made use of current evidence based guidance in the provision of care.
- There was some evidence of clinical audits which demonstrated quality improvement.
- Staff had the skills and knowledge to deliver effective care and treatment. However, it was difficult to ascertain the level of supervision and support staff received.

Inadequate



# Summary of findings

- The practice did not consistently respond in a timely manner to information received relating to patients. There was a back log of patient information that had not been actioned leading to delays in patients care and treatment. Practice monitoring had been ineffective in resolving this.
- Systems in place did not always ensure timely referrals leading to delays in patients receiving appropriate care and treatment. We received information of concern about a delayed referral and saw the practice had received several complaints relating to this.
- Staff told us they worked with other health care professionals to understand and meet the range and complexity of patients' needs. However, health care professionals experienced a range of difficulties which impacted on patient care when working with the practice.

## Are services caring?

The practice is rated as good for providing caring services.

**Good**



- Data from the national GP patient survey showed that patients rated the practice in line with local and national averages for several aspects of care. However, patients rated the practice slightly lower than others in relation to involvement in decisions about their care and treatment.
- Patients said they were treated with compassion, dignity and respect.
- Information for patients about the services available was easy to understand and accessible.
- We saw staff treated patients with kindness and respect.
- Within the confines of the building the practice had put arrangements in place to improve privacy in the reception area.

## Are services responsive to people's needs?

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

**Requires improvement**



- Practice staff reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group to secure improvements to services where these were identified. The practice participated in the CCG led Aspiring to Clinical Excellence scheme.
- Not all patients found it easy to make an appointment. However, the practice was in the process of recruiting additional clinical staff to help improve access.
- The practice had facilities which enabled it to treat patients and meet their needs.

# Summary of findings

- Information about how to complain was available and easy to understand, although information available on the practice website needed updating.
- Complaints were handled appropriately. However, the practice did not effectively use trends in complaints to support service improvement and learning.

## Are services well-led?

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

- The practice had a vision to deliver high quality services but told us of the challenges in delivering this and the actions they were taking to resolve the issues.
- The practice had no clear leadership structure and was unable to demonstrate effective team working.
- The roles and responsibilities of staff were not always clear.
- The practice had a number of policies and procedures to govern activity which had been reviewed. These were available to all staff.
- The practice held regular governance meetings however, the governance arrangements were not effective in ensuring risks were adequately managed and supported service improvements.
- The practice sought feedback from staff and patients but it was not clear how effective the arrangements were.
- There was no formal system in place to monitor if all staff had received inductions and regular performance reviews.

Inadequate



# 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

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

- Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people.
- The practice was participating in the ambulance triage scheme in which the GPs provided advice to paramedics and supported patients in primary care as an alternative to attendance to accident and emergency departments.
- Home visits and urgent appointments were available for those with enhanced needs.
- The practice offered flu vaccinations.
- The practice was accessible to patients with mobility difficulties.
- However, improvements were required in the management of patients with end of life care needs to ensure these patients consistently received the care and support they needed.

Inadequate



### People with long term conditions

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

- The practice had a long term locum nurse who supported the practice in chronic disease management. They had additional training in the management of long term conditions including asthma, chronic obstructive pulmonary disease, diabetes and heart disease.
- The practice had systems in place to follow up patients who were at risk of unplanned hospital admissions. For those patients with the most complex needs, the GPs worked with relevant health and care professionals to deliver a multidisciplinary package of care.
- Overall performance for diabetes related indicators (2015/16) was 90% which was comparable to the CCG and national average of 90%.
- Patients with long term conditions received a structured annual review to check their health and medicines needs were being met.

Inadequate



# Summary of findings

## Families, children and young people

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

- There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. Immunisation rates were relatively high for all standard childhood immunisations.
- Uptake for the cervical screening programme (2015/16) was at 81% which was similar to the CCG average of 79% and national average of 81%.
- Appointments were available outside of school hours with both doctors and nurses and the premises were suitable for children and babies. The practice had baby changing facilities and was accessible to pushchairs.
- Child health clinics and monthly meetings with the health visitor took place.

Inadequate



## Working age people (including those recently retired and students)

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

- The practice offered extended opening Monday to Friday between 7.30am and 8pm. However, not all patients found it easy to access appointments.
- The practice offered online services (including online appointments and repeat prescriptions).
- The practice offered NHS health checks for patients aged 40-74 years. .

Inadequate



## People whose circumstances may make them vulnerable

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

- The practice held a register of patients living in vulnerable circumstances such as those with a learning disability and those with caring responsibilities.
- The practice offered longer appointments for patients with a learning disability.

Inadequate





# Summary of findings

- Data available from the practice showed that there were 83 patients on the practice's learning disability register. However, only 21 (25%) had received a health review in the last 12 months.
- Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.
- The practice worked closely with the substance misuse workers to provide support to relevant patients.
- The practice advertised the provision of information in a variety of formats.

## People experiencing poor mental health (including people with dementia)

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

- Nationally reported data for 2015/16 showed 86% of patients diagnosed with dementia had their care reviewed in a face to face meeting in the last 12 months, which was comparable to the CCG average of 85% and national average 84%.
- National reported data for (2015/16) showed 94% of patients with poor mental health had comprehensive, agreed care plans documented, in the preceding 12 months which was comparable to the CCG average of 88% and national average 89%.

Inadequate



# Summary of findings

## What people who use the service say

The latest national GP patient survey results were published in July 2016. The results showed a mixed performance overall from the practice compared to local and national averages. A total of 290 survey forms were distributed and 108 (37%) were returned. This represented 1.1% of the practice's patient list.

- 51% of patients found it easy to get through to this practice by phone compared to the CCG average of 61% and national average of 73%.
- 69% of patients were able to get an appointment to see or speak to someone the last time they tried compared to the CCG average of 69% and national average of 76%.
- 77% of patients described the overall experience of this GP practice as good compared to the CCG average of 82% national average of 85%.
- 71% of patients said they would recommend this GP practice to someone who has just moved to the local area compared to the CCG average of 75% and the national average of 80%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 32 comment cards. Patients were positive about the standard of care received from staff. However, 10 patients told us that they struggled to get an appointment and three patients said there was a lack of privacy at reception.

We spoke with three patients during the inspection (including two members of the patient participation group (PPG)). We received a mixed response from patients about the service.

Data from the practice for the friends and family test (April to December 2016) which invited patients to say whether they would recommend the practice to others showed 73% of patients said they would.

# Wake Green 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 GP specialist adviser, a second CQC inspector and a practice manager specialist adviser.

## Background to Wake Green Surgery

Wake Green Surgery is part of the NHS Birmingham Cross City Clinical Commissioning Group (CCG). CCGs are groups of general practices that work together to plan and design local health services in England. They do this by 'commissioning' or buying health and care services.

Wake Green Surgery is located in a converted house adapted to provide primary health services. Clinical services are provided on the ground and first floors. The practice registered list size is approximately 9700 patients. Services to patients are provided under a General Medical Services (GMS) contract with NHS England. A GMS contract ensures practices provide essential services for people who are sick as well as, for example, chronic disease management and end of life care and is a nationally agreed contract. The practice also provides some enhanced services such as childhood vaccinations.

Based on data available from Public Health England, the practice is located in an area with higher than average levels of deprivation.

Practice staff consists of five GP partners (four female and one male) a practice nurse and a locum practice nurse, a

health care assistant, a phlebotomist and a practice facilitator. Other staff include an interim operations and communications manager and a team of administrative / reception staff.

The practice's CQC registration certificate lists only four GP partners. Appropriate applications need to be submitted to ensure the provider registration with CQC is correct.

The practice is open Monday to Friday from 7.30am to 6.30pm, except on a Wednesday when it closes at 2.30pm. Appointment times vary between the clinical staff but usually range from 8.30am to 12.20pm and 2.30pm to 5.50pm. When the practice is closed (including Wednesday afternoons) services are provided by an out of hours provider who are reached through the NHS 111 telephone service. The practice provides extended opening hours Mondays to Fridays between 7.30am and 8am.

The practice is a training practice for qualified doctors training to become a GP.

## Why we carried out this inspection

The practice was previously inspected by CQC in August 2015. The practice was rated requires improvement overall and was found to be in breach of regulation 12 (Safe Care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This inspection was undertaken to follow up progress made by the practice since 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. The inspection was planned to check whether the provider is meeting the legal

# Detailed findings

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.

## How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 16 December 2016. During our visit we:

- Spoke with a range of clinical and non-clinical staff (including the GP partners, a locum nurse, the practice facilitator and interim operations and communications manager and administrative/reception staff).
- Reviewed an anonymised sample of the personal care or treatment records of patients.
- Observed how people were being cared for.
- Spoke with three patients including two members of the practice's Patient Participation Group (PPG).
- Spoke with five community health and social care professionals.
- Reviewed comment cards where patients and members of the public shared their views and experiences of the service.

- Reviewed documentation made available to us for the running of the practice.

To get to the heart of patients' experiences of care and treatment, we always ask the following five questions:

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

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

- Older people
- People with long-term conditions
- Families, children and young people
- Working age people (including those recently retired and students)
- People whose circumstances may make them vulnerable
- People experiencing poor mental health (including people with dementia).

Please note that when referring to information throughout this report, for example any reference to the Quality and Outcomes Framework data, this relates to the most recent information available to the CQC at that time.

# Are services safe?

## Our findings

**At our previous inspection on 17 August 2015, we rated the practice as requires improvement for providing safe services. This was because we identified weaknesses in the management of risks relating to the premises including fire safety, the control of substances hazardous to health, legionella, prescription stationery and business continuity.**

**We undertook a follow up inspection on 16 December 2016 and saw that practice had addressed some of the requirements of our previous inspection. However, we continued to identify issues relating to the provision of safe services. This included the safety and security of prescriptions, staff records, monitoring of emergency equipment, cleaning of clinical equipment, carpets and curtains and the accessibility of safety information for substances hazardous to health.**

### Safe track record and learning

There was a system in place for reporting and recording incidents and significant events.

We reviewed incidents and significant events that had been reported over the last 12 months. There was a total of 10 significant events, two of which were also classed by the practice as severe incidents. These related to a sharps injury and an information governance breach.

There was an 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 from the incident reports relating to the two significant events and saw that these had been investigated and learning identified.

The practice told us they shared significant events at collaborative meetings with other practices within the locality and at staff meetings within the practice. However, of the practice meeting minutes seen over the last three months there was only one reference to a significant event or incidents.

We were also alerted to an incident involving the vaccinations fridge which had not been recorded as an

incident although, there was evidence that it had been acted on. We were told that public health had not been informed of this incident due to the time lapsed when they had become aware of the need to inform them and the issue being resolved.

Staff told us that they would talk to patients directly if affected by an incident but did not have any specific examples.

The practice had effective systems in place for the management of safety alerts received such as those from the Medicines and Healthcare Products Regulatory Agency (MHRA). Comprehensive records were maintained of actions taken in response to the alerts.

### Overview of safety systems and processes

The practice had clearly defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from abuse, which included:

- Arrangements were in place to safeguard children and vulnerable adults from abuse. These arrangements reflected relevant legislation and local requirements. Policies were accessible to staff. Contact information was available for practice staff for further guidance if they had concerns about a patient's welfare. This information was also displayed in the waiting area. There was a lead GP for safeguarding. Staff demonstrated they understood their responsibilities and all had received training on safeguarding children and vulnerable adults relevant to their role. GPs were trained to child protection or child safeguarding level three. An alert on the patient record system ensured clinical staff were aware at the point of contact if a patient was at risk and we saw evidence of discussions relating to a vulnerable adult with appropriate follow up. The practice had recently carried out an audit to check the accuracy of the coding used to highlight safeguarding concerns on patients records.
- Notices were displayed throughout the practice which advised patients that chaperones were available if required. Staff who acted as chaperones had undertaken training for the role. At our previous inspection we identified that not all staff who acted as a chaperone had a Disclosure and Barring Service (DBS) check or an adequate risk assessment. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles

## Are services safe?

where they may have contact with children or adults who may be vulnerable). At this inspection not all staff had a DBS check in place. The practice told us that they had lost information through an information governance breach and were in the process of replacing it and we were given dates of when these checks were undertaken. Our previous inspection report in August 2015 had not identified any concerns with the recruitment process.

- The practice had some arrangements in place to manage the standards of cleanliness and hygiene at the practice. The clinical rooms appeared visibly clean and tidy. However, areas of the practice were in need of refurbishment. Practice staff had access to appropriate hand washing facilities and personal protective equipment. An in-house cleaner was employed and we saw cleaning schedules in place to show what had been done. The infection control lead had carried out infection control checks of clinical rooms to ensure standards were being maintained. We saw that the CCG Infection control team had undertaken an audit of the practice in August 2016. The practice achieved a red rating and were given an action plan to complete which was still in progress. Many of the actions related to refurbishment of the premises and we saw evidence of a refurbishment plan in place. However, during the inspection we found that the cleaning schedule for clinical equipment was not being actively utilised and there were no schedules in place to demonstrate that carpets and fabric privacy curtains were regularly cleaned. This was also identified in our previous inspection in August 2015. However, we did see a receipt for the cleaning of curtains for October 2016. The infection control policy did not include information on the management of bodily fluid spills.
- We looked at the arrangements for managing medicines, including emergency medicines and vaccines, in the practice to keep patients safe (including obtaining, prescribing, recording, handling, storing, security and disposal). We looked at the records of six patients on high risk medicines which required regular monitoring and saw that these patients were appropriately managed. Patient Group Directions had been adopted by the practice to allow nurses to administer medicines in line with legislation. The practice had three medicine fridges for the storage of vaccinations, these were monitored to ensure vaccinations were stored at the temperatures

recommended by the manufacturers to ensure their effectiveness. In two out of three fridges vaccinations were stored in an organised way to help ensure medicines were used in date order but in one fridge they were not. The practice advised us that this was a stock fridge only which they used to restock the other two medicine fridges and that they rotated the stock used.

- The practice did not have effective systems for managing prescription stationery safely and securely. This included prescriptions used for drug misuse instalments. This was also noted in our previous inspection report. Prescriptions are controlled stationery because stolen prescriptions may be used to unlawfully obtain prescription only medicines. No logs were maintained as to who these prescriptions were allocated to. Following the inspection the practice told us that they had revised their protocols and sought pharmacy advice to maintain accurate records and that these were now kept securely. The stock room in which the prescription stationery for printers was kept locked but was untidy and disorganised. Practice staff had difficulty locating logs of prescription stock. Only one member of staff maintained these logs but was unable to ascertain accuracy because when they were not available the prescription logs were not updated. Only hand written prescriptions showed evidence that they were signed out by clinicians.
- We identified uncollected prescriptions for patients that were over three months old and two were dated June 2016. There were no evidence of clear systems for following up uncollected prescriptions. This did not reflect the practice's repeat prescribing policy (dated April 16) which stated the prescription collection box should be checked on a monthly basis. Following the inspection the practice told us that they had now allocated this specific task to a member of staff to ensure they were reviewed on a monthly basis.
- We reviewed personnel files for three members of staff which identified gaps in the recruitment checks. For example, there was no DBS check available for one of the clinical staff who had been working at the practice for approximately a year although the DBS check had recently been applied for. There was also no up to date checks for another clinical member of staff's registration with their professional body and no evidence of a job application or contract for a member of the administrative team. The practice told us that they had lost information following an information governance

# Are services safe?

incident and that they were actively trying to resolve this. Following the inspection the practice told us that the DBS check for the clinical member of staff had been completed and an email from a recruitment agency they were contracting with to say that contracts would be in place by the end of year.

## Monitoring risks to patients

Risks to patients were assessed and in most areas managed.

- At our previous inspection in August 2015 we identified concerns with the management of risks relating to the premises. In particular fire safety was a concern and we informed the Fire Safety Officer who had made recommendations. This included the carrying out a fire risk assessment, the installation of a fire alarm and detection system and emergency lighting. The practice also did not have risk assessments in relation to the control of substances hazardous to health and legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings).
- At this inspection we found the practice had taken some action to improve the safety of the premises. The practice had carried out an internal fire risk assessment, although this was brief and part of a general risk assessment. The practice had put in place measures such as the installation of a fire alarm and identification of fire marshals. Records were kept of weekly alarm checks and we saw that there had been a fire drill two days prior to our inspection.
- The practice had put in place other risk assessments to monitor safety of the premises such as an equality assessment, the control of substances hazardous to health and legionella. However, the control of substances hazardous to health safety sheets for products used on the premises were not easily accessible in an emergency.
- Electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly. These checks had been undertaken in the last 12 months.
- The practice was aware that there were staffing issues that needed to be resolved. The practice had taken

steps to address this which included the recent recruitment of two new GPs who were due to start in early 2017 and the appointment of a new practice manager in January 2017 following the departure of the previous manager. The practice was looking to recruit a new nurse as one of the practice nurses had recently left. Where needed locum staff were used.

- The practice had a backlog of unactioned blood test results over 7 days old which they were monitoring. This was reported as 23 on 28 September 2016 and 35 on the 7 December 2016. Monitoring arrangements had not been effective in consistently reducing the number of unactioned test results.

## Arrangements to deal with emergencies and major incidents

The practice had adequate arrangements in place to respond to emergencies and major incidents.

- There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency.
- Staff received annual basic life support training and there were emergency medicines available. These were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and stored securely.
- The practice had two defibrillators available on the premises and oxygen. We saw records showing that the oxygen was regularly checked to ensure it was in working order and ready for use. However, no records of routine checks were available for the defibrillators to ensure they were kept in good working order. The defibrillator pads were in date.
- We reviewed the practice's arrangements for business continuity for major incidents such as power failure or building damage. At our previous inspection in August 2015 we found that the practice manager had been unaware of business continuity plan and the plan seen lacked detail and was not clearly embedded. At this inspection we found a comprehensive business continuity plan was in place and staff were aware of it. This included reciprocal agreements with another practice should the premises become inaccessible and emergency contact numbers for some staff.



# Are services effective?

(for example, treatment is effective)

## Our findings

**At our previous inspection on 17 August 2015, we rated the practice as good. However, during the follow up inspection on 16 December 2016 we identified issues relating to the provision of effective services. We identified delays in patient referrals to secondary care and the practice did not always respond in a timely way to information received relating to patients care and treatment. There was a lack of effective working arrangements with health and social care professionals particularly in relation to end of life care.**

### Effective needs assessment

The practice assessed needs and delivered care in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines.

- Staff had access to guidelines from NICE and used this information to deliver care and treatment that met patients' needs. Examples given by staff included the treatment for adolescents with mental health needs and cancer.
- The practice told us of audits that had been carried out against NICE guidance. For example the provision of screening for hepatitis C in substance misuse.
- The locum nurse we spoke with showed a specific website which included new guidelines for various long term conditions such as asthma and COPD. They also received updates via email.

### Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent published results were for 2015/16. This showed the practice had achieved 98% of the total number of points available, which was comparable to the CCG and national average of 95%. Overall exception reporting by the practice was 7% compared to the CCG and national average of 10%.

(Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects).

This practice was not an outlier for any QOF (or other national) clinical targets. Data from 2015/2016 showed:

- Performance for diabetes related indicators was 90% which was comparable to the CCG average of 91% and national average of 90%.
- Performance for mental health related indicators was 100% which was higher than the CCG average of 91% and national average of 93%. Exception reporting was lower than CCG and national averages in five out of the six mental health indicators.

There was some evidence of quality improvement including clinical audit. The practice shared with us three recent clinical audits that had been carried out over the last two years. These included a CCG led antibiotic audit, an audit of patient care in substance misuse and an audit of referrals to the child and adolescent mental health service. The audit relating to substance misuse showed improved screening for hepatitis C and the referral audit confirmed the quality of practice referrals to the child and adolescent mental health service. The antibiotic audit which looked at areas such as face to face prescribing and choice of antibiotic in line with local guidance did not show any overall improvements. However, we did see data that showed the practice was a low prescriber of antibiotics compared to other practices in the CCG.

The practice's percentage of inadequate samples for cervical screening was lower than laboratory averages.

Practice data showed that 4.6% of patients had personalised care plans in place. However, we saw that some of these had not recently been reviewed. For example of the 148 dementia care plans 69 were due for review.

### Effective staffing

Staff had the skills and knowledge to deliver effective care and treatment. However, it was difficult to ascertain the level of supervision and support staff had received as there was no formal system to evidence this.

- During our inspection the practice had difficulty demonstrating an effective induction and appraisal processes. We were shown examples of induction forms and told that staff had shadowing opportunities when



# Are services effective?

## (for example, treatment is effective)

they first started as well as three and six months reviews. However, we saw no consistent evidence of inductions for staff. There was also a lack of evidence of appraisals for staff. The practice explained that they had lost information following an information governance incident and that they were trying to collate this information again.

- We saw some evidence that staff had received role-specific training and updating for relevant staff. For example, for those reviewing patients with long-term conditions, administering vaccinations and taking samples for the cervical screening programme.
- Staff had access to and made use of e-learning training modules and in-house training that included safeguarding, fire safety awareness, basic life support and information governance.

### Coordinating patient care and information sharing

We identified that information needed to plan and deliver patients care and treatment was not consistently actioned in a timely manner.

The practice was regularly monitoring patient information contained in their docman (patient information system) that had been received and not actioned within 14 days. This included information such as hospital discharge letters. However, despite monitoring, the practice was unable to demonstrate any overall improvements. For example: On 28 September 2016 the practice reported 124 unactioned documents over 14 days old and on 7 December 2016 there were 189 un actioned documents.

On the day of our inspection there was a backlog of 220 unactioned documents, the oldest related to the 4 November 2016. We looked at a small sample of the older unactioned documents and saw two letters dated the 9 November 2016 and 11 November 2016 with required action in relation to medicines.

The practice was also monitoring the backlog of unactioned test results over 7 days old. This was reported as 23 on 28 September 2016 and 35 on the 7 December 2016.

Although the practice was monitoring the backlogs in unprocessed patient information there were no clear plans or systems in place for effectively resolving the issue. Patients were therefore at risk of potential delays in care and treatment.

Prior to our inspection we had been alerted to information of concern relating to delays in referrals to secondary care. We also saw during the inspection that the practice had received four other complaints in relation to this area. There had been no review of the referral process undertaken to identify how it might be improved to minimise the risk of delays to care or treatment. Following our inspection the practice told us that they had reviewed the referral process with locums and trainee GPs to ensure a more timely process, although further review was still needed to identify other potential delays.

We spoke with five community health and social care staff who worked closely with the practice. They confirmed that regular multidisciplinary meetings took place to discuss and co-ordinate the care of some of the practice's most vulnerable patients. However, they also raised various difficulties they had experienced such as delays with the practice responding to requests for home visits, prescriptions and obtaining do not resuscitate orders for relevant patients. Community and social care staff gave examples where home visit requests had not taken place for palliative care patients. In addition we had also received information of concern relating to end of life care provided by the practice.

### Consent to care and treatment

Staff sought patients' consent to care and treatment in line with legislation and guidance.

- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005 and guidelines for capacity to consent in children and young people.
- Staff also understood relevant guidance in relation to capacity to consent when providing care and treatment for children and young people.
- We saw that formal consent was obtained for the fitting of intrauterine devices and implants which were carried out at the practice.

### Supporting patients to live healthier lives

Information was displayed in the practice to support health promotion and prevention. The practice website also provided links to various health information for patients to refer to. Staff were able to refer patients to various services such as smoking cessation and counselling as appropriate.

# Are services effective?

(for example, treatment is effective)

The practice's uptake for the cervical screening programme was 81%, which was comparable to the CCG average of 79% and the national average of 81%. There were failsafe systems in place to ensure results were received for all samples sent for the cervical screening programme and the practice followed up women who were referred as a result of abnormal results. Administrative staff supported the nurses in recalling patients where appropriate for their cervical screening test.

The uptake of national screening programmes for bowel and breast cancer screening was also comparable to the CCG and national averages. For example,

- 67% of females aged 50-70 years of age had been screened for breast cancer in the last 36 months compared to the CCG average of 69% and the national average of 72%.

- 60% of patients aged 60-69 years, had been screened for bowel cancer in the last 30 months compared to the CCG average of 50% and the national average of 58%.

Childhood immunisation rates for the vaccinations given to under two year olds and five year olds were meeting national standards of 90%.

Patients had access to appropriate health assessments and checks. These included health checks for new patients and NHS health checks for patients aged 40-74.

Data available from the practice showed that there were 83 patients on the practice's learning disability register. However, only 21 (25%) had received a health review in the last 12 months.

# Are services caring?

## Our findings

**At our previous inspection on 15 August 2015, we rated the practice as good for providing caring services**

### Kindness, dignity, respect and compassion

During the inspection we observed members of staff were courteous and helpful to patients and treated them with dignity and respect.

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

We received feedback from 32 patients through the Care Quality Commission comment cards and three patients we spoke with on the day. We mostly received positive feedback about the care and treatment they received. Most patients said they found staff caring and told us that they were treated with dignity and respect. However, we also received comments about staff attitude and lateness of appointments.

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

- 87% of patients said the GP was good at listening to them compared to the clinical commissioning group (CCG) average of 88% and the national average of 89%.
- 84% of patients said the GP gave them enough time compared to the CCG average of 86% and the national average of 87%.
- 92% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 92% and the national average of 92%.
- 81% of patients said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 84% and the national average of 85%.

- 90% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 89% and national average of 91%.
- 84% of patients said they found the receptionists at the practice helpful compared to the CCG average of 84% and the national average of 87%.

The practice had undertaken its own in-house annual patient survey. The latest was carried out in September 2016 and completed by 400 patients, the results had been discussed by the PPG but had yet to be acted upon. The main issues related to appointments.

### Care planning and involvement in decisions about care and treatment

Feedback from the CQC patient comment cards indicated that most patients felt involved in decision making about the care and treatment they received.

Results from the national GP patient survey (published July 2016) showed patient responses to questions about their involvement in planning and making decisions about their care and treatment were slightly lower than local and national averages. For example:

- 79% of patients said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 86% and the national average of 86%.
- 74% of patients said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 81% and national average of 82%.
- 77% of patients said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average of 83% and national average of 85%.

Practice staff told us that they had recruited two additional GPs which would help meet service demand and had undertaken an in-house patient survey.

The practice provided facilities to help patients be involved in decisions about their care and treatment. This included translation services for patients who did not speak English as a first language. We saw notices in the reception areas informing patients this service was available. The practice also had a hearing loop and a notice displayed in the waiting area which told patients that they could request information in an alternative format.

### Patient and carer support to cope emotionally with care and treatment

## Are services caring?

Patient information leaflets and notices were available in the patient waiting area which told patients how to access a number of support groups and organisations.

The practice's computer system alerted GPs if a patient was also a carer. There was a leaflet at reception asking patients to identify themselves as carers and informing them of a local carers hub they could contact for further advice. The practice had identified 136 patients as carers (1.4% of the practice list). Practice staff told us that patients on the carers register would be offered a health check, flexibility with appointments and telephone consultations via triage

system. They also told us they were working on implementing a carers pack and that in conjunction with the patient participation group were planning a campaign to raise awareness of support available to carers.

Staff told us that if families had suffered bereavement their usual GP would write to them with information about local counselling services and to offer support from the practice. There was also a bereavement leaflet which gave advice on support available.

# Are services responsive to people's needs?

(for example, to feedback?)

## Our findings

**At our previous inspection on 17 August 2015, we rated the practice as good for providing responsive services. However, during the follow up inspection on 16 December 2016 we identified issues relating to the provision of responsive services. We identified a high number of complaints and although trends had been identified there had been no effective action taken to address those trends.**

### Responding to and meeting people's needs

The practice reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. The practice was participating in the CCG led Aspiring to Clinical Excellence (ACE) programme aimed at driving standards and consistency in primary care and delivering innovation.

- The practice offered extended opening hours Monday to Friday between 7.30am and 8pm for working patients and those with other commitments who could not attend during normal opening hours.
- Staff told us that they would allocate longer appointments for patients who needed them.
- Home visits were available for patients who had clinical needs which resulted in difficulty attending the practice.
- Same day appointments were available for children and those patients with medical needs who required same day consultations.
- The practice did not currently provide any travel advice or vaccinations, this had been temporarily suspended due to staffing issues. However, the locum nurse we spoke with was able to provide details of alternative clinics.
- There were disabled facilities, including parking spaces, disabled toilet facilities and ramp access into the premises. A bell outside the practice alerted staff if any patient was in need of assistance.
- The practice had a hearing loop and translation services were available. Notices were also displayed in reception offering patients information in different formats on request.

- The practice had no lifts and the nurses room was the only clinical room located on the first floor. We saw evidence that if a person was unable to use the stairs they would be seen in downstairs.
- The practice provided baby changing facilities and was accessible to pushchairs.
- The practice worked with a substance misuse worker to provide support to relevant patients.
- The practice was also participating in an ambulance triage scheme in which the GPs provide advice to paramedics and facilitated support for patients within primary care as an alternative to attendance to the accident and emergency department.

### Access to the service

The practice was opened Monday to Friday 7.30am to 6.30pm, except on a Wednesday when it closed at 2.30pm. Appointment times varied between the clinical staff but usually ranged from 8.30am to 12.20pm and 2.30pm to 5.50pm. When the practice was closed services (including Wednesday afternoons) services were provided by an out of hours provider which were reached through the NHS 111 telephone service. In addition to pre-bookable appointments that could be booked up to two weeks in advance, urgent and same day appointments were released on a daily basis for people that needed them.

The practice offered a duty doctor system in which once appointments were filled calls would be triaged to assess the urgency of need.

Results from the national GP patient survey (published July 2016) showed that patient's satisfaction with how they could access care and treatment was still below local and national averages. There was no improvement since our previous inspection which reported the results from the previous national GP patient survey published in July 2015.

- 70% (previously 74%) of patients were satisfied with the practice's opening hours compared to the CCG average of 74% and national average of 76%.
- 51% (previously 59%) of patients said they could get through easily to the practice by phone compared to the CCG average of 61% the national average of 73%.

Of the 32 completed CQC patient comment cards 10 patients told us that they experienced difficulties accessing appointments.

# Are services responsive to people's needs?

(for example, to feedback?)

We saw on the day of our inspection that the next available routine GP appointment was within 4 working days (with same day appointments due for release after 12pm on the day). The next nurse appointment was available on the day of our inspection and phlebotomy (blood taking) appointment within two working days.

Practice staff told us about action they were taking to improve access in response to patient feedback. This included the recruitment of two new salaried GPs due to start in January 2017. We were told that a new telephone system was also planned.

## Listening and learning from concerns and complaints

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

- Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England.
- There was a designated responsible person who handled all complaints in the practice.

- We saw that information was available to help patients understand the complaints system. A complaints leaflet was available for patients to take away which provided details such as expected timescales and what to do if the patient is unhappy with the practice's response. However, we noticed that this information had not been updated on the practice website and contained details of an organisation that no longer existed.

The practice had received 38 complaints during 2016. We looked at a sample of four complaints in detail and saw that these had been appropriately managed with openness and dealt with in most cases in a timely way.

Complaints were discussed at the regular partners meetings. We saw that trends had been identified in relation to the nature of the complaints but no specific action was taken in response to those trends. For example, there were several complaints relating to referrals and prescribing processes. The practice did not effectively use complaints to improve the service and learn from them.



# Are services well-led?

Inadequate 

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

## Our findings

**At our previous inspection on 17 August 2015, we rated the practice as requires improvement for providing well-led services as the provider had not taken effective action to protect persons employed, service users and others who may be at risk against identifiable risks relating to care and treatment.**

**When we undertook a follow up inspection of the service on 16 December 2016 our concerns continued and we found that the practice governance arrangements were not effective in managing risks to persons employed, service users and others.**

### Vision and strategy

The partners told us about the future vision for the practice. The practice had joined as a member of Our Health Partnership. Our Health Partnership consisted of over 30 local practices working together to help respond to the changing demands faced by GP practices.

The practice had experienced recent difficulties. They had been without a permanent practice manager since June 2016 and had suffered a significant information governance incident in which practice information had been lost which they informed us about in August 2016. They told us that they were trying to replace the lost information. However, we were unable to identify the extent of progress made as the practice was not clear about what information had been lost.

The partners told us that they had tried to secure new accommodation to meet service demand as there was limited opportunities for expansion at the current location. However, they felt relocation was now unlikely having explored different possibilities and had put in place plans for refurbishment of the premises. The partners told us that they had recruited two new GPs and a practice manager who were due to start in early 2017.

### Governance arrangements

We found the practice's governance arrangements were not effective and lacked robust systems to assess and monitor risks and enable the delivery of service improvements

- There was no clear leadership in the practice.

- There was sometimes a lack of established team work in place. For example, in addressing the delays in actioning of test results and in the management of prescription stationery.
- We saw delays in implementing actions following audits. For example, the CCG had completed an infection control audit in August 2016 and had identified an action to monitor the cleaning of equipment which had yet to be implemented.
- We saw the practice had reviewed and updated policies and procedures following the loss of information and that these were of high standard and accessible to all staff. Although, we found some policies missing such a policy for the cleaning of bodily fluid spills.
- At our previous inspection we were concerned about the practice's management of some risks associated with the premises and had specifically identified the lack of risk assessment for the control of substances hazardous to health. We saw that this risk assessment had been put in place. However, safety information was not easily accessible to all staff in an emergency.
- The practice had a high number of complaints and had identified trends however, there was no evidence of action taken in response to specific themes identified such as complaints about referrals or prescriptions.

However,

- The practice demonstrated that they were performing well in terms of patient outcomes and the quality outcomes framework.

### Leadership and culture

The provider was aware of and had systems in place to ensure compliance with the requirements of 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). Following the information governance incident the practice had informed relevant agencies. The partners encouraged a culture of openness and honesty and had systems in place to ensure that when things went wrong with care and treatment patients received an apology.

Staff told us the partners were approachable and that they received regular staff meetings. Minutes were available for these.

# Are services well-led?

Inadequate 

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

However, during the inspection we found the practice disorganised. Systems and processes were not always effectively implemented for example monitoring of prescriptions. Staff lacked direction and were not always clear about their roles and responsibilities.

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

The practice encouraged feedback from patients and had a leaflet informing patients on how they could provide feedback about the service. There was an area in the waiting room for the patient participation group (PPG) which encouraged new members.

- The PPG met regularly and had carried out a patient survey during September 2016. This had identified areas for improvement which had been left with practice to take forward. There were six active PPG members and we spoke with two of the members. They told us that they had not always felt listened to and there was a general reluctance to change. Although, they felt there had been some improvements since the interim operations and communications manager had been in

place. The PPG members told us that they had been involved in the development of the practice website. We saw that the practice had collated feedback from various sources including the patient survey, friends and family test and NHS choices and that there was an ongoing action plan in place. Action to date included improving privacy around reception and some areas of refurbishment.

- Staff provided examples of feedback given to the practice but we were unable to confirm during the inspection whether some of the feedback had been acted on. For example the locum nurse informed us that they had advised on the need for purple sharps boxes but we were unable to confirm during the inspection process that these were on order.

## Continuous improvement

The practice was a training practice for qualified doctors training to become a GP.

We were unable to verify during the inspection whether all staff received inductions and regular performance reviews with clear objectives.



## 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 Treatment of disease, disorder or injury	<p>Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment</p> <p><b>Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.: Safe care and treatment</b></p> <p><b>How the regulation was not being met:</b></p> <p>The practice did not have effective systems in place for managing prescription stationery and for uncollected prescriptions.</p> <p>The working arrangements with other health and social care professionals was not consistently effective in supporting the needs of vulnerable patients such as those with end of life care needs.</p> <p>The infection control policy did not include information on the management of bodily fluid spills.</p> <p>This was in breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.</p>
Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Treatment of disease, disorder or injury	<p>Regulation 17 HSCA (RA) Regulations 2014 Good governance</p> <p><b>Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Good governance</b></p> <p><b>How the regulation was not being met:</b></p> <p>The practice did not have effective governance arrangements to proactively assess, manage and</p>

## Requirement notices

monitor risks to persons employed, services users and others who may be at risk against identifiable risks of receiving care or treatment and for responding to feedback on the services provided. This included:

- Systems for the monitoring of the cleaning of clinical equipment, carpets and curtains
- Systems for checking emergency equipment (defibrillator) is in working order.
- The availability of safety information for products used in the practice.
- Systems for effectively managing incidents and significant events and trends in complaints to ensure learning and to support safety improvements.

This was in breach of regulation 17 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

## Enforcement actions

### Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Treatment of disease, disorder or injury	<p>Regulation 17 HSCA (RA) Regulations 2014 Good governance</p> <p><b>Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Good governance</b></p> <p><b>How the regulation was not being met:</b></p> <p>The practice did not have effective systems in place for managing the back log of unactioned patient information received.</p> <p>The practice did not have effective systems to ensure referrals were not missed or delayed.</p> <p>This was in breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.</p> <p>The following conditions have been imposed on the provider's registration:</p> <ol style="list-style-type: none"><li>1. The registered person must ensure that it operates effective systems at Wake Green Surgery to ensure patient information received is responded to in a timely way and according to contractual obligations.</li><li>2. The registered person must ensure that it implements an effective system at Wake Green Surgery to minimize the risk of patient referrals being missed or delayed.</li><li>3. Systems implemented (in conditions 1 and 2) must be audited on a monthly basis and a copy of the audit must be sent to CQC to demonstrate progress made on the first working day of each month.</li></ol>