Birstall Medical Centre

Quality Report

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

Ratings

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

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced follow-up inspection at Birstall Medical Centre on 15 March 2016. This inspection was a follow-up to our inspection of 21 and 29 May 2015 when the practice as rated as 'Inadequate'. The practice was placed into Special Measures in September 2015 and required to make significant improvements. The practice submitted an action place detailing how they would meet the regulations governing providers of health and social care.

At our follow-up inspection, we found the practice had made improvements across all five domains of safe, effective, caring, responsive and well led. However, some improvement was still required and overall the practice is rated as requires improvement.

Our key findings across all the areas we inspected were as follows:

- There was a system in place for reporting and investigating significant events. However, the practice acknowledged and had plans in place to improve staff awareness regarding the definition of a significant event.
- Administrative staff were unaware of local requirements in relation to safeguarding and the practice safeguarding policies did not outline the local requirements or contacts. Not all administrative staff has received safeguarding training relevant to their role.
- Not all staff with chaperone responsibilities had a Disclosure and Barring Service (DBS) check.
- The arrangements for managing medicines did not always keep people safe; this included the safe storage of prescriptions and monitoring of uncollected repeat prescriptions.

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- Appropriate recruitment checks were not always carried out before employment. There was no system in place to ensure annual checks on professional registrations, where required, were carried out.
- A local agency was used for the provision of locum GPs that provided appropriate recruitment checks.
- The practice had adequate emergency equipment and medicines, and checks were carried out to ensure they were fit for use.
- Not all staff have received basic life support training.
- A comprehensive business continuity plan was in place to support the service in the event of a major disruption.
- The practice was reviewing patient care plans to ensure they assessed the needs of patients and care was delivered in line with relevant and current evidence based guidance and standards.
- Data from the Quality and Outcomes Framework showed patient outcomes were comparable to the national averages.
- Clinical audits were carried out and actions taken as a result, the practice also participated in local audit and peer review.
- The practice had reviewed and identified gaps in training needs for staff to ensure they had the right skills, knowledge and experience to deliver effective care and treatment.
- There was no active supervision for locum GPs working at the practice.
- Staff worked with multidisciplinary teams to understand and meet the range and complexity of patients' needs.
- A new system had been implemented to ensure pathology results and incoming mail was reviewed and acted upon within a specified timescale.
- Training data demonstrated only one staff member had training in the Mental Capacity Act.
- Various information leaflets and posters in the patient waiting area promoted support groups to assist patients to live healthier lives.
- Data from the National GP Patient Survey showed patients rated the practice lower than others for several aspects of care.
- Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.
- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.
- There was a process in place to identify carers and provide relevant support.
- Practice staff were actively working with the Clinical Commissioning Group (CCG) to ensure services met the needs of its local population.
- The practice had recently changed its appointment system and we saw urgent and routine appointments were available, at both Birstall Medical Centre and Border Drive Surgery.
- Patients said they found it easy to make an appointment and there had been an improvement in making an appointment since the change in the system.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- Information about how to complain was available and easy to understand and evidence showed the practice responded quickly to issues raised. However, informal complaints were not documented and lessons learnt.
- The practice had a short-term and medium-term strategy in place to improve the current service provision, as well as ensuring patients received high quality care.
- The practice was developing a new governance framework, which supported the delivery of the strategy and good quality care.
- Practice specific policies had been recently reviewed, implemented and were available to all staff. However, safeguarding policies did not include local authority contact details or outline what the local

Summary of findings

requirements were in relation to raising a safeguarding concern. There was also no protocol in place to support the process to contact patients who did not attend for cervical screening tests.

- There were some arrangements for identifying, recording and managing risks. However, there was no risk assessment in relation to control of substances hazardous to health (COSHH) products. The practice had not identified the potential risk to prescriptions not securely stored, or the risk to patients if a repeat prescription was not collected. Not all staff with chaperone responsibilities had appropriate Disclosure and Barring Service (DBS) checks.
- There was a leadership structure in place, which was still undergoing review by the practice. Staff felt supported by management and were positive about the changes to the service.
- The provider was aware of and complied with the requirements of the Duty of Candour.
- The practice was unable to demonstrate any actions taken as a result of patient surveys or feedback. However, had plans in place to introduce local patient surveys involving the patient participation group (PPG).
- Limited progress was made by the practice as a result of feedback from the PPG, however the PPG were hopeful with the new practice management team, feedback would be acted on.

The areas where the provider must make improvements are:

- Ensure policies and procedures contain relevant and necessary information, and they support current processes and systems.
- Ensure staff carry out relevant and mandatory training.
- Ensure Disclosure and Barring Service (DBS) checks are carried out on staff members with chaperone responsibilities.
- Ensure recruitment checks are carried out before employment and annual checks on professional registration statuses are carried out.
- The safe storage of prescriptions.
- Implement a process to review uncollected repeat prescriptions.
- Provide supervision to locum GPs working at the practice.
- Review data from the National GP Patient Survey and take action where necessary.
- Ensure all appropriate risk assessments are carried out.
- Review patient feedback and patient surveys to take action to improve services provided.

In addition the provider should:

- Ensure staff are aware of what constitutes a significant event so these can be reported and investigated thoroughly.
- Continue to review patient care plans to ensure care is provided in line with relevant and current evidence based guidance and standards.
- Document, record and investigate informal complaints.
- Finalise the governance framework to support the delivery of the strategies and good quality care.
- Finalise the leadership structure and continue to involve all staff members in discussions.
- Improve the communication with the PPG and act on feedback.

I confirm that this practice has improved sufficiently to be rated 'Requires improvement' overall. The practice will be removed from special measures.

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?

Requires improvement

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

- There was a system in place for reporting and investigating significant events. However, the practice acknowledged and had plans in place to improve staff awareness regarding the definition of a significant event.
- When there were unintended or unexpected safety incidents, patients were offered a meeting to discuss the incident and received an apology.
- The systems, processes and practices to keep patients safe and safeguarded from abuse required improvement.
- Administrative staff were unaware of local requirements in relation to safeguarding and the practice safeguarding policies did not outline the local requirements or contacts. Not all administrative staff has received safeguarding training relevant to their role.
- Not all staff with chaperone responsibilities had a Disclosure and Barring Service (DBS) check.
- The arrangements for managing medicines did not always keep people safe; this included the safe storage of prescriptions and monitoring of uncollected repeat prescriptions.
- Appropriate recruitment checks were not always carried out before employment. There was no system in place to ensure annual checks on professional registrations, where required, were carried out.
- A local agency was used for the provision of locum GPs that provided appropriate recruitment checks.
- The practice had a variety of risk assessments in place to monitor safety of the premises such as infection control and legionella, however they had not carried out a risk assessment in relation to control of substances hazardous to health (COSHH).
- The practice had adequate emergency equipment and medicines, and checks were carried out to ensure they were fit for use.
- Not all staff have received basic life support training.
- A comprehensive business continuity plan was in place to support the service in the event of a major disruption.

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Are services effective?

Requires improvement

The practice is rated as requires improvement for providing effective services, as there are areas where improvements should be made.

- The practice was reviewing patient care plans to ensure they assessed the needs of patients and care was delivered in line with relevant and current evidence based guidance and standards.
- The practice had implemented locally led care plans and templates, as well as local prescribing guidelines.
- Data from the Quality and Outcomes Framework showed patient outcomes were comparable to the national averages.
- The practice had identified coding errors, which did not reflect relevant treatment and tests had been carried out. As a result, additional work was being done with the GPs and nursing team.
- Clinical audits were carried out and actions taken as a result, the practice also participated in local audit and peer review.
- The practice had reviewed and identified gaps in training needs for staff to ensure they had the right skills, knowledge and experience to deliver effective care and treatment.
- There was no active supervision for locum GPs working at the practice.
- Staff worked with multidisciplinary teams to understand and meet the range and complexity of patients' needs.
- A new system had been implemented to ensure pathology results and incoming mail was reviewed and acted upon within a specified timescale.
- Training data demonstrated only one staff member had training in the Mental Capacity Act.
- Various information leaflets and posters in the patient waiting area promoted support groups to assist patients to live healthier lives.

Are services caring?

Requires improvement

The practice is rated as requires improvement for providing caring services, as there are areas where improvements should be made.

- Data from the National GP Patient Survey showed patients rated the practice lower than others for several aspects of care. The January 2016 results demonstrated some improvements from the July 2015 results; however, the practice had not reviewed the recent results and identified areas for improvement.
- Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.

Summary of findings

- Information for patients about the services available was easy to understand and accessible.
- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.
- There was a process in place to identify carers and provide relevant support.

Are services responsive to people's needs?

Requires improvement

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

- Practice staff were actively working with the Clinical Commissioning Group (CCG) to ensure services met the needs of its local population.
- The practice had recently changed its appointment system and we saw urgent and routine appointments were available, at both Birstall Medical Centre and Border Drive Surgery.
- At the time of our inspection, the practice did not offer extended hours however planned to discuss future possibilities with the CCG to improve access to patients.
- Patients said they found it easy to make an appointment and there had been an improvement in making an appointment since the change in the system.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- Information about how to complain was available and easy to understand and evidence showed the practice responded quickly to issues raised. However, informal complaints were not documented and lessons learnt.

Are services well-led?

Requires improvement

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

- The practice had a short-term and medium-term strategy in place to improve the current service provision, as well as ensuring patients received high quality care.
- Staff were aware of the strategies and their roles in achieving them.
- The practice was developing a new governance framework, which supported the delivery of the strategy and good quality care.
- Practice specific policies had been recently reviewed, implemented and were available to all staff. However, safeguarding policies did not include local authority contact

details or outline what the local requirements were in relation to raising a safeguarding concern. There was also no protocol in place to support the process to contact patients who did not attend for cervical screening tests.

- A programme of clinical and internal audit, which was used to monitor quality and to make improvements.
- There were some arrangements for identifying, recording and managing risks. However, there was no risk assessment in relation to control of substances hazardous to health (COSHH) products. The practice had not identified the potential risk to prescriptions not securely stored, or clinical waste bins not securely stored. Not all staff with chaperone responsibilities had appropriate Disclosure and Barring Service (DBS) checks.
- There was a leadership structure in place, which was still undergoing review by the practice. Staff felt supported by management and were positive about the changes to the service.
- With the support and leadership from the new GP partner and practice management team, the practice was improving.
- The provider was aware of and complied with the requirements of the Duty of Candour.
- The practice was unable to demonstrate any actions taken as a result of patient surveys or feedback. However, had plans in place to introduce local patient surveys involving the patient participation group (PPG).
- Limited progress was made by the practice as a result of feedback from the PPG, however the PPG were hopeful with the new practice management team, feedback would be acted on.

Summary of findings

The six population groups and what we found

We always inspect the quality of care for these six population groups.

Older people

Requires improvement

The provider was rated as requires improvement for all five of the key questions we ask; is it safe, effective, caring, responsive and well led. The issues identified as requiring improvement affected all patients included this population group. There were, however, examples of good practice.

- The practice offered personalised care to meet the needs of the older people in its population.
- The practice was responsive to the needs of older people, and offered home visits and urgent appointments for those with enhanced needs.
- Those patients identified as high risk had a care plan in place and the practice worked with other health and social care professionals to ensure their needs were met.
- Patients over 75 and requiring an urgent home visit were referred to the Acute Visiting Service (AVS).

People with long term conditions

Requires improvement

The provider was rated as requires improvement for all five of the key questions we ask; is it safe, effective, caring, responsive and well led. The issues identified as requiring improvement affected all patients included this population group. There were, however, examples of good practice.

- Patients at risk of hospital admission were identified as a priority.
- Performance for diabetes related indicators, for example monitoring of blood sugar levels, was better compared to the national average. 89% compared to 78%.
- Longer appointments and home visits were available when needed.
- Patients with a new diagnosis of diabetes were offered a longer appointment.
- Patients had a named GP and this was identified on the patient record system. However, the practice was carrying out an additional review to ensure all patients with long-term conditions had a named GP.
- An annual review was carried out to check patients' health and medicines needs were being met. For those patients with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Summary of findings

Families, children and young people

Requires improvement

The provider was rated as requires improvement for all five of the key questions we ask; is it safe, effective, caring, responsive and well led. The issues identified as requiring improvement affected all patients included this population group. There were, however, examples of good practice.

- 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.
- 72% of patients diagnosed with asthma had an asthma review in the last 12 months. This was comparable to the national average of 75%.
- The practice's uptake for the cervical screening programme was 75%, which was comparable to the CCG average of 78% and the national average of 82%.
- Appointments were available outside of school hours and the premises were suitable for children and babies.
- The practice provided facilities for baby changing and mothers wishing to breastfeed.
- The practice provided a room for antenatal visits so pregnant women could be seen at the surgery.

Working age people (including those recently retired and students)

Requires improvement

The provider was rated as requires improvement for all five of the key questions we ask; is it safe, effective, caring, responsive and well led. The issues identified as requiring improvement affected all patients included this population group. There were, however, examples of good practice.

- The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. This included offering late appointments to see a GP.
- The practice offered online services to book appointments and request repeat prescriptions, as well as a full range of health promotion and screening that reflected the needs for this age group.
- NHS Health Checks were offered to patients, which were repeated every five years.

Summary of findings

- Telephone triage was offered to patients to minimise the need for patients to attend the practice.

People whose circumstances may make them vulnerable

Requires improvement

The provider was rated as requires improvement for all five of the key questions we ask; is it safe, effective, caring, responsive and well led. The issues identified as requiring improvement affected all patients included this population group. There were, however, examples of good practice.

- The practice held a register of patients living in vulnerable circumstances including homeless people and those with a learning disability.
- The practice offered longer appointments for patients with a learning disability, as well as an annual health check.
- The practice worked with multi-disciplinary teams in the case management of vulnerable people and had improved the vulnerable patient register to ensure the correct health and social care professionals were involved in the patients care.
- Staff knew how to recognise signs of abuse in vulnerable adults and children. However, administrative staff were unaware of relevant agencies that would need to be contacted if they had a safeguarding concern.
- The practice had a named safeguarding lead.

People experiencing poor mental health (including people with dementia)

Requires improvement

The provider was rated as requires improvement for all five of the key questions we ask; is it safe, effective, caring, responsive and well led. The issues identified as requiring improvement affected all patients included this population group. There were, however, examples of good practice.

- 100% of patients with a diagnosis of schizophrenia, bipolar affective disorder or other had a comprehensive and agreed care plan in place, compared to the national average of 88%.
- 85% of patients with a diagnosis of dementia had their care reviewed in a face-to-face review, compared to the national average of 84%.
- The practice referred patients to support groups including community mental health teams.
- The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those living with dementia.

Summary of findings

- The practice had a system in place to follow up patients who had attended accident and emergency where they may have been experiencing poor mental health.
- Staff had a good understanding of how to support patients with mental health needs and those living with dementia. However, a limited number of staff had received training in the Mental Capacity Act.

Summary of findings

What people who use the service say

The national GP patient survey results published in January 2016. The results showed the practice was performing in line with national averages. 314 survey forms were distributed and 124 were returned. This represented 1.6% of the practice's patient list.

- 72% found it easy to get through to this surgery by phone compared to a national average of 73%.
- 70% were able to get an appointment to see or speak to someone the last time they tried (national average 76%).
- 77% described the overall experience of their GP surgery as fairly good or very good (national average 85%).
- 66% said they would definitely or probably recommend their GP surgery to someone who has just moved to the local area (national average 79%).

As part of our inspection, we also asked for CQC comment cards to be completed by patients before our inspection. We received 11 comment cards, which were positive about the standard of care received. Patients said they felt listened to and were happy with their treatment plans. One patient also commented it was still difficult at times to get an appointment and another acknowledged the improvements in the service in the last 12 months. The NHS Friends and Family Test as of October 2015 showed 55% of patients would recommend the practice.

We spoke with 10 patients during the inspection. All patients said they were happy with the care they received and thought staff were approachable and caring. The NHS Friends and Family Test results for March 2016 showed 80% of patients would recommend the practice.

Areas for improvement

Action the service MUST take to improve

The areas where the provider must make improvements are:

- Ensure policies and procedures contain relevant and necessary information, and they support current processes and systems.
- Ensure staff carry out relevant and mandatory training.
- Ensure Disclosure and Barring Service (DBS) checks are carried out on staff members with chaperone responsibilities.
- Ensure recruitment checks are carried out before employment and annual checks on professional registration statuses are carried out.
- The safe storage of prescriptions.
- Implement a process to review uncollected repeat prescriptions.
- Provide supervision to locum GPs working at the practice.
- Review data from the National GP Patient Survey and take action where necessary.
- Ensure all appropriate risk assessments are carried out.
- Review patient feedback and patient surveys to take action to improve services provided.

Action the service SHOULD take to improve

In addition the provider should:

- Ensure staff are aware of what constitutes a significant event so these can be reported and investigated thoroughly.
- Continue to review patient care plans to ensure care is provided in line with relevant and current evidence based guidance and standards.
- Document, record and investigate informal complaints.
- Finalise the governance framework to support the delivery of the strategies and good quality care.

Summary of findings

- Finalise the leadership structure and continue to involve all staff members in discussions.
- Improve the communication with the PPG and act on feedback.

Birstall Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector**.** The team included a GP specialist adviser, a second CQC inspector and a practice manager specialist adviser.

Background to Birstall Medical Centre

Birstall Medical Centre provides primary medical services to approximately 7,495 patients from two sites, Birstall Medical Centre and Border Drive Surgery, Leicester. The two sites share a common patient list. We inspected both sites.

The practice has two GP partners and one salaried GP. The nursing team consists of a nurse, advanced nurse practitioner and a healthcare assistant. They are supported by a Business Manager (also a business partner), a Practice Manager and reception and administrative staff.

West Leicestershire Clinical Commissioning Group (WLCCG) commission the practice's services.

Border Drive Surgery is located in Mowmacre Hill which is a relatively less affluent area compared to Birstall. The practice is located in a converted house. Birstall Medical Centre is located in a purpose-built two-storey building. All patients' facilities are located on the ground floor at both sites.

Birstall Medical Centre is open between 8am and 6.30pm Monday to Friday. Border Drive Surgery is open between 8.30am to 6pm Monday to Wednesday and Friday, it is open from 8.30am to 1pm on Thursdays. GP consultations are available between 8.30am and 11.30am. In the afternoon, consultations start at either 2pm or 3pm and usually finish at 5.30pm.

Patients can access out of hours support from the national advice service NHS 111. The practice also provides details for the nearest urgent care centres, as well as accident and emergency departments.

A new practice management team started on 29 February 2016. Between them starting and the inspection on 15 March 2016, new systems have been implemented and numerous concerns from the May 2015 inspection had been resolved.

Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory function. In May 2015, the practice had been rated as Inadequate and was placed into Special Measures in September 2015. Being placed into

Special Measures represents a decision by the Care Quality Commission (CQC) that a service has to improve within six months to avoid CQC taking steps to cancel the providers' registration.

This inspection was carried out to consider whether sufficient improvements have been made and to identify if the provider is now meeting legal requirements and associated regulations.

Detailed findings

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 15 March 2016. During our visit we:

- Spoke with a range of staff including GPs, advanced nurse practitioner, nurses, healthcare assistants and practice management.
- Spoke with patients who used the service and observed how patients were being cared for.
- Reviewed an anonymised sample of the personal care or treatment records of patients.
- Reviewed comment cards where patients and members of the public shared their views and experiences of the service.

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.

Requires improvement

Are services safe?

Our findings

Following our inspection in May 2015, the practice was rated as 'Inadequate' for the provision of safe care and treatment and was required to make improvements.

In May 2015, we found the practice did not carry out investigations when things went wrong and lessons learned were not communicated. Systems and processes were not in place in a way to keep patients safe, for example, incoming mail regarding patients was prioritised by non-clinical staff without a process for them to follow. The practice could not demonstrate that any infection prevention and control audit had been conducted and the infection prevention and control policy had last been reviewed in 2013. The business continuity plan did not contain relevant information in the event of a major disruption to the service. Drugs in GP bags taken on home visits had passed the manufacturers expiry date.

Safe track record and learning

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

- Staff told us they would report any incidents through the practice incident reporting system.
- The practice carried out a thorough analysis of the significant events and staff were able to reflect on recent significant events and any lessons learned as a result.

When there were unintended or unexpected safety incidents, patients were offered a meeting to discuss the incident and any actions to improve processes to prevent the same thing happening again. Patient also received a verbal or written apology.

The practice management team told us that although a system was in place, they were not confident all serious incidents were reported correctly to ensure they were thoroughly investigated and lessons were learnt. They were working with staff to ensure they understood what a significant event was and a new policy had been implemented.

Safety alerts had recently been implemented as a standing agenda item at clinical meetings to ensure they were discussed and action was taken as necessary.

Overview of safety systems and processes

The practice had systems, processes and practices in place to keep patients safe and safeguarded from abuse. However, there were some gaps within the processes which had not been adhered to, the practice management team were aware of this and had plans in place to address it.

- Safeguarding children and vulnerable adults' policies clearly outlined who to contact within the practice for further guidance if staff had concerns about a patient's welfare. Staff members were aware of their responsibilities and informed us they would raise any concerns with the safeguarding lead. However, staff were unsure of any external organisations they could contact if they had a concern and policies and procedures did not outline what the local requirements were. The nursing team and GPs had received safeguarding adult and children training relevant to their role. However, out of eight administrative staff, three had not completed training for safeguarding vulnerable adults and two had not completed training for safeguarding children. Vulnerable patients were identified on the practices' computer system and there were plans to streamline this process to reflect the patient age to ensure appropriate external health and social care professionals were involved in the patients care, as necessary. Multidisciplinary meetings were held every six weeks to discuss any safeguarding concerns and the lead was taken by the appropriate clinician.
- A notice in the waiting room advised patients that chaperones were available if required. All staff who acted as chaperones were trained for the role; however, three staff members had not received a Disclosure and Barring Service check (DBS check). (DBS
- The practice maintained appropriate standards of cleanliness and hygiene. We observed the premises at Birstall Medical Centre and Border Drive Surgery to be visibly clean and tidy. The practice nurse and advanced nurse practitioner were the infection control clinical leads who liaised with the local infection prevention teams to keep up to date with best practice. There was an infection control protocol in place and staff had received up to date training. The treatment room at Birstall Medical Centre had recently been refurbished in line with infection control best practice guidance. However, we noted clinical waste bins stored outside were locked but not stored securely.

Requires improvement

Are services safe?

- The arrangements for managing medicines, including emergency medicines and vaccinations, in the practice did not always keep patients safe. The practice carried out regular medicines audits, with the support of the local CCG medicine management teams, to ensure prescribing was in line with best practice guidelines for safe prescribing. Patient Group Directions (PGDs) had been adopted by the practice to allow nurses to administer medicines in line with legislation. The practice management team told us they were reviewing the PGDs to see what was necessary for staff and to ensure all competencies were up to date. The practice had a robust system in place for patients collecting prescriptions that contained controlled drugs (CDs). This included patients providing identification and signing to state the prescription had been collected. (A controlled drug is a medicine that requires extra checks and special storage arrangements because of their potential for misuse). Prescriptions were not securely stored and there were no systems in place to monitor their use. There was also no system in place to monitor uncollected prescriptions. Prescriptions were stored at the back of the collection box for six months and shredded. There was no documentation in patient records or clinical review to ensure the patient was not vulnerable. Fridge temperatures, where vaccinations and immunisations were stored, were recorded and within recommended temperature ranges. However, we noted at Border Drive Surgery temperatures were not taken on a Friday, as there were no staff from the nursing team present.
- 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.

We reviewed five personnel files. We found not all appropriate recruitment checks had been undertaken before employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service. The practice had taken action to identify what was missing from all staff files and provided us with evidence to show they were actively asking staff to provide information in relation to these recruitment checks.

The practice did not have a process to check the ongoing registration status with the appropriate professional body for GPs and nurses, for example the General Medical Council (GMC) and Nursing and Midwifery Council (NMC). Registration with the GMC and NMC should be renewed by individuals on an annual basis. During our inspection, the practice management team checked the registration status of their clinical staff and provided this to us.

Monitoring risks to patients

Some risks to patients were assessed and well managed.

- There were procedures in place for monitoring and managing risks to patient and staff safety. The practice had up to date fire risk assessments and carried out regular fire drills. The outcomes of the fire drills were documented, reflected on and discusses with staff members. All electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly. The practice had a variety of other risk assessments in place to monitor safety of the premises such as infection control and legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings). We noted where actions had been identified as a result of a risk assessment, these had been completed. Data sheets were kept for control of substances hazardous to health (COSHH) products; however, the practice had not carried out a risk assessment.
- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system in place for the different staffing groups to ensure that enough staff were on duty. Administration staff covered planned and unplanned leave.
- The level of clinical and administrative support was under review to ensure it was sufficient to provide high quality patient care. The practice management team informed us this would be under review for roughly nine months to ensure processes and policies were embedded.
- The practice used a local agency for the provision of locum GPs to provide cover for planned leave. The agency maintained records of relevant recruitment checks, including professional registration status, proof of identification and qualifications, which was accessed by the practice.

Requires improvement

Are services safe?

Arrangements to deal with emergencies and major incidents

The practice had adequate arrangements in place to respond to emergencies and major incidents, however not all staff had received basic life support training.

- There was an instant messaging system on the computers in all the consultation and treatment rooms, which alerted staff to any emergency.
- Fifteen out of 19 staff members had received basic life support training. The practice was unable to provide dates of when the remaining four staff members would attend training, however acknowledged there were various gaps in mandatory training, which they were working with staff to complete.
- Emergency medicines were available at both sites in a secure area of the practice and staff knew of their location.
- The practice had a defibrillator available on the premises and oxygen with adult and children's masks. A first aid kit was also available behind the reception desk.
- The practice had a comprehensive business continuity plan in place for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff and service providers, as well as alternative premises that could be used in an emergency.

Requires improvement

Are services effective?

(for example, treatment is effective)

Our findings

Following our inspection in May 2015, the practice was rated as 'Requires Improvement' for the provision of effective care and treatment.

In May 2015, we found staff had not received training appropriate to their roles. Some further training had been identified and planned to meet these needs.

Effective needs assessment

The practice had plans in place to review patient care plans to ensure they assessed the needs of patients and care was delivered in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines.

- The practice used locally led care plans and templates to assist with patient care in line with best practice.
- An external clinical review had been requested, which was intended to review all patients with a long term condition to ensure care was delivered appropriately in line with relevant and current evidence based guidance. Following this review, additional plans were in place to review all patients with three or more medical conditions and all patients with four or more repeat prescriptions.
- The practice used a local formulary regarding prescribing guidelines to ensure they adhered to best practice. Locum GPs were aware of the local prescribing guidelines and used them.

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality and 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 96.5% of the total number of points available, with 13% exception reporting. (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 2014/15 showed;

- Performance for diabetes related indicators, for example monitoring of blood sugar levels, was better compared to the national average. 89% compared to 78%.
- The percentage of patients with hypertension having regular blood pressure tests was comparable to the national average. 82% compared to 84%.
- Performance for mental health related indicators was better compared to the national average. For example, 100% of those with a diagnosis of schizophrenia, bipolar affective disorder or other had a comprehensive and agreed care plan in place, compared to 88%. 85% of patients with a diagnosis of dementia had their care reviewed in a face-to-face review, compared to 84%.

  The practice had high exception reporting in various clinical targets compared to the CCG and national averages. In particular, coronary heart disease, stroke and transient ischaemic attack (TIA), asthma, chronic kidney disease and diabetes. The practice reviewed this information and demonstrated issues with coding on the practices' computer system when tests had been carried out. Work was ongoing with the GPs and nursing team to ensure tests were correctly coded and recorded, which included a monthly audit regarding QOF clinical achievements.

  Clinical audits demonstrated quality improvement.
- There had been four clinical audits completed in the last two years, where the improvements made were implemented and monitored. These included the use of methotrexate, the use of medication post acute coronary syndrome, patients in atrial fibrillation and minor surgery.
- The practice participated in local audits and peer review.
- Findings were used by the practice to improve services. For example, patients were invited into the practice if it had been identified that they needed to start on particular medication or if their current medication needed to be changed.

The practice planned to review all patients over 40 with a risk of being diagnosed with dementia. This would ensure early diagnosis and appropriate provision of help and support to these patients.

Effective staffing

Requires improvement

Are services effective?

(for example, treatment is effective)

The practice had reviewed and identified the gaps in training needs for staff to ensure they had the right skills, knowledge and experience to deliver effective care and treatment.

- The practice had an induction programme for all newly appointed staff and a mentor was also assigned to the new staff member. The induction programme covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality.
- Locum GPs had a brief induction to the practice and there was no active supervision to the locums working at the practice.
- Training data supplied by the practice did not demonstrate continued role-specific training and updates for relevant staff. For example, for those reviewing patients with long-term conditions and staff administering immunisations. Some training data was supplied to demonstrate staff taking samples for the cervical screening programme had received specific training, which had included an assessment of competence.
- The learning needs of staff were identified through a system of appraisals and meetings. Staff informed us they had a recent appraisal and historically training was difficult to attend. The practice management team had identified staff training needs and also planned to utilise current staff skills to provide development opportunities. There was facilitation and support for revalidating GPs. Most staff had had an appraisal within the last 12 months.
- Staff had access to training through e-learning training modules. However, the training matrix identified various gaps in staff training. This included fire procedures, information governance awareness and health and safety. Practice management were aware of the identified gaps and were working with staff to ensure training was completed. Staff also told us they found it difficult to find time to complete training during working hours.

Coordinating patient care and information sharing

The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practice's patient record system.

- This included care and risk assessments, care plans, medical records and investigation and test results. Information such as NHS patient information leaflets were also available.
- The practice shared relevant information with other services in a timely way, for example when referring patients to other services.
- The practice had a new system in place to review incoming mail. All staff were aware of the process and any mail marked as urgent or requires immediate attention was given to the relevant GP immediately. There was no backlog of mail at either site during our inspection.
- There was a system in place to ensure pathology results were reviewed on a daily basis and GPs provided cover for each other when they had leave.

Staff worked together and with other health and social care services to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. This included when patients moved between services, including when they were referred, or after they were discharged from hospital. We saw evidence that multi-disciplinary team meetings took place every six weeks. The appropriate clinician led on the patients' care plan, which was discussed at the meeting and reviewed and updated as necessary.

Consent to care and treatment

Staff sought patients' consent to care and treatment in line with legislation and guidance, however training data demonstrated not all staff had received appropriate training.

- < >taff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005 (MCA). When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance.
- Where a patient's mental capacity to consent to care or treatment was unclear, the GP or practice nurse assessed the patient's capacity and, recorded the outcome of the assessment.
- Training information provided by the practice showed only one staff member had received training in MCA. A

Requires improvement

Are services effective?

(for example, treatment is effective)

GP also told us they had received training in MCA and Deprivation of Liberty Safeguards (DoLS) as a result of a significant event. However, there was no evidence to support GPs had received appropriate training.

- Consent forms were used for patients undergoing minor surgery at the practice. These were scanned onto the practices' computer system and attached to the patient record. However, the process for seeking consent was not monitored through records audits.

Supporting patients to live healthier lives

The practice was reviewing their systems, which identified patients who may be in need of extra support.

- These included patients in the last 12 months of their lives, carers and those at risk of developing a long-term condition. For example, patients newly diagnosed with diabetes were offered a longer appointment to discuss the condition and provide advice and support. Patients were also signposted to the relevant service.
- The practice was reviewing all patients with a named and accountable GP to ensure this was reflected on the practices' computer system to ensure appropriate support was offered.
- Various information leaflets and posters in the patient waiting area promoted support groups to assist patients to live healthier lives. This included LEAP: lifestyle eating and activity programme, and pregnancy and flu.

The practice's uptake for the cervical screening programme was 75%, which was comparable to the CCG average of 78% and the national average of 74%. There was a process in place to follow up a patient three times if they did not attend for their cervical screening test; however, there was no protocol to support this process.

The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening. However, the percentage of patients who took up the invitation for bowel and breast cancer screening was lower than the CCG and national averages.

- 68% of females aged between 50 and 70 were screened for breast cancer within 6 months of invitation, compared to the CCG average of 83% and national average of 73%.
- 50% of patients aged between 60 and 69 were screened for bowel cancer within 6 months of invitation, compared to the CCG average of 60% and national average of 55%.

Data as of December 2015 showed that the percentage of patients fitting the criteria for bowel and breast cancer screening had already improved compared to the overall figure for 2014/15.

Childhood immunisation rates for the vaccinations given were comparable to CCG averages. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 93% to 100% and five year olds from 97% to 100%.

Patients had access to appropriate health assessments and checks. These included health checks for new patients, NHS health checks for people aged 40–74 and annual health checks for patients with a learning disability. Appropriate follow-ups for the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.

Requires improvement

Are services caring?

Our findings

Following our inspection in May 2015, the provider was rated as 'Inadequate' for the domain of caring.

In May 2015, we found the practice was below average for its patient satisfaction scores on consultations with doctors. Patients did not respond positively to questions about their involvement in planning and making decisions about their care and treatment with satisfaction scores well below the CCG averages.

Kindness, dignity, respect and compassion

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

- 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.

All of the 11 patient Care Quality Commission comment cards we received were positive about the service experienced. One acknowledged the improvements the practice had made in the last 12 months. Patients said they felt the practice offered a high standard of care.

Comment cards highlighted that staff were courteous and friendly and that patients were treated with the greatest respect.

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

- 73% said the GP was good at listening to them compared to the CCG average of 88% and national average of 89%.
- 71% said the GP gave them enough time (CCG average 86%, national average 86%).
- 88% said they had confidence and trust in the last GP they saw (CCG average 95%, national average 95%).
- 66% said the last GP they spoke to was good at treating them with care and concern (national average 85%). This was similar to the GP survey results published in July 2015.
- 94% said the nurse was good at listening to them compared to the CCG average of 91% and national average of 91%.
- 91% said the nurse gave them enough time (CCG average 92%, national average 92%).
- 98% said they had confidence and trust in the last nurse they saw (CCG average 98%, national average 97%).
- 83% said the last nurse they spoke to was good at treating them with care and concern (national average 91%).
- 85% said they found the receptionists at the practice helpful (CCG average 86%, national average 87%).

Care planning and involvement in decisions about care and treatment

Patients told us they felt listened to and GPs were helpful. Patient feedback on the comment cards we received also said patients felt listed to and referred on to specialist care when needed.

Results from the national GP patient survey showed improvements in patients' satisfaction regarding their involvement in planning and making decisions about their care and treatment. However, satisfactions scores specific to GPs were still lower than the CCG and national averages. For example:

- 69% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 86% and national average of 86%. This was a 10% improvement from the GP survey results published in July 2015.
- 64% said the last GP they saw was good at involving them in decisions about their care (national average 82%). This was a small improvement (4%) from the GP results published in July 2015.
- 91% said the last nurse they saw was good at explaining tests and treatments compared to the CCG average of 90% and national average of 90%.

Requires improvement

Are services caring?

- 85% said the last nurse they saw was good at involving them in decisions about their care (national average 85%).

Staff told us that translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patients this service was available.

Patient and carer support to cope emotionally with care and treatment

Notices in the patient waiting room 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. The practice had identified 0.9% of the practice list as carers. The practice had identified carers dependant on if they were an informal carer, a relative or a primary carer. Written information was available to direct carers to the various avenues of support available to them, including VASL: Carers Health Wellbeing Service.

Staff told us that if families had suffered bereavement, a sympathy card was sent to the family. We noted the sympathy card had been designed to be culturally neutral. A leaflet was sent with the sympathy card providing information on local counselling services. Family members were also offered an appointment, which was ideally booked for the end of a clinic to allow a longer period of time with the family member.

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Following our inspection in May 2015, the provider was rated as 'Inadequate' for the responsiveness of the practice to the needs of patients.

In May 2015, we found the practice had not put in place a plan to secure improvements for all of the areas identified to meet the needs of the local population. Feedback from patients included access to a named GP was not always available quickly and continuity of care was limited. There was no evidence that learning from complaints had been shared with staff, nor were patients who wished to complain given the appropriate information.

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 management team also informed us they planned to discuss the provision of extended hours with the CCG to improve access to patients.

- Same day appointments were available for children and those with serious medical conditions.
- The practice offered telephone triage, online booking for appointments and online requests for repeat prescriptions.
- Patients were able to receive travel vaccinations available on the NHS as well as those only available privately.
- There were disabled facilities, a hearing loop and translation services available.
- The practice offered baby changing facilities as well as a private area for mothers wishing to breastfeed.
- The practice provided a room for antenatal visits so pregnant women could be seen at the surgery.
- We saw some patients at Border Drive Surgery had difficulty entering and exiting the practice, particularly patients with pushchairs. The practice management team told us an access audit had not been carried out at either location to ensure all reasonable adjustments were made to ensure patients did not find it hard to access services.
- The practice had a robust system in place to provide care and treatment to patients with 'no fixed abode', this included patients living at a local hostel. Adults were registered at the practice for a duration of three months and children aged five and under were remained registered to ensure they could be seen for childhood immunisations.
- Patients over 75 who required an urgent home visit were referred to the acute visiting service (AVS) team to allow care closer to home.
- The practice offered social care support by referring patients to Health and Social Care Co-ordinators.

Access to the service

Birstall Medical Centre was open between 8am and 6.30pm Monday to Friday. Border Drive Surgery was open between 8.30am to 6pm Monday to Wednesday and Friday, and from 8.30am to 1pm on Thursdays. GP consultations were available between 8.30am and 11.30am. In the afternoon, consultations started at either 2pm or 3pm and usually finished at 5.30pm. In addition to pre-bookable appointments that could be booked up to four weeks in advance, urgent appointments were also available for people that needed them.

The practice had recently changed its appointment system and we saw urgent and routine appointments were available, at both Birstall Medical Centre and Border Drive Surgery. At the time of our inspection, the practice did not offer extended hours however planned to discuss future possibilities with the CCG to improve access to patients.

Results from the national GP patient survey showed that patient's satisfaction with how they could access care and treatment was mixed compared to local and national averages.

- 75% were satisfied with the practice's opening hours compared to the national average of 78%. This was similar to the GP survey results published in July 2015.
- 72% said they could get through easily to the surgery by phone (national average 73%). This was a 12% decrease compared to the results from the GP survey published in July 2015.
- 22% said they always or almost always see or speak to the GP they prefer (national average 36%).
- 78% said the last appointment they got was convenient compared to the CCG average of 93% and the national average of 92%.
- 62% described their experience of making an appointment as good (CCG average 73%, national average 73%). The practice management team had

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

acknowledged access to the practice by telephone in the morning was problematic and were actively trying to get additional phone lines to make this easier for patients.

- 65% felt they did not normally have to wait too long to be seen (CCG average 61%, national average 58%).

Patients at Border Drive Surgery told us they were able to get appointments when they needed them, either with a GP or advanced nurse practitioner. A new system had been implemented and the majority of appointments were bookable on the day and patients were aware of this new system. Patients at Birstall Medical Centre told us they still had some difficulties getting appointments, however had seen an improvement.

Listening and learning from concerns and complaints

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

- Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England.
- Staff were aware of the process to follow if a patient wanted to raise a concern or make a complaint.
- There was a designated responsible person who handled all complaints in the practice.
- A copy of the complaints process was displayed in the patient waiting area during our inspection.

We looked at three complaints received in the last 12 months and found these were responded to in a timely way and were open and transparent when investigating the complaint. However, we witnessed during our previous inspection in May 2015 a patient stating they wished to make a complaint. We could not find any reference to this complaint with the records kept by the practice. We were told the practice did not record informal complaints and acknowledged that this was an area they needed to improve on.

Are services well-led?

Requires improvement

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

Our findings

Following our inspection in May 2015, the provider was rated as 'Inadequate' for the domain of well-led.

In May 2015, we found staff were not clear about their responsibilities in relation to the practice vision or strategy. Policies and procedures that governed activity were not personalised to the practice, some were in draft form and others were over five years old and had not been reviewed since. The practice did not hold regular governance meetings and issues were discussed at ad

hoc meetings. The practice was unable to produce any records of these meetings. The practice had not planned or taken into account the need for additional staff as previous staff had left. The updating of new patient summaries notes were six months behind. There was no evidence of any staff feedback and there had been no staff appraisals for last 18 months.

Vision and strategy

The practice had a short-term and medium-term strategy in place to improve the current service provision, as well as ensuring patients received high quality care. This included utilising existing staff potential and offering development opportunities and reviewing clinical data.

Staff were aware of the strategies and their roles in achieving them.

Governance arrangements

The practice was developing a new governance framework, which supported the delivery of the strategy and good quality care.

- Staff were aware of their own roles and responsibilities. The practice management team told us there were plans to review staff responsibilities to ensure the most appropriate person had a lead role and the skills to undertake this role.
- Practice specific policies had been recently reviewed, implemented and were available to all staff. However, safeguarding policies did not include local authority contact details or outline what the local requirements were in relation to raising a safeguarding concern. There was also no protocol in place to support the process to contact patients who did not attend for cervical screening tests.
- A programme of continuous clinical and internal audit, which was used to monitor quality and to make improvements.
- There were some arrangements for identifying, recording and managing risks. However, there was no risk assessment in relation to control of substances hazardous to health (COSHH) products. The practice had not identified the potential risk to prescriptions not securely stored, or the risk to patients if a repeat prescription was not collected. Not all staff with chaperone responsibilities had appropriate Disclosure and Barring Service (DBS) checks.

Leadership and culture

A new GP partner had started with the practice as well as a new practice management team to support current staff. They prioritised safe, high quality and compassionate care and were reviewing current policies, procedures and systems in place to ensure they supported the provision of high quality care. The partners and practice management team were visible in the practice and staff told us they were approachable and now felt able to contribute to ideas. With the support and leadership from the new GP partner and practice management team, the practice was improving.

The provider was aware of and complied with the requirements of the Duty of Candour. The partners encouraged a culture of openness and honesty. The practice had systems in place for knowing about notifiable safety incidents

When there were unexpected or unintended safety incidents:

- The practice gave affected people reasonable support, an explanation and a verbal or written apology
- They kept written records of verbal interactions as well as written correspondence and a meeting was offered to the patient to discuss the incident.

There was a leadership structure in place, which was still undergoing review by the practice. Staff felt supported by management and were positive about the changes to the service.

- The practice management team told us clinical meetings were held on a weekly basis and practice meetings were held on a monthly basis. A new meeting

Are services well-led?

Requires improvement

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

structure was to be implemented to ensure a set agenda was in place to discuss complaints, incidents, mortality and morbidity and new guidelines published by the National Institute for Health and Care Excellence (NICE).

- Staff felt they were now able to raise any issues, concerns or suggestions and the practice management team would support them.
- Staff said the new practice management team had kept them informed of all new changes to service delivery. The new GP partner said it was very important to keep staff well informed to minimise any anxieties regarding changes to the practice.

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

The practice was unable to demonstrate any actions taken as a result of patient surveys or feedback.

- There was a patient participation group (PPG) which met regularly. They told us they were actively trying to recruit more members to the PPG and felt their role was to help patients understand how best to use the practice and provide feedback, where possible, to the practice. The PPG had found it difficult to encourage patients to complete questionnaires and had actively sat in the waiting area to gain patient feedback. However, limited progress was made by the practice as a result and the PPG were hopeful with the new practice management team, feedback would be acted on.
- The practice management team informed us they planned to carry out an internal patient survey, which would be designed with the help of the PPG. The intention was for the surveys to be carried out three times a year.
- An internal survey had been carried out before our inspection visit to trial how the survey would work and to gain some initial feedback from patients. The feedback from Birstall Medical Centre was overall positive and 94% of the feedback from Border Drive surgery was positive. The survey asked how helpful the consultation was and how the patient would rate their visit to the practice.
- The practice had not reviewed the GP survey results published in January 2016 to identify areas for improvement and implement actions.
- Staff told us they now felt involved and engaged to improve how the practice was run.

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 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.: Safe care and treatment **How the regulation was not being met:** The registered person did not do all that was reasonably practicable to assess, monitor, manage and mitigate risks to the health and safety of service users. This included: Ensuring all appropriate risk assessments were carried out, including in relation to control of substances hazardous to health (COSHH). Maintaining the safe storage of prescriptions. Reviewing uncollected repeat prescriptions to ensure vulnerable patients received necessary medicines. This was in breach of regulation 12(1)(2)(a)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Good governance **How the regulation was not being met:** The registered person did not do all that was reasonably practicable to ensure systems or processes were established. This included:

This section is primarily information for the provider

Requirement notices

Ensuring policies and procedures contained relevant and necessary information, and that they supported current processes and systems.

Seek and act on patient feedback and patient surveys.

Seek and act on data from the National GP Patient Survey.

This was in breach of regulation 17(1)(2)(d)(ii)(e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Staffing **How the regulation was not being met:** The registered person did not do all that was reasonably practicable to ensure persons employed received appropriate training, professional development and supervision. This included: Ensuring staff received relevant and mandatory training. The provision of supervision to locum GPs working at the practice. This was in breach of regulation 18(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Fit and proper persons employed **How the regulation was not being met:**

This section is primarily information for the provider

Requirement notices

The registered person did not do all that was reasonably practicable to ensure persons employed for their purpose was of good character.

Information specified in schedule 3 of the Health and Social Care Act 2008 was not available.

Checks were not carried out on an annual basis to ensure persons employed and registered with a professional body were renewed on an annual basis.

This was in breach of regulation 19(1)(a)(3)(a)(4)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.