Dr Binoy Kumar

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.

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Summary of findings

Overall summary

Dr Binoy Kumar is registered with the Care Quality Commission (CQC) to provide the regulated activities of Diagnostic and Screening Procedures, Treatment of Disease, Disorder and Injury, Family Planning and Maternity and Midwifery Services.

Patients told us they found it easy to access appointments, both routine and urgent. Patients commented on the friendliness of all the staff and the professionalism of the doctor and nurse. Patients told us they did not feel rushed and were treated with dignity and respect

Systems and procedures to ensure the practice is safe are inadequate. There is a lack of evidence to show how the practice learned from incidents.

Systems in place did not ensure the individual care and welfare of patients in any emergency situation would be appropriately managed.

The Patient Participation Group within the practice is used to consider and respond to patient feedback. The patients we spoke with were happy with the access to appointments and how the practice was run to meet their needs.

Systems to monitor and reduce risks within the practice are ineffective. Policies and clear procedures for staff to follow are either not in place or require updating.

The practice recruitment policy and processes are not followed. Staff files are inconsistently maintained and did not demonstrate staff are recruited and employed safely.

The GP is not meeting Regulation 9 of the Health and Social Care Act 2008: Care and Welfare of people who use services.

The GP is not meeting Regulation 10 of the Health and Social Care Act 2008: Assessing and monitoring the quality of service provision.

The GP is not meeting Regulation 21 of the Health and Social Care Act 2008: Requirements relating to workers.

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?
Systems and procedures to ensure the practice was safe were inadequate. There was a lack of evidence to show how the practice learned from incidents. Systems to monitor and reduce risks within the practice were ineffective. Emergency medicines were not available.

Are services effective?
The practice was not always effective in meeting the individual needs of the patients. Systems required improvement to support this.

Are services caring?
The practice was caring. Patients spoke highly of the practice as a whole and commented that it felt like a family. People told us they did not feel rushed and were treated with dignity and respect.

Are services responsive to people's needs?
The practice was responsive to the needs of patients. The practice had developed formalised ways to respond to patient views. For example, a Patient Participation Group was used to consider and respond to patient feedback. The patients we spoke with were happy with the access to appointments and the way the practice was run to meet their needs.

Are services well-led?
A lack of formal governance systems meant the monitoring of quality and the identification and management of risks within the practice were ineffective. Policies and procedures were not in place or required updating.

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
Staff were knowledgeable about the health needs of older patients using the service. The computer system allowed them to identify patient's age, health conditions, and carer's information.

People with long-term conditions
The practice was knowledgeable about the overall health needs of patients with long-term health conditions. They co-operated when appropriate to do so with other health services and agencies to provide appropriate support.

Mothers, babies, children and young people
The practice provided services to meet the needs of this population group with childhood development checks and implemented childhood vaccination and immunisation programmes.

Staff were knowledgeable about child protection. The practice monitored any non-attendance of babies and children at vaccination clinics and worked with the health visiting service to follow up any concerns.

The working-age population and those recently retired
The practice provided a range of services for patients and self-help guidance literature both on-line and within the practice. Appointments were available for telephone consultations with GPs, as well as in an extended hours surgery. The practice website provided information to signpost patients to the most appropriate service during the out-of-hours periods

People in vulnerable circumstances who may have poor access to primary care
The practice accepted new patients to their patient list. This included individuals with no fixed abode and transient population groups.

People experiencing poor mental health
The practice had a register of patients who experienced mental health problems and had arrangements in place to carry out annual reviews.

Summary of findings

What people who use the service say

We spoke with two patients and received 17 CQC comment cards on the day of our visit. We also spoke with a further six patients over the phone and four members of the Patient Participation Group. We spoke with men and women, retired patients, working patients and mothers with children. Patients were complimentary about the care provided by the clinical staff and each patient we spoke with commented on the positive and friendly atmosphere of the practice as a whole. Two people told us they had problems with receiving a referral to a specialist. Patients reported that the whole practice staff team treated them with dignity and respect.

The National GP survey results published in December 2013 found that 76% of people rated the overall experience of the GP surgery as good, which was lower than the national average of 87%, however patients rated the ease of getting through to someone at the GP surgery on the phone as 81%, higher than the national average of 75%.

Areas for improvement

Action the service MUST take to improve

The practice must take appropriate steps to ensure recruitment procedures meet legal requirements and that information specified in Schedule 3 of the Health and Social Care Act 2008 is available. Relevant checks should be made to ensure that qualified staff are registered with their relevant professional body.

The practice must have systems in place to deal with emergencies which could be reasonably expected to arise. The delivery of care should be planned in such a way as to ensure the welfare and safety of patients.

The practice must ensure that medicines are available when patients present in an emergency situation.

The practice must effectively assess and monitor the quality of systems to ensure all patients are protected against the risks of unsafe or inappropriate care.

The practice must have guidance for staff in relation to care for vulnerable adults.

Action the service SHOULD take to improve

The practice did not have procedures to formally monitor, record and evaluate staff learning.

Dr Binoy Kumar

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC inspector. The team included a further CQC inspector, a GP and a Specialist Advisor (Practice Manager).

Background to Dr Binoy Kumar

The practice provides a weekday service for 2152 patients in the Preston area. The practice opens from Monday to Friday from 9am and closes at 6pm each week night with the exception of Thursdays when it closes at 1pm and Monday when extended hours are offered until 7pm.

When the practice is closed patients can receive medical advice and treatment by contacting NHS 111 or by visiting the out of hours service, Preston Primary Care Centre, based at the local NHS hospital.

The practice team includes; a GP, a practice nurse, one practice manager, two reception staff and a secretary. The nurse works eight hours per week spilt over two days; Tuesday afternoon and Wednesday morning. Patients requiring nursing treatments outside these times are referred to the district nursing service.

The practice use the same locum GP, when required, for continuity of service and support for their patients. Other services run by the practice include a baby clinic on Wednesday morning for childhood development checks and vaccinations. Ante-natal clinics are held with the community midwives and a podiatry clinic is held monthly.

The premises were purpose built and offered access and facilities for disabled patients and visitors.

Why we carried out this inspection

We inspected this out-of-hours service as part of our new inspection programme to test our approach going forward. This provider had not been inspected before and that was why we included them.

How we carried out this inspection

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

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

The inspection team always looks at the following six population areas at each inspection:

- Vulnerable older people (over 75s)
- People with long term conditions
- Mothers, children and young people
- Working age population and those recently retired
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing poor mental health.

Before visiting, we reviewed a range of information we had received from the out-of-hours service and asked other organisations to share their information about the service.

We carried out an announced visit on 9th July 2014 and we spent nine hours at the practice.

Detailed findings

During our visit we spoke with a range of staff, including the GP and locum GP, Practice Manager, Reception and Administration staff. We also contacted the Practice Nurse by telephone, as they were not available on the day of the inspection.

We spoke with two patients who used the service, face to face and also spoke with six patients by telephone. We received 17 completed Care Quality Commission (CQC) comment cards.

Are services safe?

Our findings

Systems and procedures to ensure the practice was safe were inadequate. There was a lack of evidence to show how the practice learned from incidents. Systems to monitor and reduce risks within the practice were ineffective. Emergency medicines were not available.

Safe patient care

The practice had systems in place to monitor patient safety but we found these were not used consistently. A significant events file held records of incidents, accidents and complaints. Paperwork was not always dated and was found to be in no particular order, some information was relevant to the recorded events and some was not. There was no central log of significant events or systematic reporting of them, or of the changes made as a result. Any agreed actions were not consistently recorded or dated. Although staff told us that significant events were discussed at staff meetings, we did not see any recorded information to confirm which incident or event had been discussed or when. It was not clear if identified actions had led to improvements in order to reduce the risk of the event reoccurring. We saw no documented evidence of any actions that would lead to improvements in care.

Staff we spoke with told us they were aware of how to report an accident. However, information was not collated and actions were not clear as to the lessons learnt to reduce risk to patients and staff.

Learning from incidents

Staff told us monthly staff meetings, which included discussions around learning from incidents, took place. These meetings were not documented. The practice nurse did not attend these meetings as these were held on days when she was not in work. The practice nurse told us she received informal, verbal updates on her next day in work, following the meeting. The lack of recorded practice meetings meant there was no audit trail of incidents discussed and it was not clear how improvement actions were monitored. We saw no documented evidence which demonstrated any learning from incidents for staff.

We were told by staff that safety alerts were monitored and shared with clinical staff and acted upon as necessary. Again we saw no documented evidence of this

Safeguarding

The practice had policies, procedures and a wall chart in place for managing and dealing with safeguarding children concerns. There was no policy in place for safeguarding vulnerable adults.

Staff we spoke with had an understanding of safeguarding and said they would report anything of concern to the practice manager or the GP. The GP had received level three safeguarding training. The practice nurse told us they had level three training arranged through another employer, but there was only evidence of level two training on file. Non-clinical staff told us they had recently received training from the practice manager in their monthly meetings but there was no documented evidence of this.

Staff told us how information was recorded on patient notes if a safeguarding concern was raised about a child. Staff were proactive in monitoring children who frequently missed appointments. These children were brought to the attention of the GP or practice nurse who worked closely with other health professionals such as the health visitor. The health visitor spoke positively about the communication within the practice.

Most staff were aware of the term 'Whistleblowing'. There was a policy in place; however this required updating to reflect current guidelines.

Monitoring safety and responding to risk

The GP and practice manager had agreed the requirements for safe staffing levels at the practice and staff worked, in general, regular set hours and set days each week to consistently maintain the service provided. Staffing levels were monitored through patient and staff feedback. The practice manager and secretary were able to cover for reception staff absence. The female practice nurse was available on two half days each week.

The GP took all the lead roles in the practice, such as infection control and safeguarding adults and children. The GP attended staff meetings and, we were told, fed back information to the team. However, there were no minutes to support this or to ensure staff who were unavailable to attend meetings, received this information. We were told by staff information was relayed verbally.

Clinical staff had received recent cardiopulmonary resuscitation (CPR) training. However there was no defibrillator or usable oxygen at the practice for use in

emergencies. Oxygen was stored in the practice but had not been checked and was out of date. The practice had not undertaken an appropriate risk assessment for arrangements to respond to an emergency situation.

Within the practice adrenaline was the only emergency drug available within in practice... However, when we spoke separately to the doctor he believed Benzyl Penicillin was available within the practice. Benzyl penicillin is an antibiotic used to treat infections such as bacterial meningitis and recommended to be administered in such cases by the National Institute for Health and Care Excellence (NICE). Potential medical emergencies had not been assessed and the GP and staff could not be sure the emergency medicines were available to treat such an emergency.

We did not see any system in place to verify the number the home visits undertaken The GP also told us he did not carry medication to home visits.

Medicines management

An informal system was in place to ensure medication changes were safely added to patient records. The practice manager was responsible for updating patient records with information from hospital discharges, for example, which were then checked and authorised by the GP. This helped to ensure patients were receiving the required medication.

We were told that repeat prescriptions for medication were reviewed weekly. Staff told us that they checked prescriptions on a Friday and recorded attempts to contact the patients. We saw that on the two most recent completions the serial numbers from the prescription pads had not been logged. NHS Protect security of prescription forms guidance August 2013, recommends recording of the serial numbers as best practice.

We looked at how the practice stored and monitored medicines and vaccines. Vaccines were in date and stock rotation was evident. The fridges were checked daily to ensure the temperature was within the required range for the safe use of vaccines.

Quality, Innovation, Productivity and Prevention (QIPP) comparator data in relation to prescribing spend by each practice, found this practice was not within budget. The QIPP initiative sets out how the NHS plan to make savings so there are more funds available to treat patients and to allow the NHS to respond to changing demands. The practice had an agreed action plan target with the Clinical Commissioning Group (CCG) for a reduction in this indicator.

Cleanliness and infection control

Each patient we spoke with confirmed they found the practice to be clean. On the day of our inspection we found this to be the case

Equipment used for routine cleaning was colour coded and stored appropriately. Staff told us that infection control was covered in their induction. Staff could explain the systems for handling patient samples.

We saw sharps bins and foot operated clinical waste bins were in use in the consulting and treatment rooms. There was a waste collection contract in place to collect clinical waste each month.

We were told there were ample supplies of personal protective equipment (PPE), such as aprons and gloves, and this was evident in treatment rooms.

An infection control audit was conducted in 2014 by the GP who was the lead in infection prevention and control. We did not see any action plan in place to clearly identify the changes required or to monitor progress.

We were told the practice did not use any instruments which required decontamination between patients and all instruments were single use only. Staff told us there was little clinical waste generated and so this was collected only on a monthly basis from individual rooms. Having any amount of clinical waste stored within rooms for this length of time had not been risk assessed.

Staffing and recruitment

The practice had a policy for the safe recruitment of staff which included guidelines about seeking references, proof of identity as well as obtaining disclosure and barring (DBS) checks for all staff. A DBS check is a criminal record check requested by an employer. We found the practice were not following this policy. Staff files were poorly organised and inconsistent in the information they contained.

The practice failed to make basic checks to ensure the suitability of their clinical staff. DBS checks and references had not been obtained. There were no initial or on-going checks of the registrations or professional indemnity of the

Are services safe?

qualified clinical staff. The practice manager told us that these staff members were employed elsewhere where the checks would have been completed, but this had not been verified or recorded.

There was no system to monitor staff training. The practice nurse was responsible for performing Cytology (smear) tests and childhood immunisations. However we found the training certificates were due for renewal. We spoke to the nurse about this who confirmed they had completed this update earlier in the year but had not been asked by the practice to provide the documentation.

Dealing with Emergencies

The practice had a business continuity plan in place which was kept within the building. This covered plans for a number of potentially disruptive events. We discussed the need for this to also be available offsite should staff be unable to collect this from the practice in an emergency.

Equipment

There was a contract in place to ensure that medical equipment was calibrated to ensure it was in working order.

The practice did not have a reliable system in place to monitor when checks to equipment were due. We found that the electrical equipment portable appliance test (PAT) checks were out of date. We brought this to the attention of the Practice Manager who believed these had already been completed. It was confirmed by the practice that no electrical checks had been made on any equipment for over 12 months

Are services effective?

(for example, treatment is effective)

Our findings

The practice was not always effective in meeting the individual needs of the patients. Systems required improvement to support this.

Promoting best practice

The GP was aware of how to access National Institute for Health and Care Excellence (NICE) guidelines. However there was no system in place to receive updates as they became available therefore there was the potential for current best practice guidance to be missed.

We found a number of policies and protocols did not reflect current guidance. The consent policy had not been updated to include information about the Mental Capacity Act 2005. We spoke to the GP and practice nurse about assessing patient's capacity to give consent to treatment. We were assured that should people lack capacity then decisions would be made involving carers and/or other professionals involved in their care. We also spoke to the practice nurse who was knowledgeable about obtaining consent from patients under 18 years of age.

The patients we spoke with confirmed they had been asked for their consent before they received treatment at the practice.

Management, monitoring and improving outcomes for people

We saw no evidence of any completed clinical audit cycles or any other system in place which monitored and improved outcomes for patients.

We spoke to the GP about the poor uptake of cytology testing as identified by the most recently available Quality and Outcomes (QOF) results, which showed only 53.6% of women, had presented for testing, as opposed to the target of 80%. We were told that figure was mainly due to a cultural issue and the practice had attempted to remedy this by raising awareness through advertising and offering clinics run by a female practice nurse. The nurse told us that as well as reminder letters for patients, she reviewed this with each female who attended appointments. Female patients we spoke with confirmed this was the case.

The flu vaccination program offered at the practice was well structured and resulted in a high uptake. Vascular health checks were offered, however these were not as well structured and had not been accessed as well by patients.

We spoke with three people who had experience of long term health complaints. They confirmed they received regular health reviews and were called by the practice to arrange these. We saw evidence of these systems in the practice.

Staffing

Staff told us they had received relevant training from the practice manager, in areas such as safeguarding and health and safety in the last twelve months, but we did not see certificates or evidence to support this.

Staff told us they received annual appraisals and other more informal supervision. We saw evidence to suggest appraisals were taking place and objectives were discussed. However it was not possible to evidence that objectives were planned and achieved as there were no current records of recent training.

There were no records in staff files to demonstrate an induction process for new staff members. However staff confirmed that they had received a "thorough" induction when they commenced with the practice which meant they felt comfortable in performing their role

Working with other services

The practice worked with other agencies and professionals to support continuity of care for patients. Information received from other agencies, for example, accident and emergency was read and actioned by the GP and scanned onto patient's records in a timely manner.

We were told a quarterly meeting took place with the palliative care team to discuss support given to patients during the later stages of life and we saw previous minutes to support this. The GP explained there were currently no patients at this stage but described how such care would be reviewed and actions would be agreed at these meetings.

The local hospital trust provided a midwife to attend the practice one day a week. Patients who had accessed post and antenatal care were happy with the service they received.

On the day of our inspection we spoke to a health visitor who was visiting the practice. They were very complimentary about the practice as a whole and raised no concerns.

Patients we spoke with who had been referred to other services told us that the practice liaised well to keep them

Are services effective?

(for example, treatment is effective)

informed about their treatment. Most but not all patients we spoke with were happy that they had been referred in a timely manner. Two patients commented that they felt they had not been referred to a specialist quickly enough.

We spoke with two carers who told us they felt effective systems were in place to ensure their relative had appropriate care and support and that they as carers were identified and signposted to support services.

Health, promotion and prevention

The practice supported patients to manage their health and wellbeing. The practice offered vaccination programs, long term condition reviews and provided health promotion information to patients. A variety of health promotion leaflets were available in the waiting area, including details of smoking cessation. Information was available to allow patients to make informed choices.

The practice also provided patients with information about other health and social care services such as carers support. Representatives from agencies such as carers groups and Age Concern had recently visited the surgery to speak to staff and patients to make them aware of the services they could provide.

The practice had a single piece of apparatus in the waiting room to measure blood pressure, weight and height which was referred to as The Pod. Patients could review this information about their health whenever the practice was open and were encouraged to book an appointment to discuss the findings if required

Are services caring?

Our findings

The practice was caring. Patients spoke highly of the practice as a whole and commented that it felt like a family. People told us they did not feel rushed and were treated with dignity and respect.

Respect, dignity, compassion and empathy

Staff we spoke to were clear to point out that they prided themselves on good patient care and experience. On the day of our inspection we saw patients were spoken to in a friendly manner and with respect. There was information available to staff in the reception area which encouraged good customer care.

The patients we spoke to commented on the 'family feel' of the surgery. Staff were known by their first name and patients described an open and welcoming environment. Staff took the time to get to know patients and their families.

We saw information available to patients about bereavement support.

We spoke to patients about confidentiality in the practice. Patients told us reception staff were careful to close the plastic fascia at the front of the reception desk when they answered the phone so that personal information could not be heard. Some patients told us they thought the open plan nature of the reception desk could cause embarrassment when discussing sensitive issues. The staff we spoke to assured us they would offer patients a private room, if required, however this was not advertised to patients.

Staff said they had received training on how to act as a chaperone for patients, but there was no evidence of this in their personal files.

There was a notice in the reception area advising patients that a chaperone service was available.

Involvement in decisions and consent

Patients told us they felt involved in the decisions made about their care. They told us they felt the GP would listen if they had any issues or concerns and that their consultations were never rushed. We were told that if patients wished for a friend or family member to attend for support, that this was not a problem.

Patients told us that information was given to them in a way they understood. The GP could speak Hindi and Urdu in addition to English which aided communication with some of the Asian community. However, we were made aware of a growing eastern European population in the practice area. Staff told us they encouraged people to bring a translator with them to appointments and this was normally a family member. We were told that this had not been risk assessed. We asked the practice to consider the suitability and safety of using family or friends as translators in terms of obtaining valid consent and ensuring the information relayed to the patient was correct.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

The practice was responsive. The practice had developed formalised ways to respond to patient views. For example, a Patient Participation Group was used to consider and respond to patient feedback. The patients we spoke to were happy with the access to appointments and how the practice was run to meet their needs.

Responding to and meeting people's needs

The patients we spoke with were happy with the care and treatment they received from the practice and found it to be safe. Patients commented on the consultation, referrals and treatment provided. Most patients told us they were happy that the doctor referred them to specialists in a timely manner.

We spoke with twelve patients either on the phone or face to face on the day of our inspection. All except one told us the practice met their needs and they were referred appropriately when required. Individual clinics were not held as patients needs were met through routine appointments. All except one patient told us that this system worked for them. We received 17 CQC comment cards. The majority were very positive about the service. One comment indicated dissatisfaction about the time it took to be referred to a specialist.

We were told by clinical staff how the practice worked with patients to ensure they received the treatment they required. This included follow up phone calls to women who had not attended for screening appointments after reminder letters had been sent. The GP and practice nurse explained how they had tried several ways to improve uptake of smears but had seen little improvement.

The GP and staff knew most of their patients personally and the patients we spoke to commented on the 'family feel' of the practice.

Three patients told us they thought the practice would benefit from access to a female GP. We were told that a female practice nurse was employed for two sessions per week and that new patients were made aware of this when registering. Patients also confirmed that the practice did not take blood and when this was required for tests they had to attend another local clinic. Most patients were happy with this. One patient felt this service should be provided by the practice.

The practice had an active and effective Patient Participation Group (PPG). We met with four members of the PPG on the day of our inspection and saw minutes of PPG meetings were published on the practice website. Patients were encouraged to join the PPG and the members we spoke to spoke highly of the process. Practice staff and outside agencies attended these meetings and we were told there was an open discussion about suggestions for improvement. The group members we spoke to told us they were listened to and the GP always fed back to them at following meetings.

Access to the service

The practice was open later on Monday evenings to accommodate those people who could not attend the practice during normal working hours. The Practice Nurse was also available until 5.40pm one day each week. All the patients we spoke with were happy with their access to appointments.

We were told that the GP often saw patients who did not have a pre-booked appointment. On the day of our inspection we saw this was the case for one patient who attended. The majority of patients we spoke to were happy with the time they had to wait to be seen.

We looked at the suggestion book in the practice reception. Three out of the last four entries commented that the GP was late for his surgery times; these had not yet been signed as reviewed by the practice.

The practice had produced a practice information leaflet and a website. The website provided a variety of up to date information specific to the practice and health in general.

The practice offered an extended hours service on Monday evenings to ensure that patients who worked and who required appointments could access the service.

Each patient we spoke with was happy they could get an appointment when they needed to. Reception staff showed us how the appointment system worked. Emergency slots were available each day and pre bookable appointments were available in advance. A number of appointment slots were reserved each day and the GP conducted telephone consultations. Most patients spoke highly of this system.

Are services responsive to people's needs?

(for example, to feedback?)

Concerns and complaints

The patients we spoke with told us they had never had to raise a complaint but were confident that they would be listened to if they had the need.

Three complaints had been made between March 2013 and March 2014. We saw evidence of complaints being investigated appropriately.

The practice complaints policy was out of date. We saw four different policies all signed as reviewed on the same date. However each one gave conflicting and incorrect information.

Are services well-led?

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

Our findings

A lack of formal governance systems meant the monitoring of quality and the identification and management of risks within the practice were ineffective. Policies and procedures were not in place or required updating.

Leadership and culture

Staff we spoke to told us the GP was in charge at the practice but it was the practice manager who was their immediate supervisor. The practice manager had been in post at this practice for many years. Each member of staff told us they felt they could approach her and found her open and willing to listen to their concerns.

Each member of staff we spoke with told us they took pride in providing a friendly and quality service to the patients. We saw information about good customer care on display in the reception which reinforced this ethos. Staff spoke respectfully about patients.

Governance arrangements

The staff we spoke with were clear on their role and responsibilities in the practice. As this was a small practice staff were available to cover absence for other members of the team. For example, the secretary or practice manager would often cover reception duties. The secretary was also able to assist with some of the practice manager's role. However we found there was often a lack of supportive policies and clear systems for the governance of the practice. For example, the practice manager was solely responsible for the reporting of significant incidents for which there was no written policy or procedures to follow. In her absence the lack of supportive information about the processes to follow meant staff may not be able to report serious incidents quickly and effectively.

We found a number of policies required updating, including complaints, whistleblowing and recruitment. Although these had been recently signed by the doctor as up to date, the system in place to check their relevance was not effective.

Systems to monitor and improve quality and improvement

We saw some examples of regular clinical audits. Some of these audits were reviewed and showed a complete improvement cycle was in place, but this was not always consistent.

There was no business plan in place for the practice and no evidence how the practice would continue to monitor and improve services for patients.

Patient experience and involvement

The practice had a Patient Participation Group (PPG). We met four members of this group who commended the doctor and the practice as a whole for their ability to listen and learn from patient feedback.

We saw minutes of PPG meetings which confirmed that other services in the local area, such as carers group and age concern had attended these meetings.

Feedback we received from patients was, on the whole, very positive. Most people were happy with the timeliness of their diagnosis. The two people who were not had not made a complaint to the service.

Patients confirmed that they were often encouraged to complete surveys. We saw that the results of these were posted onto the practice website.

Staff engagement and involvement

Staff confirmed and we saw evidence that annual appraisals were completed. Staff told us this gave them the chance to discuss what was working well, areas for improvement and any learning objectives. As there was no evidence of training certificates or any other means of monitoring what training had been completed we could not assess if these objectives were met.

Staff told us that practice meetings were held once a month. They confirmed that this was a chance to discuss any issues or suggestions to improve the running of the practice. The practice nurse had not attended any of these meetings, so we were told information was relayed verbally. There were no minutes of these meetings to evidence what was discussed. The absence of minutes meant there was a possibility that information could be missed by those who did not attend.

Learning and improvement

We were told by practice staff that they had attended in-house training in the last 12 months. There were no records and we could not evidence what training had been completed The staff however told us they felt the training provided meant they were confident in their roles.

Are services well-led?

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

We saw the GP had links with the Local Medical Committee (LMC) and we saw evidence of sharing Clinical Commissioning Group (CCG) case studies around cancer care.

Identification and management of risk

We saw evidence that significant incidents were recorded. However these records were inconsistent and difficult to follow. The staff we spoke to told us that identified learning was discussed at staff meetings however there was no written record of this.

We saw some examples of actions identified but did not always see the action completed in full. There was also a lack of audit of these systems meaning inconsistencies in their recording were not identified.

We saw the GP had signed policies and procedures as current, the week before our inspection. However we found that this review was ineffective and had failed to identify up to date guidance.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services **The practice did not have systems in place to deal with emergencies which could be reasonably expected to arise. The planning and delivery of care was not organised in such a way to ensure the welfare and safety of patients.**

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers **The practice recruitment policy and processes are not followed. Staff files are inconsistently maintained and did not demonstrate staff are recruited and employed safely.**

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers **The practice did not have effective systems in place to assess and monitor the quality of the service to ensure all patients were protected against the risks of inappropriate or unsafe care and treatment.**