Pelham Medical Practice

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?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Inadequate

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Pelham Medical Practice on 30 March 2016. The overall rating for the practice was requires improvement. The full comprehensive report on the March 2016 inspection can be found by selecting the 'all reports' link for Pelham Medical Practice on our website at www.cqc.org.uk.

This inspection was an announced focused inspection carried out on 4 January 2017 to confirm that the practice had carried out their plan to meet the legal requirements in relation to the breaches in regulations that we identified in our previous inspection on 30 March 2016.

This report covers our findings in relation to those requirements which we found were not sufficiently met as significant action had not been taken by the practice to make improvements since our last inspection. Additionally, a breach of the legal requirements was

found because systems and processes had not been established and operated effectively. As a result, the provider was not assessing, monitoring and improving the quality and safety of the services provided and mitigating the risks related to the health, safety and welfare of service users and others. Therefore, a Warning Notice was served in relation to Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 17 Good Governance.

Overall the practice is still rated as requires improvement.

Our key findings were as follows:

- The practice had devised a new system to manage national patient safety alerts, however, they were unable to demonstrate that alerts were being discussed at clinical meetings or that action was being taken in relation to receipt of alerts. Documents provided after the inspection demonstrated that alerts were discussed and that action was taken in relation to these.
- Infection control audits had been carried out but there was no evidence of action being taken where issues were highlighted. Documents provided after the inspection demonstrated that action had been taken.
- Medicines were not always managed safely.
- The practice were unable to demonstrate that all staff were up to date with training. For example, safeguarding, infection control and basic life support. Documents provided after the inspection

Summary of findings

demonstrated that the practice were working with the clinical commissioning group (CCG) to identify role and person specific training requirements and to implement this for all staff.

- The practice had revised the staff appraisal system and records showed that the practice had introduced a process where GP partners carried out nurses' appraisals instead of non-clinical staff.
- Data from the GP patient survey was deemed comparable to other practices.
- The practice was not an outlier for the aspects of QOF identified at the comprehensive inspection on 30 March 2016, and some improvements had been made to address clinical targets.
- A new scanning protocol had been introduced; however, the practice was unable to demonstrate that the process for receiving patient information and scanning this onto the patient record was carried out in a timely way. Documents provided after the inspection showed that all scanning was up to date and that a timeframe had been added to the scanning protocol so that all information was scanned onto the system within 48 hours.
- There had been two clinical audits undertaken since our previous inspection in March 2016 and these were completed audits where the improvements made were implemented and monitored.
- A confidentiality marker line and flag had been established at a distance from the reception desk to separate the patient speaking at reception from the queue.
- The practice had revised their governance structure and had made some improvements.
- The practice had employed a new practice manager who was able to provide documents to demonstrate the implementation of a structure to support delivery.
- The practice had revised and updated their duty of candour statement.

There were areas of practice where the provider needs to make improvements.

Importantly, the provider must:

- At our previous inspection on 30 March 2016, we told the practice that they must ensure that training is in place for all staff. At this inspection we found that training for staff had still not improved. The provider must ensure that training appropriate to job role is completed by all clinical and non-clinical staff and GPs, including safeguarding children and vulnerable adults.
- Ensure that policies and procedures provide suitable guidance to staff with regards to the storage of medicine and the disposal of out of date medicine and blood bottles.
- At our previous inspection on 30 March 2016, we told the practice that they must take action to address identified concerns with infection prevention and control practice. At this inspection we found that the action had not been sufficiently taken. The provider must take action to address identified concerns with infection prevention and control.
- At our previous inspection on 30 March 2016, we told the practice that they must ensure that protocols for the scanning of clinical correspondence are adhered to. At this inspection we found that the process for scanning patient information had still not improved. The provider must ensure that a timely system is introduced for scanning information onto patient records and their IT system.

The areas where the provider should make improvement are:

- Continue to embed the process to share information regarding safety alerts and take action as required.

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

At our previous inspection on 30 March 2016 we rated the practice as requires improvement for providing safe services as the practice was unable to demonstrate that they had an effective system for acting on patient safety alerts; that they had implemented a system to ensure all staff undertook child and adult safeguarding training at the appropriate level; that the arrangements in respect of cleanliness and infection were adequate and that medicines were managed safely.

Some of these arrangements had improved when we undertook a follow up inspection on 4 January 2017, however the improvements made were not sufficient and the practice is still rated as requires improvement for providing safe services.

Are services effective?

Requires improvement

At our previous inspection on 30 March 2016, we rated the practice as inadequate for providing effective services as the arrangements in respect of access to NICE guidelines, large and very large identified variations in meeting QOF figures, staff training and the arrangements for co-ordinating patient care and information sharing needed improving.

Some of these arrangements had improved when we undertook a follow up inspection on 4 January 2017, however the improvements made were not sufficient and the practice is still rated as requires improvement for providing effective services.

Are services caring?

Good

At our previous inspection on 30 March 2016 we rated the practice as requires improvement for providing safe services as data from the national GP patient survey showed patients rated the practice lower than others for some aspects of care and privacy at the reception desk was compromised.

These areas had improved when we undertook a follow up inspection on 4 January 2017and the practice is now rated as good for providing caring services.

Are services responsive to people's needs?

Good

At our previous inspection on 30 March 2016, we rated the practice as requires improvement for providing responsive services as feedback from patients reported that access to a named GP and continuity of care was not always available quickly, although urgent appointments were usually available the same day.

Summary of findings

These areas had improved when we undertook a follow up inspection on 4 January 2017, and the practice is now rated as good for providing responsive services.

Are services well-led?

Inadequate

At our previous inspection on 30 March 2016, we rated the practice as requires improvement for providing well-led services as there was no overarching governance structure.

We issued a requirement notice in respect of these issues but found that arrangements had not significantly improved when we undertook a follow up inspection of the service on 4 January 2017. The practice is now rated as inadequate for being well-led. A Warning Notice was served in relation to Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 17 Good Governance, because systems and processes had not been established and operated effectively. As a result, the provider was not assessing, monitoring and improving the quality and safety of the services provided and mitigating the risks related to the health, safety and welfare of service users.

Pelham Medical Practice

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.

Background to Pelham Medical Practice

Pelham Medical Practice is located in a residential area of Gravesend, Kent and provides primary medical services to approximately 14,000 patients.

The Practice is based in a large Victorian house which is not purpose built, but does have access for wheelchair users and disabled facilities. There is a car park for patient use.

There are four GP partners at the practice, all male, and three salaried GPs, all female.

There are six female members of the nursing team; four practice nurses, one health care assistant (HCA) and a phlebotomist, all female. GP's and nurses are supported by a practice manager and a team of reception/administration staff.

The practice is a training practice and two of the partners are currently GP trainers for registrars and foundation year GP trainees.

The practice is open between 8am and 6.30pm Monday to Friday. Appointments are from 8.30am to 12pm every morning and 3pm to 6.30pm daily. Extended hours appointments are offered between 6.30pm and 8pm on Tuesday, Wednesday and Thursday. The practice is closed between 12.30pm and 1.30pm every day except Wednesday when it is closed from 12.30pm to 1.15pm. The telephones are answered during this time. In addition to pre-bookable appointments up to six weeks in advance, urgent appointments are also available for people that need them. An out of hours service was provided by Integrated Care 24.

The practice has a higher than average percentage of children aged from 0 to 19 years and is in an area of high deprivation. There are a significant number of people in the area who do not have English as their first language, with a large number of Polish and Punjabi speaking people.

The practice runs a number of services for its patients including; chronic disease management, new patient checks, minor surgery, family planning, anti-coagulation monitoring and immunisations. It also offers a free acupuncture service and a sleep apnoea clinic.

Services are provided from; 17 Pelham Road, Gravesend, Kent, DA11 0HN and from St Gregory's Medical Practice, 116 St Gregory's Crescent, Gravesend, Kent, DA12 4JW, which is a branch practice. The branch practice was not inspected.

Why we carried out this inspection

We undertook a comprehensive inspection of Pelham Medical Practice on 30 March 2016 under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The practice was rated as requires improvement. The full comprehensive report following the inspection on Month Year can be found by selecting the 'all reports' link for Pelham Medical Practice on our website at www.cqc.org.uk.

Detailed findings

We undertook a follow up focused inspection of Pelham Medical Practice on 4 January 2017. This inspection was carried out to review in detail the actions taken by the practice to improve the quality of care and to confirm whether the practice was now meeting legal requirements.

How we carried out this inspection

During our visit we:

- Spoke with a range of staff including GPs, the practice manager, practice nurses and reception and administration staff.
- Observed how patients were being cared for in the reception area.
- Reviewed an anonymised sample of the personal care or treatment records of patients.
- Looked at information the practice used to deliver care and treatment plans.

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

At our previous inspection on 30 March 2016 we rated the practice as requires improvement for providing safe services as the practice was unable to demonstrate that they had an effective system for acting on national patient safety alerts; that they had implemented a system to ensure all staff undertook child and adult safeguarding training at the appropriate level; that the arrangements in respect of cleanliness and infection control were adequate and that medicines were managed safely.

Some of these arrangements had improved when we undertook a follow up inspection on 4 January 2017, however the improvements made were not sufficient and the practice is still rated as requires improvement for providing safe services.

Safe track record and learning

At our previous comprehensive inspection on 30 March 2016, the practice was unable to demonstrate that they had an effective system for acting on patient safety alerts, although these were received and shared. Staff told us that the alerts came in to the practice managers, who forwarded them to all clinicians. They told us that there was no process in place regarding who checks the alerts or follows them up and that they were not kept or stored. Staff told us that these were not discussed at meetings.

At our focused inspection on 4 January 2017 we saw that there was a new protocol regarding safety alerts dated July 2016 which stated that two copies should be printed, one for the hard copy file and one to be attached to the agenda for the next clinical meeting. A file with alerts was seen, and documents were sent after the inspection which demonstrated that alerts were discussed and that action was being taken in relation to these. These were now a standing weekly agenda item at the partners meeting.

Overview of safety systems and process

At our previous comprehensive inspection, the practice was unable to demonstrate that they had implemented a system to ensure all staff undertook child and adult safeguarding training at the appropriate level. For example, four of the six nursing team were trained to level 2 in safeguarding children and ten of the non-clinical staff were trained to level 1. However, not all staff had completed safeguarding adults training and according to the training schedule one of the six members of the nursing team and one member of the non-clinical staff team had completed it.

At our focused inspection on 4 January 2017 the practice was unable to demonstrate that they had implemented a system to ensure all staff undertook child and adult safeguarding training at the appropriate level. For example, according to the training schedule, four of the six members of the nursing team had not completed safeguarding adults training. Documents provided after the inspection demonstrated that the practice were working with the CCG to identify role and person specific training requirements and to implement this for all staff.

At our previous inspection on 30 March 2016 the arrangements in respect of cleanliness and infection were not adequate. There was an infection control protocol in place and an infection control lead person at the practice who had received training on the 29 March 2016. An infection control audit had been undertaken in March 2016 and we saw that areas for action were identified. However, the audit had failed to identify incorrectly assembled sharps bins and an unsealed surface around a hand wash sink in a consulting room. Cleaning schedules were available; however, there were no records to show that the performance of the cleaning contractors was monitored.

At our focused inspection on 4 January 2017 we saw that two infection control audits had been carried out in June 2016 and September 2016. However, one audit referred to carpets that required cleaning (not in treatment or consulting rooms) and the practice was unable to provide a schedule to show that identified action had been taken. Documents received after the inspection demonstrated that the carpets at the practice had been cleaned, and that infection control was a standing item on the agenda for the weekly partners meeting.

A monthly contract cleaner audit was carried out and this was on-going. The premises looked clean and tidy. The infection control policy stated that all staff recruited would undertake training within six weeks of starting, however, according to the training schedule only one nurse and two GPs had completed the training. Documents provided after the inspection demonstrated that the practice were working with the Clinical Commissioning Group (CCG) to identify role and person specific training requirements and to implement this for all staff.

Requires improvement

Are services safe?

At our previous inspection on 30 March 2016 the arrangements for managing medicines, including vaccines, in the practice did not always keep patients safe. The two vaccine fridges at the practice were examined and the one in the nurses room was locked with a log of temperatures recorded which were all within an appropriate range for the storage of vaccines. (Vaccines must be stored at between 2 and 8 degrees Celsius, with a mid-range of 5 degrees Celsius being good practice). The second fridge was locked, although not in a locked room and there were four occasions in February 2016 when the maximum temperature was recorded as 14 degrees Celsius and there were no documented actions taken by the practice in relation to this. Health care assistants administered vaccines and medicines against a direction from a prescriber, however; these were not patient specific.

At our focused inspection on 4 January 2017 we saw that the fridge temperatures were recorded regularly, and were within range. Staff spoken with were able to give an example of a recent breach in the cold chain and the action they had taken to address this. We also saw eight vials of out of date local anaesthetic medicine unsecured in an unoccupied GP consulting room dated August 2015 and 1 vial of an anti-inflammatory injection dated 31/10/16. Six boxes of 50 out of date blood bottles were observed and some of these were in use on the phlebotomist's trolley with dates between October and December 2016. Health care assistants administered vaccines and medicines against a direction from a prescriber and these were now patient specific. Documents provided after the inspection demonstrated that medicine and medical consumable dates and storage in clinical and consulting rooms are part of the quartlerly infection control audit which is carried out at the practice. The findings of the audit are reported at the weekly partners meeting.

Requires improvement

Are services effective?

(for example, treatment is effective)

Our findings

At our previous inspection on 30 March 2016, we rated the practice as inadequate for providing effective services as the arrangements in respect of large and very large identified variations in meeting QOF figures, staff training and the arrangements for co-ordinating patient care and information sharing needed improving.

Some of these arrangements had improved when we undertook a follow up inspection on 4 January 2017, however the improvements made were not sufficient and the practice is still rated as requires improvement for providing effective services.

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 system intended to improve the quality of general practice and reward good practice).

At our previous comprehensive inspection on 30 March 2016 the practice had achieved 90% of the total number of Quality and Outcomes Framework (QOF) points available. There were a number of clinical domains where exception reporting was higher than the Clinical Commissioning Group (CCG) and national averages. (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). For example:

- The percentage of patients diagnosed with dementia whose care had been reviewed in a face-to-face review in the preceding 12 months was 72% compared to the CCG average of 82% and the national average of 84%. The exception rate for this was 43% compared to the CCG average of 12% and the national average of 8%.

At our focused inspection on 4 January 2017 the most recent published QOF results were 95% which showed improved outcomes for patients.

The practice had reduced some of the clinical domains where exception reporting was higher than the Clinical Commissioning Group (CCG) and national averages and had made improvement towards meeting targets. For example:

- The percentage of patients diagnosed with dementia whose care had been reviewed in a face-to-face review in the preceding 12 months was 94% which was higher than the CCG average and the national average of 84%. The exception rate for this was 5% which was comparable to the CCG average of 6% and the national average of 7%.

At our previous comprehensive inspection on 30 March 2016 the practice was an outlier for some aspects of QOF (or other national) clinical targets. Data from 2014/2015 showed that there was a very large variation in the performance indicators for regular (at least 3 monthly) multidisciplinary case review meetings where all patients on the palliative care register were discussed, as these were not taking place at the practice. Large variations in performance where the related indicators were worse than the national average was seen regarding:

- The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) was 140/80 mmHg or less(01/04/2014 to 31/03/2015) was 57% which was worse than the CCG average of 76% and the national average of 78%.
- The percentage of patients with diabetes, on the register, in whom the last IFCCHbA1c was 64 mmol/mol or less in the preceding 12 months (01/04/2014 to 31/03/2015), was 73% which was lower than the CCG average of 77% and the national average of 78%.

A large variation in performance where the related indicators were worse than the national average was seen regarding:

- The percentage of patients with hypertension in whom the last blood pressure reading measured in the preceding 12 months was 150/90mmHg or less (01/04/2014 to 31/03/2015) was 76% which was lower than the national average of 84%.

A further large variation was noted in relation to responses to the national patient survey, where:

- The percentage of respondents to the GP patient survey who stated that the last time they saw or spoke to a GP, the GP was good or very good at treating them with care and concern. (01/01/2015 to 30/09/2015) was 71% compared to a national average of 85%.

Requires improvement

Are services effective?

(for example, treatment is effective)

At our focused inspection on 4 January 2017 the practice was not an outlier for any aspects of QOF. Improvements had been made to address clinical targets, for example:

- The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) was 140/80 mmHg or less (01/04/2015 to 31/03/2016) was 64% which was comparable to the CCG and national average of 78%.
- The percentage of patients with diabetes, on the register, in whom the last IFCCHbA1c was 64 mmol/mol or less in the preceding 12 months (01/04/2015 to 31/03/2016) was 76% which was comparable to the CCG average of 77% and the national average of 78%.
- The percentage of patients with hypertension in whom the last blood pressure reading measured in the preceding 12 months was 150/90mmHg or less (01/04/2015 to 31/03/2016) was 82% which was comparable to the CCG and the national average of 83%.

Multi-disciplinary meetings where patients on the palliative care register and other vulnerable patients are reviewed were taking place at the practice and minutes were seen from November 2016.

At our previous comprehensive inspection on 30 March 2016 there was some evidence of clinical audit.

- There had been five clinical audits completed in the last two years, however, none of these were completed audits where the improvements made were implemented and monitored. The last completed two cycle audit was carried out in 2013.

At our focused inspection on 4 January 2017 the practice were able to demonstrate that they had undertaken two clinical audits and these were completed audits where the improvements made were implemented and monitored. For example, patients on high dosage of inhaled corticosteroids were reviewed and those patients where there was no step down of treatment in place were identified and consultations were conducted to determine whether the medicine could be reduced. The practice introduced quarterly reviews for patients on a high dosage of the medicine to reduce this where possible.

Effective staffing

At our previous comprehensive inspection on 30 March 2016 the nursing team were appraised by the practice managers who did not have a clinical background.

At our focused inspection on 4 January 2017 the practice had revised the staff appraisal system and records showed that the practice had introduced a process where GP partners carried out nurses' appraisals instead of non-clinical staff.

Coordinating patient care and information sharing

At our previous comprehensive inspection on 30 March 2016 not all information was available to be acted on in a timely way. For example, letters from secondary care were not consistently scanned onto the system and made available for the required action to be taken. We saw that a letter from secondary care regarding a patient requiring a hormone implant was not on the system and was discovered in the scanning pile, and on the day of the inspection we were told that a letter had been sent from secondary care to the practice and hand delivered on two separate occasions and action had not been taken.

At our focused inspection on 4 January 2017 we saw that a new scanning protocol had been introduced; however, a backlog of scanning was still in place at the practice, with a non-priority box filled with documents to be scanned. A small sample of information was taken from the box which included 'new baby transfer of care' forms and temporary patient notes from March 2016 that had not been scanned onto the patients' records. The business as usual scanning backlog was from 5 December 2016. An action plan stated that a second scanning machine would be sought from the IT department or purchased by the practice, but this had not happened. A work around had been introduced, where 'urgent' documents were placed into a tray for the specified GP to action and we saw evidence that the GPs addressed these.

A document provided after the inspection demonstrated that the practice had discussed the scanning backlog at a weekly practice meeting and had agreed that overtime would be offered to staff members to address the backlog immediately and that timescales would be introduced into the scanning protocol. Further documents provided showed that all scanning had been completed by 13th February 2017 and a second scanning machine had been purchased.

Good

Are services caring?

Our findings

At our previous inspection on 30 March 2016 we rated the practice as requires improvement for providing safe services as data from the national GP patient survey showed patients rated the practice lower than others for some aspects of care and privacy at the reception desk was compromised.

These areas had improved when we undertook a follow up inspection on 4 January 2017, and the practice is now rated as good for providing caring services.

Kindness, dignity, respect and compassion

At our previous comprehensive inspection on 30 March 2016, there was no means of separating the queue of patients from the patients speaking with reception staff at the reception desk.

At our focused inspection on 4 January 2017 we saw that a confidentiality marker line and flag had been established at a distance from the reception desk to separate the patient speaking at reception from the queue.

At our previous comprehensive inspection on 30 March 2016 results from the national GP patient survey showed patients did not always feel they were treated with compassion, dignity and respect. For example:

- The percentage of respondents to the GP patient survey who stated that they always or almost always see or speak to the GP they prefer was 29% compared with a national average of 36%.
- 77% of respondents said that the last GP they saw or spoke to was good at listening to them, compared to 87% within the CCG and 89% at national average.
- 94% of respondents said they had confidence and trust in the last GP they saw compared to the CCG and national average of 95%.
- 71% of respondents said the last GP they spoke to was good at treating them with care and concern compared to the national average of 85%.
- 92% of respondents said the last nurse they spoke to was good at treating them with care and concern compared to the national average of 91%.
- 90% of respondents said they found the receptionists at the practice helpful compared to the CCG average of 86% and the national average of 87%.

At our focused inspection on 4 January 2017 results from the national GP patient survey published in July 2016 showed some improvement. For example:

- The percentage of respondents to the GP patient survey who stated that they always or almost always see or speak to the GP they prefer was 61% compared with 52% at CCG level and 60% at national average
- The percentage of respondents to the GP patient survey who stated that the last GP they saw or spoke to was good at listening to them, was 79% compared with 86% at CCG level and 89% at national average. This was an improvement over the last result of 77% published at the time of our previous inspection.

However, there were still areas where improvement was needed. For example:

- 86% of respondents said they had confidence and trust in the last GP they saw compared to the CCG and national average of 92% and this was deemed to be comparable to other practices.
- 70% of respondents said the last GP they spoke with was good at treating them with care and concern compared to the CCG average of 81% and the national average of 85% and this was deemed to be comparable to other practices.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

At our previous inspection on 30 March 2016, we rated the practice as requires improvement for providing responsive services as feedback from patients demonstrated that access to a named GP and continuity of care was not always available quickly, although urgent appointments were usually available the same day.

These areas had improved when we undertook a follow up inspection on 4 January 2017, and the practice is now rated as good for providing responsive services.

Access to the service

At our previous comprehensive inspection on 30 March 2016, results from the national GP patient survey showed that patient's satisfaction with how they could access care and treatment was comparable to or lower than local and national averages.

- 73% of patients were satisfied with the practice's opening hours compared to the CCG average of 74% and the national average of 78%.
- 61% of patients said they could get through easily to the practice by telephone compared to the CCG average of 66% and the national average of 73%.

At our focused inspection on 4 January 2017 results from the national GP patient survey published July 2016 showed that patient's satisfaction with how they could access care and treatment was deemed to be comparable to local and national averages. Both the practice and the local and national averages were lower than the in the previous data.

- 71% of respondents were satisfied with the practice's opening hours compared to the CCG average of 72% and the national average of 76%.
- 60% of respondents said they could get through easily to the practice by telephone compared to the CCG average of 64% and the national average of 73%

Are services well-led?

Inadequate

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

Our findings

At our previous inspection on 30 March 2016, we rated the practice as requires improvement for providing well-led services as there was no overarching governance structure.

We issued a requirement notice in respect of these issues but found that arrangements had not significantly improved when we undertook a follow up inspection of the service on 4 January 2017. The practice is now rated as inadequate for being well-led and a Warning Notice was served in relation to Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 17 Good Governance, because systems and processes had not been established and operated effectively. As a result, the provider was not assessing, monitoring and improving the quality and safety of the services provided and mitigating the risks related to the health, safety and welfare of service users and other. The practice worked to make improvements to the service immediately after the inspection and additional documentation has been provided since the inspection which demonstrates this.

Governance arrangements

At our previous comprehensive inspection on 30 March 2016 the practice had a framework which supported delivery; however this did not always operate effectively, for example,

- An understanding of the performance of the practice was maintained by holding meetings regarding QOF. However, the practice was unable to demonstrate they had plans to maintain and improve the quality of patient care where required.
- The practice did not have a programme of continuous clinical and internal audit. The last two cycle clinical audit was carried out in 2013. Audits are used to monitor quality and to make improvements.

There were some arrangements for identifying, recording and managing risks, however, risk management failed to identify all of the risks at the practice, for example there were no patient specific directions and not all clinical staff had completed infection control training.

At our focused inspection on 4 January 2017 the practice had revised their governance structure and made some improvements. For example,

- Some of the QOF figures for the practice had improved.
- The practice had employed a new practice manager who was able to provide documents to demonstrate the implementation of a structure to support delivery. The new practice manager had been in post for one month at the point of inspection but had started to implement changes to the governance structure. For example, a clear meeting process had been devised and minutes were seen of a multi-disciplinary meeting from November 2016. The agenda and minutes of a weekly partners meeting have been provided on two occasions since the inspection.
- There had been two clinical audits undertaken since our previous inspection in March 2016 and these were completed audits where the improvements made were implemented and monitored.

However, risk management systems had not sufficiently improved. For example,

- The practice had devised a new system to manage national patient safety alerts, however, they were unable to demonstrate that alerts were being discussed at clinical meetings or that action was being taken in relation to receipt of alerts. Documents provided after the inspection demonstrated that alerts were discussed and that these were a standing agenda item for the weekly partners meeting.
- Infection control audits had been carried out but had not identified key risks and there was no evidence of action being taken where issues were highlighted. Documents provided after the inspection showed that the carpets had been cleaned and that infection control was discussed as a standing item on the weekly agenda for the partners meeting.
- The practice had failed to implement systems to avert the risks from unsecured out of date medicine and blood bottles and the backlog of paper records received that had not been scanned onto the patients notes. Documents provided after the inspection showed that scanning was now up to date at the practice and that a timeframe had been introduced to the protocol to ensure that all information was scanned onto the system within a 48 hour period. Documents provided after the inspection also showed that a second scanner had been acquired for the practice.
- The practice were unable to demonstrate that all staff were up to date with training. For example, safeguarding, infection control and basic life support.

Are services well-led?

Inadequate

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

Documents provided after the inspection showed that the practice were working with the clinical commissioning group (CCG) to identify role and individual specific training and to make this available to all staff.

Leadership and culture

At our previous comprehensive inspection on 30 March 2016 the provider was aware of the requirements of the duty of candour and had included a statement on their website which outlined candour and the aims of the practice regarding this. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment). However, the statement was out of date as it referred to the Primary Care Trust rather than the Clinical Commissioning Group.

At our focused inspection on 4 January 2017 the practice had revised and updated their duty of candour statement which was available on their website.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17 HSCA (RA) Regulations 2014 Good governance. The registered provider did not have established systems or processes to assess monitor and improve the quality and safety of the services provided or to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users. The provider must ensure a system for acting on safety alerts is embedded at the practice. The provider must ensure that training appropriate to job role is completed by all clinical and non-clinical staff and GPs, including safeguarding children and vulnerable adults. The provider must take action to address identified concerns with infection prevention and control. The provider must ensure that policies and procedures provide suitable guidance to staff with regards to the storage of medicine and the disposal of out of date medicine and blood bottles. The provider must ensure that the recruitment process includes all required checks and information being in place prior to a member of staff starting work at the practice. The provider must ensure that a timely system is introduced for scanning information onto patient records and their IT system. This was in breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.