Dr SKS Swedan & Partner

Quality Report

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

Ratings

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

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Dr SKS Swedan & Partner on 10 May 2016 and rated the practice as inadequate for safety and well-led, requires improvement for effective, caring and responsive and an overall rating of inadequate. The provider was placed into special measures and the full comprehensive report on the May 2016 inspection can be found by selecting the 'all reports' link for Dr SKS Swedan & Partner on our website at www.cqc.org.uk.

This inspection was an announced comprehensive inspection carried out on 23 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 10 May 2016. This report covers our findings in relation to those requirements. The overall rating from this visit was requires improvement. Our key findings across all the areas we inspected were as follows:

- There was limited staff cover and failsafe systems to ensure results were received for all samples sent for the cervical screening programme had lapsed.
- Most arrangements for identifying, recording and managing risks, issues and implementing mitigating actions were effective but some had gaps such as recruitment, fire safety and infection control.
- Patients did not always find it easy to make an appointment or get through to the practice by telephone.
- There were concerns around staffing such as conduct and time keeping that had not been managed.
- Not all patients treated with dignity and respect. However, patients said they were involved in decisions about their care and treatment.
- Patient Participation Group (PPG) members were happy with the clinical care they received from GPs but raised concerns relating to leadership and governance at the practice.
- There was evidence of systemic problems such as breakdowns in working relationships and divides between staff.

Summary of findings

- The leadership team did not consistently demonstrate they had the experience, capacity and capability to run the practice and ensure high quality care.
- There was an open and transparent approach to safety and an effective system in place for reporting and recording significant events.
- The provider was aware of and complied with the requirements of the duty of candour.
- Staff had been trained and demonstrated relevant skills, knowledge and experience to deliver effective care and treatment, with the exception of infection control.
- Staff assessed patients' needs and delivered care in line with current evidence based guidance and there was evidence of staff appraisals and personal development plans.
- Information about how to complain was available and easy to understand and evidence showed the practice responded quickly to issues raised.
- The practice had good facilities and was well equipped to treat patients and meet their needs.

The areas where the provider must make improvements are:

- Ensure effective systems to assess, monitor and mitigate risks to patients such as cervical screening, staff employment checks, and infection prevention and control.
- Implement effective systems and processes for fire safety and arrangements for receiving and acting on communications in the event of staff absence.
- Implement clear and effective systems to run the practice and monitor and improve the quality of services such as patient care.

The areas where the provider should make improvements are:

- Take effective action in response to feedback from relevant persons including GP patient survey results and the PPG to continually evaluate and improve services.

This service was placed in special measures after our previous inspection our previous inspection on 10 May 2016. Insufficient improvements have been made such that there remains a rating of inadequate for well led. Therefore we are taking action in line with our enforcement procedures to second a Warning Notice under Reg 17 as the majority of previous issues under safe are addressed but a poor working culture persists and systems and processes are still lacking. The service will be kept under review and if needed could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within six months, and if there is not enough improvement we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

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?

Inadequate

At our previous inspection on 10 May 2016 not all arrangements for safe services were effective such as accident and incident reporting, systems for acting on safety alerts, patients chaperoning, infection control and legionella, recruitment checks, failsafe systems for cervical screening, and staff safeguarding, basic life support, infection control, and fire safety training. At this inspection most safety concerns had been rectified but some safety systems or processes continued to have weaknesses. The practice is rated as inadequate for providing safe services.

- Most arrangements for identifying, recording and managing risks, issues and implementing mitigating actions were effective but some had gaps such as systems or processes for fire safety and follow up of actions identified in the infection control audit.
- The practice had systems, processes and practices in place to keep patients safe and safeguarded from abuse.
- Most peak flow meters were obsolete which meant there was a risk some readings would be inaccurate. (A peak flow meter is a small handheld device for commonly used for patients with Asthma that is used to measure how well air moves out of the lungs which is an important part of managing asthma symptoms and preventing an asthma attack).
- Failsafe systems to ensure results were received for all samples sent for the cervical screening programme had lapsed.
- Most staff recruitment checks had been undertaken but the practice had not taken steps to ensured appropriate medical indemnity insurance for a clinician and was unaware a clinician had been cautioned by their professional registering body.
- There was an effective system in place for reporting and recording significant events.
- Lessons were shared to make sure action was taken to improve safety in the practice.
- When things went wrong patients received reasonable support, truthful information, and a written apology. They were told about any actions to improve processes to prevent the same thing happening again.

Are services effective?

Good

At our previous inspection on 10 May 2016 we identified concerns due to shortages of staff that impacted on patient's care, gaps in seeking and recording patient's consent and in staff induction,

Summary of findings

annual appraisal or supervision. At this inspection the practice continued to attempt to recruit new staff to address shortages; however, all remaining concerns had been addressed. The practice is rated as good for providing effective services.

- Data from the Quality and Outcomes Framework (QOF) showed patient outcomes were comparable to the national average.
- Staff assessed needs and delivered care in line with current evidence based guidance.
- Clinical audits demonstrated quality improvement.
- Staff generally had the skills, knowledge and experience to deliver effective care and treatment with the exception of infection control.
- There was evidence of staff appraisals and personal development plans.
- Staff worked with other health care professionals to understand and meet the range and complexity of patients' needs.
- Staffing levels were depleted whilst the practice was continuing to attempt to recruit more nursing, health care assistant and reception staff cover whilst also covering for absent practice management staff.

Are services caring?

Good

At our previous inspection on 10 May 2016 data from the national GP patient survey generally showed patients rated the practice as comparable to others for aspects of GP care, but scores for nurses were lower, some patients said a particular member of reception staff had not always been polite. The practice had identified less than 1% of carers on its list and could not provide examples of how they used the register to improve care for carers. At this inspection we found patients were not always treated with dignity and respect by reception staff but other concerns had been rectified. The practice is rated as good for providing caring services.

- Data from the national GP patient survey showed patients rated the practice as comparable for aspects of care.
- Not all patients said they were treated with compassion, dignity and respect, for example on patient comment cards, but all said they were involved in decisions about their care and treatment.
- Most staff treated patients with kindness and respect; however, patients and the PPG notified us of unsatisfactory reception staff performance in this area, we also observed this and noted it had not been addressed appropriately by the leadership or management team.
- Staff maintained patient and information confidentiality.

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Are services responsive to people's needs?

Requires improvement 

At our previous inspection on 10 May 2016 concerns identified were that we found no evidence longer appointments had been provided for patients with a learning disability and the practice patient's information leaflet did not accurately reflect GP sessions. At this inspection there were no concerns identified with appointments for patients with a learning disability. However, some results from the national GP patient survey relating to patients access were below local and national averages and effective actions to continually evaluate and improve services had not been taken.

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

- Practice staff reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group to secure improvements to services where these were identified. For example, it had identified it had a relatively high population of working age women and provided contraceptive services delivered by female clinicians, such as insertion and removal of coils.
- Results from the national GP patient survey showed that patients' satisfaction with how they could access care and treatment was comparable to or below local and national averages.
- 60% were able to get an appointment to see or speak to someone the last time they tried compared to the CCG average of 66% and the national average of 76%.
- 60% found it easy to get through to this surgery by phone compared to the CCG average of 60% and the national average of 73%.
- Information about how to complain was available and easy to understand and evidence showed the practice responded quickly to issues raised.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- The practice had a website and offered online appointment booking and prescription requests through the online national patient access system.

Are services well-led?

Inadequate 

At our previous inspection on 10 May 2016 concerns included a high level of staff absence or turnover of key staff, management emails had not being dealt with in a timely way, lack of strategy or supporting business plans, an absence or weakness of policy implementation including aspects of medicines management and business continuity emergency planning. There was evidence of

Summary of findings

divides between staff and breakdowns in working relationships including the leadership team and issues staff had raised had not been addressed, including safety issues. The leadership team did not consistently demonstrate they had the experience, capacity and capability to run the practice and ensure high quality care and the patient participation group only met annually, was not routinely kept updated, and did not receive PPG meeting minutes. At this inspection we continued to be concerned about a number of issues regarding staffing and governance. The practice is rated as inadequate for being well-led.

- The delivery of high-quality care was not assured by the leadership, governance or culture in place.
- The practice had a mission statement but staff were not aware of it or of the values of the practice.
- Not all leaders and managers had the necessary knowledge, capacity or capability to fulfil their role.
- There were low levels of staff satisfaction and staff did not feel respected, valued or appreciated.
- The practice did not have business plans but had implemented an action plan and had made improvements since our previous inspection.
- Most arrangements for identifying, recording and managing risks, issues and implementing mitigating actions were effective but some had weaknesses such as systems or processes for fire safety, staff recruitment checks, and follow up of actions identified in the infection control audit.
- Practice specific policies were available to all staff and were mostly implemented but some risk management arrangements had gaps such as clinical equipment cleaning and appropriate disposal of certain sharps.
- A comprehensive understanding of the performance of the practice was maintained but not necessarily acted upon, for example failsafe procedures to follow up patients' cytology test results had lapsed at the previous inspection 10 May 2016 and again at this inspection.
- Actions in response to lower GP patient survey scores for telephone or appointments access did not demonstrate sufficient progress or impact to improve patient's outcomes.

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

Inadequate

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

- The practice offered proactive, 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.
- The practice participated in an initiative to improve preventative medical care for frail older patients and avoid unnecessary admissions into hospital.

People with long term conditions

Inadequate

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

- Patients with chronic diseases at risk of hospital admission were identified as a priority.
- Performance for diabetes related indicators was below national averages. For example, the percentage of patients with diabetes, on the register, in whom the last IFCCHbA1c (blood sugar level) was 64 mmol/mol or less in the preceding 12 months was 68%, compared with the national average of 78%. Overall exception reporting for diabetes was 9% compared to 7% within the CCG and 12% nationally.
- The percentage of patients with hypertension having regular blood pressure tests was 78%, which is similar to national average of 83%. Overall exception reporting for hypertension was 5% compared to 3% within the CCG and 4% nationally.
- Longer appointments and home visits were available when needed.
- These patients had a named GP and a structured annual review to check their 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

Inadequate

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

- There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances.
- 76% of patients diagnosed with asthma, on the register had an asthma review in the last 12 months which was the same as 76% nationally.
- Childhood immunisation rates for under two year olds ranged between 92% and 94%, (the national expected coverage of vaccinations is 90%); and the Measles, Mumps and Rubella (MMR) vaccine for five year olds was 91% for Dose 1 compared to 94% nationally; and 80% for Dose 2 compared to 88% nationally.
- Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this.
- The practice's uptake for the cervical screening programme was 75%, which was comparable to the national average of 81%.
- Appointments were available outside of school hours and the premises were suitable for children and babies.
- We saw positive examples of joint working with midwives and health visitors.

Working age people (including those recently retired and students)

Inadequate

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

- 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.
- The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group.
- The practice had online appointment booking and prescription requests.

Summary of findings

- The practice offered NHS health checks for patients aged 40–74. Appropriate follow-ups for the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.
- Telephone consultations with clinicians were available to meet the needs of this population group.

People whose circumstances may make them vulnerable

Inadequate

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

- The practice held a register of patients living in vulnerable circumstances including those with a learning disability.
- The practice offered longer appointments for patients with a learning disability.
- The practice had six patients on the register with a learning disability, four (67%) of these patients had received an annual health check in the last 12 months.
- The practice regularly worked with other health care professionals in the case management of vulnerable patients.
- The practice informed vulnerable patients about how to access various support groups and voluntary organisations.
- Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

People experiencing poor mental health (including people with dementia)

Inadequate

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

- 100% of patients diagnosed with dementia had their care reviewed in a face to face meeting in the last 12 months, which was above the national average of 84%
- The practice had identified 21 patients on its register with a mental health condition, 16 (76%) of these patients had received an annual health check in the last 12 months. Overall exception reporting for mental health was 19% compared to 8% within the CCG and 11% nationally.

Summary of findings

- The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those with dementia.
- The practice carried out advance care planning for patients with dementia.
- The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations.
- 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 dementia.

Summary of findings

What people who use the service say

The national GP patient survey results were published in July 2016. The results showed the practice was performing in line with local and national averages. Three hundred and sixty forms were distributed and 81 were returned. This represented 3% of the practice's patient list.

- 60% were able to get an appointment to see or speak to someone the last time they tried compared to the CCG average of 66% and the national average of 76%.
- 71% described the overall experience of their GP surgery as fairly good or very good compared to the CCG average of 75% and the national average of 85%.
- 66% said they would recommend their GP surgery to someone who has just moved to the local area compared to the CCG average of 68% national average of 80%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. Thirty three of the 45 comment cards we received were positive about the service experienced, ten were mixed and two were negative. Patients predominantly said they felt the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect. However, themes in the mixed or negative comment cards included difficulty getting through on the phone and managerial, reception or administrative staff attitude or professional competence. Two comment cards had a letter attached, both expressed concerns regarding practice management and reception staffing standards.

We spoke with six patients during the inspection. All six patients said they were satisfied with the care they received and thought staff were approachable, committed and caring. Three said they experienced some difficulty booking appointments either getting through on the telephone or appointments being delayed on the day, although they generally felt this was understandable.

The practice friends and family test patient satisfaction scores showed 72% said they would recommend the surgery.

Areas for improvement

Action the service MUST take to improve

- Ensure effective systems to assess, monitor and mitigate risks to patients such as cervical screening, staff employment checks, and infection prevention and control.
- Implement effective systems and processes for fire safety and arrangements for receiving and acting on communications in the event of staff absence.
- Implement clear and effective systems to run the practice and monitor and improve the quality of services such as patient care.

Action the service SHOULD take to improve

- Take effective action in response to feedback from relevant persons including GP patient survey results and the Patient Participation Group to continually evaluate and improve services.

Dr SKS Swedan & Partner

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a lead CQC inspector and included a GP, practice nurse and practice manager specialist advisers.

Background to Dr SKS Swedan & Partner

Dr SKS Swedan & Partner is situated within the Newham Clinical Commissioning Group (CCG). The practice provides services under a Personal Medical Services (PMS) contract to approximately 3,000 patients. The practice provides a full range of enhanced services including, child and travel vaccines and minor surgery. It is registered with the Care Quality Commission to carry on the regulated activities of maternity and midwifery services, family planning services, treatment of disease, disorder or injury, surgical procedures and diagnostic and screening procedures.

The staff team at the practice includes two part time female GP partners providing a total of nine sessions per week, two regular part time male locum GPs each providing one session per week, a part time locum female practice nurse working 12 hours over three session per week, a practice manager who became absent at short notice for an indeterminate period a few days before our inspection, an assistant practice manager who was covering the practice manager role in the interim, and a team of reception and administrative staff all working a mixture of part time hours.

The practice's opening hours are 8.30am to 6.30pm every weekday except Thursday when it opens from 8.30am to 1.00pm, and its doors and telephone lines remain open throughout these periods. GP appointments are available:

- Monday and Wednesday 8.30am to 12.00pm and 4.00pm to 6.00pm
- Tuesday and Friday 9.00am to 12.30pm and 4.00pm to 6.00pm
- Thursday 9.00am to 12.30pm

Appointments include home visits, telephone consultations and online pre-bookable appointments. Urgent appointments are available for patients who need them. Extended hours are available through the Newham GP Co-op service every weekday from 6.30pm to 9.00pm and on Saturday from 9.00am to 1.00pm. Patients telephoning when the practice is closed are transferred automatically to the local out-of-hours service provider.

The Information published by Public Health England rates the level of deprivation within the practice population group as three on a scale of one to ten. Level one represents the highest levels of deprivation and level ten the lowest. The practice area has a higher percentage than national average of people whose working status is unemployed (13% compared to 5% nationally) and a lower than average percentage of people over 65 years of age (5% compared to 17% nationally). The average male and female life expectancy for the practice is 77 years for males (compared to 77 years within the CCG and 79 years nationally), and 83 (compared to 82 years within the CCG and 83 years nationally) years for females. The practice provided data showing its patients demographic is approximately 80% of black and ethnic minority origin.

Why we carried out this inspection

Following the comprehensive inspection of the provider on 10 May 2016 the practice was given a rating of inadequate for safety and well-led, and requires improvement for

Detailed findings

effective, caring and responsive, and an overall rating of inadequate. Requirement notices were set for regulations 12, and 18, and a Warning notice was issued for regulation 17 of the Health and Social Care Act 2008.

We carried out a comprehensive follow up inspection of this service on 23 January 2017 under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 23 January 2017.

During our visit we:

- Spoke with a range of staff (two GP partners, a practice management staff member and three reception and administrative staff) and spoke with patients who used the service.
- Observed how patients were being cared for and talked with carers and/or family members.
- Reviewed a 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.

Inadequate

Are services safe?

Our findings

At our previous inspection on 10 May 2016 not all arrangements for safe services were effective such as accident and incident reporting, systems for acting on safety alerts, patients chaperoning, infection control and legionella, recruitment checks, failsafe systems for cervical screening, and staff safeguarding, basic life support, infection control, and fire safety training. At this inspection most safety concerns had been rectified but some safety systems or processes continued to have weaknesses.

Safe track record and learning

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

- Staff told us they would inform the practice manager of any incidents and there was a recording form available on the practice's computer system. The incident recording form supported the recording of notifiable incidents under the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).
- We saw evidence that when things went wrong with care and treatment, patients were informed of the incident, received reasonable support, truthful information, a written apology and were told about any actions to improve processes to prevent the same thing happening again.
- The practice carried out a thorough analysis of the significant events.

We reviewed safety records, incident reports, patient safety alerts and minutes of meetings where these were discussed. We saw evidence that lessons were shared and action was taken to improve safety in the practice. For example, the practice analysed an event that they had managed effectively after a vulnerable person who was not a patient had walked into the practice describing symptoms that required urgent care. The receptionist recognised the patients' symptoms required urgent medical attention and alerted the GP who saw the patient immediately. An ambulance was called and relevant emergency medicines were available. Reception staff managed other patients' appointments and the waiting area appropriately, and the GP had followed up to contact the patient's next of kin to inform them of the situation. The practice found most staff were trained in Basic Life Support (BLS) and arranged for the remainder to be trained in November 2016.

Overview of safety systems and processes

Most systems, processes and practices were in place to keep patients safe and safeguarded from abuse, but some had gaps:

- Arrangements were in place to safeguard children and vulnerable adults from abuse. These arrangements reflected relevant legislation and local requirements and policies were comprehensive and accessible to all staff. Non-clinical staff were unclear who the safeguarding lead was but otherwise demonstrated they understood their responsibilities and knew they should alert lead GPs for further guidance if they had concerns about a patient's welfare. The GPs attended safeguarding meetings when possible and always provided reports where necessary for other agencies. All staff received training on safeguarding children and vulnerable adults relevant to their role. GPs and nurses were trained to child protection or child safeguarding level 3 and non-clinical staff to level 1. After inspection the practice told us that prior to inspection a poster with named safeguarding leads had been in the reception area, that it had emailed staff asking them to update on safeguarding policies and had reminded of safeguarding arrangements again on 10 January 2017 before our inspection, but this did not explain why staff remained unclear.
- 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 and had received a Disclosure and Barring Service (DBS) check. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).
- The practice maintained appropriate day-to-day standards of cleanliness and hygiene and we observed the premises to be clean and tidy. The senior GP partner was the infection control clinical lead and annual infection control audits were undertaken. The most recent audit was in December 2016 but there was no action plan or evidence actions had been taken to address improvements identified as a result such as

listing contact details for local infectious disease control staff and having infection control on the agenda at practice meetings. An Infection Prevention and Control audit undertaken in 2015 indicated paper couch rolls should be wall mounted with a completion timescale of four weeks but by the day of our inspection this had not been completed. The December 2016 audit was jointly signed off by the GP infection control lead and a member of the management team. However, the management team member had no recollection of being involved in the audit. Information contained in the audit indicated persons completing it did not have relevant knowledge to do so effectively. For example, an audit question about cleaning chemicals was marked not applicable, but it was applicable for appropriate cleaning of clinical equipment such as the ear irrigator. After inspection the practice told us two out of the three consulting rooms paper couch rolls were mounted, and they were looking into arranging for remaining roll to be mounted in March 2017.

- There were discrepancies between what was stipulated in the practice infection control protocol and what was implemented at the practice. For example, the policy stated purple lidded sharps bins were required for disposal of certain sharps from injectable medicines that were administered at the practice, but there were no such sharps bins in the practice. We brought this to the attention of the infection control lead GP but they had no awareness about the existence or purpose of purple lidded sharps bins. The lead infection control GP told us there was a log book for cleaning of clinical equipment which was kept in the nurses' room, this was later found behind the reception area, it contained no record of any clinical equipment cleaning since 20 November 2016 but clinical equipment was visibly clean. Staff told us no patients had their ears irrigated since that date.
- Staff had received up to date infection control training, including the lead GP. We asked two non-clinical staff about how to clean a spillage of bodily fluids to assess their competence on this issue. We expected that staff would tell us they would use the "spillage kit" kept at the practice. One staff member told us they would clean a spillage of bodily fluids with paper towels and gloves and the other said they would clean it with liquid that kills bacteria which did not demonstrate sufficient infection control understanding in accordance with their role, for example in the event of spillages of bodily fluids such as vomit. After we raised this the practice told us it would contact the local infection control team to request a repeat infection control audit, train staff, repeat the audit and support the practice to develop a full action plan to include the ear irrigator issue.
- The arrangements for managing medicines, including emergency medicines and vaccines, in the practice kept patients safe (including obtaining, prescribing, recording, handling, storing, security and disposal). Processes were in place for handling repeat prescriptions which included the review of high risk medicines. The practice carried out regular medicines audits, with the support of the local CCG pharmacy teams, to ensure prescribing was in line with best practice guidelines for safe prescribing. Blank prescription forms and pads were securely stored and there were systems in place to monitor their use. Patient Group Directions (PGDs) had been adopted by the practice to allow nurses to administer medicines in line with legislation. PGDs are written instructions for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment.
- Most of the peak flow meters in use at the practice had a measurement scale that had been obsolete for more than ten years which meant some readings would be inaccurate. A peak flow meter is a small handheld device for commonly used for patients with Asthma that is used to measure how well air moves out of the lungs which is an important part of managing asthma symptoms and preventing an asthma attack. After inspection the practice sent us evidence it had ordered new peak flow meters.
- We reviewed personnel files and found appropriate recruitment checks had generally been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service. However, there was no evidence one clinical member of staff had medical indemnity insurance and a "Caution Order" on their file from their professional registering body which the practice was not aware of. A Caution Order means the clinician is allowed to practice without any restriction but has been made the subject of a caution order following an investigation into their fitness to practise. This can last from between one and five years. We brought this to the attention of the

partner GPs who told us they were unaware and surprised about the caution order and shocked there was no evidence of medical indemnity insurance for the clinician. Partner GPs told us the management staff member responsible for implementing these recruitment checks was currently off duty and a junior manager was covering the role.

After inspection we found evidence partner GPs were aware of a request for the clinicians' medical indemnity cover in December 2016. The practice told us it had looked into the clinicians caution order which showed this was sufficient to maintain the public's confidence in the profession and the regulatory process, that risk assessment had been undertaken and it was appropriate for the clinician to continue duties, and they were still awaiting confirmation of medical indemnity but applied for alternative medical indemnity to ensure cover in the meantime.

The practice subsequently added a recruitment checklist had been in place prior to our inspection and a member of the practice management team noted the clinician's medical indemnity insurance being placed on their file in December 2016, but the filed copy had since disappeared amongst other items. The practice told us it was in the process of dealing with this issue.

Monitoring risks to patients

Risks to patients were not always assessed or well managed.

- There were procedures in place for monitoring and managing risks to patient and staff safety. There was a health and safety policy available with a poster in the reception office which identified local health and safety representatives. The practice had a fire risk assessment dated May 2016 which recommended a fire drill be undertaken in November 2016, but this had not occurred. Staff were trained in fire safety but the designated lead was not aware of the risk assessment recommended date for the next fire drill. There was no written evacuation procedure; however, the fire safety lead was able to explain actions they would take to ensure patients and staff safety. The last fire extinguisher annual safety checks appeared to be overdue and last undertaken in May 2015. There were no other nominated fire safety leads for in the absence of the designated lead. After inspection the practice told us the estates manager had checked fire extinguishers in August 2016 and had not logged this but a sticker was displayed on the extinguisher. The practice sent us evidence the premises landlord had been delayed in undertaking the fire drill planned in November 2016 that subsequently took place on 25 January 2017 and an amended record showing fire extinguisher checks undertaken in August 2016.
- 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 control of substances hazardous to health and legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings).
- Appropriate arrangements were not in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. Lead GPs identified a shortage of practice nursing cover and told us they attempted to recruit further practice nursing cover and wanted to recruit a health care assistant but could only do so with appropriate practice nursing provision in place. The practice was also advertising for a member of reception staff.
- At our previous inspection 10 May 2016 we found failsafe systems to ensure results were received for all samples sent for the cervical screening programme had lapsed due to gaps in practice nursing cover. At this inspection we asked staff to run a search of patients cervical cytology test results and it showed 33 patients results within the last two years had not been received by the practice, nor had cervical screening tests been repeated for these patients. Failsafe systems to ensure results were received for all samples sent for the cervical screening remained ineffective. The practice showed us emails regarding problems with receiving patients' cervical cytology results dating back to June 2016 indicating GPs should use a specific IT system. After inspection the practice sent us evidence it contacted the pathology IT department informing them that smear results are not coming through the relevant link, and that in the interim the partners had worked through the list of patients where last cervical cytology result was missing using alternative IT system that showed no results were missing by 24 January 2017. The practice

also subsequently told us it had allocated a GP Partner to provide oversight; they would add this issue as a standing agenda at monthly practice meetings and were confident the procedure was being followed.

Arrangements to deal with emergencies and major incidents

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

- There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency.
- All staff received annual basic life support training and there were emergency medicines available in the treatment room.
- The practice had a defibrillator available on the premises and oxygen with adult and children's masks. A first aid kit and accident forms were available.
- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and stored securely.

The practice had 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.

Good

Are services effective?

(for example, treatment is effective)

Our findings

At our previous inspection on 10 May 2016 we identified concerns due to shortages of staff that impacted on patient's care, gaps in seeking and recording patient's consent and in staff induction, annual appraisal or supervision. At this inspection the practice continued to attempt to recruit new staff to address shortages. However, all remaining concerns had been addressed.

Effective needs assessment

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

- The practice had systems in place to keep all clinical staff up to date. Staff had access to guidelines from NICE and used this information to deliver care and treatment that met patients' needs.
- The practice monitored that these guidelines were followed through risk assessments, audits.

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 92% of the total number of points available, with 5% 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).

Data from 1 April 2015 to 31 March 2016 showed the practice was an outlier for QOF clinical targets:

- Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) was 0.65 compared to 0.88 within the CCG and 1.01 nationally.
- Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) was 0.05 compared to 0.47 within the CCG and 0.98 nationally.

We asked GPs the reason for the deviation and they told us they were careful with antibiotics and hypnotics prescribing.

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

- Performance for diabetes related indicators was similar to national averages. For example, the percentage of patients with diabetes, on the register, in whom the last IFCCHbA1c (blood sugar level) was 64 mmol/mol or less in the preceding 12 months was 68%, compared with the national average of 78%.
- The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less in the preceding 12 months was 79%, compared with the national average of 78%. Overall exception reporting for diabetes was 9% compared to 7% within the CCG and 12% nationally.
- The percentage of patients with hypertension having regular blood pressure tests was 78%, which is similar to national average of 83%. Overall exception reporting for hypertension was 5% compared to 3% within the CCG and 4% nationally.
- Performance for mental health related indicators was similar to the national average. For example, the percentage of patients diagnosed with schizophrenia, bipolar affective disorder and other psychoses who had a comprehensive, agreed care plan documented in the record in the preceding 12 months was 100% compared with a national average of 89%. Overall exception reporting for mental health was 19% compared to 8% within the CCG and 11% nationally.

There was evidence of quality improvement including clinical audit.

- There had been five clinical audits completed in the last two years, two of these were completed two cycle audits where the improvements made were implemented and monitored. For example, the practice had improved health checks for patients with schizophrenia by increasing the amount of patients receiving health checks from five patients (56%) to seven patients (78%) of patients.
- The practice participated in local audits and benchmarking. Findings were used by the practice for

example to improve prescribing for patients on antidepressants in line with best practice guidelines, and to ensure patients at risk were followed up promptly after being discharged from hospital.

Effective staffing

Staff had the skills, knowledge and experience to deliver effective care and treatment.

- The practice had an induction programme for all newly appointed staff. This covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality but
- The practice could demonstrate how they ensured role-specific training and updating for relevant staff. For example, for those reviewing patients with long-term conditions.
- Staff administering vaccines and taking samples for the cervical screening programme had received specific training which had included an assessment of competence. Staff who administered vaccines were not on duty to verify how they stayed up to date with changes to the immunisation programmes, for example by access to on line resources and discussion at practice meetings.
- The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. Staff had access to appropriate training to meet their learning needs and to cover the scope of their work. This included ongoing support, one-to-one meetings, coaching and mentoring, clinical supervision and facilitation and support for revalidating GPs. Staff had received an appraisal within the last 12 months.
- Staff received training that included: safeguarding, fire safety awareness, basic life support and information governance. Staff had access to and made use of e-learning training modules and in-house training.

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 and their intranet system, with the exception of some cervical cytology results.

- This included care and risk assessments, care plans, medical records and investigation and test results.
- The practice shared relevant information with other services in a timely way, for example when referring patients to other services.

Staff worked together and with other health and social care professionals 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. Meetings took place with other health care professionals on a monthly basis when care plans were routinely reviewed and updated for patients with complex needs.

Consent to care and treatment

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

- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005.
- 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.

Supporting patients to live healthier lives

The practice identified patients who may be in need of extra support. For example:

- Patients receiving end of life care, carers, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation. Patients were signposted to the relevant service.

The practice's uptake for the cervical screening programme was 75%, which was comparable to the national average of 81%. There was a policy to offer telephone reminders for patients who did not attend for their cervical screening test. The practice demonstrated how they encouraged uptake of the screening programme by ensuring a female sample taker was available. The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening.

Childhood immunisation rates for under two year olds ranged between 92% and 94%, (the national expected

Good

Are services effective?

(for example, treatment is effective)

coverage of vaccinations is 90%); and the Measles, Mumps and Rubella (MMR) vaccine for five year olds was 91% for Dose one compared to 94% nationally; and 80% for Dose two compared to 88% nationally.

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

Good

Are services caring?

Our findings

At our previous inspection on 10 May 2016 data from the national GP patient survey generally showed patients rated the practice as comparable to others for aspects of GP care, but scores for nurses were lower, some patients said a particular member of reception staff had not always been polite. The practice had identified less than 1% of carers on its list and could not provide examples of how they used the register to improve care for carers. At this inspection we found patients were not always treated with dignity and respect by reception staff but other concerns had been rectified.

Kindness, dignity, respect and compassion

Most staff were courteous towards patients and treated them with dignity and respect.

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

However, we observed occasions where staffs approach to patients did not always demonstrate dignity and respect. After our inspection a GP partner told us they were arranging customer services training for staff and would strive to improve the patients' experience and actively seek their feedback.

Thirty three of the 45 patient Care Quality Commission comment cards we received were positive about the service experienced, ten were mixed and two were negative. Patients predominantly said they felt the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect. However, themes in the mixed or negative comment cards included difficulty getting through on the phone and reception staff attitude. Two comment cards had a letter attached, both expressed concerns regarding practice management and reception staffing standards.

We spoke with two members of the patient participation group (PPG). They also told us they were satisfied with the clinical care provided by the practice from lead GPs and said their dignity and privacy was respected.

Results from the national GP patient survey published July 2016 showed patients felt they were treated with compassion, dignity and respect. The practice was comparable for its satisfaction scores on consultations with GPs and nurses. For example:

- 81% said the GP was good at listening to them compared to the CCG average of 82% and the national average of 87%.
- 78% said the GP gave them enough time compared to the CCG average of 78% and the national average of 87%.
- 91% said they had confidence and trust in the last GP they saw compared to the CCG average of 86% and the national average of 92%.
- 76% said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 77% and the national average of 85%.
- 84% said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 80% and the national average of 91%.
- 80% said they found the receptionists at the practice helpful compared to the CCG average of 81% and the national average of 87%.

Care planning and involvement in decisions about care and treatment

Patients told us they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them. We also saw that care plans were personalised.

Results from the national GP patient survey showed patients responded comparably to questions about their involvement in planning and making decisions about their care and treatment. Results were comparable to local and national averages. For example:

- 82% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 80% and the national average of 86%.

Good

Are services caring?

- 73% said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 74% and the national average of 82%.
- 77% said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average of 78% and the national average of 85%.

The practice provided facilities to help patients be involved in decisions about their care:

- Staff told us that interpreter 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.
- Information leaflets were available in easy read format.

Patient and carer support to cope emotionally with care and treatment

Patient information leaflets and notices were available in the patient waiting area which told patients how to access a number of support groups and organisations. Information about support groups was also available on the practice website.

The practice had identified 83 patients as carers (3% of the practice list) and offered annual health checks for carers. Written information was available to direct carers to the various avenues of support available to them.

Staff told us that if families had suffered bereavement, their usual GP contacted them. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service.

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

At our previous inspection on 10 May 2016 concerns identified were that we found no evidence longer appointments had been provided for patients with a learning disability and the practice patient's information leaflet did not accurately reflect GP sessions. At this inspection there were no concerns identified with appointments for patients with a learning disability. However, some results from the national GP patient survey relating to patients access were below local and national averages and effective to continually evaluate and improve services had not been taken.

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. For example, it had identified it had a relatively high population of working age women and provided contraceptive services delivered by female clinicians such as insertion and removal of coils.

- Extended hours were available through the Newham GP Co-op service.
- There were longer appointments available for patients with a learning disability.
- Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice.
- The practice took account of the needs and preferences of patients with life-limiting progressive conditions. There were early and ongoing conversations with these patients about their end of life care as part of their wider treatment and care planning.
- Same day appointments were available for children and those patients with medical problems that require same day consultation.
- The practice sent text message reminders of appointments and test results.
- Patients were able to receive travel vaccines available on the NHS and were referred to other clinics for vaccines available privately.
- There were accessible facilities, which included a hearing loop, and interpretation services available.

Access to the service

The practice's opening hours were 8.30am to 6.30pm every weekday except Thursday when it opened from 8.30am to 1.00pm, and its doors and telephone lines remained open throughout those periods. GP appointments were available:

- Monday and Wednesday 8.30am to 12.00pm and 4.00pm to 6.00pm
- Tuesday and Friday 9.00am to 12.30pm and 4.00pm to 6.00pm
- Thursday 9.00am to 12.30pm

Appointments include home visits, telephone consultations and online pre-bookable appointments. Urgent appointments are available for patients who need them.

Results from the national GP patient survey showed that patients' satisfaction with how they could access care and treatment was comparable to or below local and national averages.

- 60% were able to get an appointment to see or speak to someone the last time they tried compared to the CCG average of 66% and the national average of 76%.
- 70% of patients were satisfied with the practice's opening hours compared to the CCG average of 74% and the national average of 76%.
- 60% found it easy to get through to this surgery by phone which was comparable to the CCG average of 60% and the national average of 73%.

We spoke to six patients on the day of inspection, three told us they were able to get appointments when they needed them and three expressed some difficulty with either getting through on the telephone or appointments being delayed on the day. We also had difficulty reaching the practice by telephone to announce our inspection. PPG members told us the telephone system needed to be improved and that callers get a ringtone when there is queue and therefore assume the phone is ringing and not answered.

The practice told us it had taken steps to improve its telephone access by delegating a manager to ensure a new telephone line installation by 31 March 2017. However, meeting minutes dated September 2016 indicated it was not possible to install an extra telephone line and meeting

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

minutes dated January 2017 showed that there were recurrent problems in the telephone being answered. We asked for any further evidence telephone improvement line works were in hand but there was none available.

Listening and learning from concerns and complaints

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

- Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England.
- There was a designated responsible person who handled all complaints in the practice.
- We saw that information was available to help patients understand the complaints system such as a complaints poster and leaflets in the reception area.

We looked at nine complaints received in the last 12 months and found they were dealt with promptly and handled satisfactorily. Lessons were learnt from individual concerns and complaints and also from analysis of trends and action was taken to as a result to improve the quality of care. For example, a complaint was made on behalf of a patient with special needs whose appointment was delayed. The practice contacted the patient and apologised and the complaint was investigated. Meetings were held with relevant staff and the practice implemented new appointment system to prevent recurrence by opening up emergency appointments as appropriate for patients with special needs.

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 10 May 2016 concerns included a high level of staff absence or turnover of key staff, management emails had not being dealt with in a timely way, lack of strategy or supporting business plans, an absence or weakness of policy implementation including aspects of medicines management and business continuity emergency planning. There was evidence of divides between staff and breakdowns in working relationships including the leadership team and issues staff had raised had not been addressed, including safety issues. The leadership team did not consistently demonstrate they had the experience, capacity and capability to run the practice and ensure high quality care and the patient participation group only met annually, was not routinely kept updated, and did not receive PPG meeting minutes. At this inspection we continued to be concerned about a number of issues regarding staffing and governance.

Vision and strategy

The practice strategy and vision was to recruit staff, come out of special measures and deliver high quality care and good outcomes for patients.

- The practice had a mission statement but staff were not aware of it or clear about the values of the practice. For example, one member of staff told us the values were to do everything for patients quickly and another said they did not know but thought staff communication should be improved.
- The practice did not have business plans but had implemented an action plan which had delivered improvements since the previous inspection in areas such as medicines management, patient chaperoning, patients record keeping and consent, identification of and support for patients that are carers, effective business continuity planning, and ensuring staff appraisals and basic life support training.

Governance arrangements

The delivery of high quality care is not effectively assured by the leadership, governance or culture of the practice. Governance arrangements were not always effective:

- There was no staff organisational list or chart but staff were generally clear on roles and responsibilities.
- Most practice specific policies were implemented and all were available to all staff, although there were some gaps in non-clinical staff knowledge such as safeguarding leads and how to deal with a spillage of bodily fluids.
- The practice had not been able to recruit to key staff roles to levels it wanted but was continuing efforts to recruit to both clinical and non-clinical staff.
- Most arrangements for identifying, recording and managing risks, issues and implementing mitigating actions were effective but some had gaps such as systems or processes for fire safety and follow up of actions identified in the infection control audit.
- A comprehensive understanding of the performance of the practice was maintained but not necessarily acted upon, for example failsafe procedures follow up for patient's cytology test results had lapsed again at this inspection after being highlighted at our previous inspection on 10 May 2016.
- Clinical audit was used to monitor quality and to make improvements.
- There were weaknesses in management arrangements. For example, a member of the management team was absent from work for an indeterminate period. We asked management staff about arrangements to access and manage the absent staffs emails and were advised this had not been considered yet. Covering management staff were not aware of how to address this issue. There was also a lack of management staff recollection or knowledge in fundamental areas such as changes to the appointment system following a patients' complaint. After inspection the practice told us it had asked staff to make appropriate email redirection arrangements but this had not occurred and that the relevant arrangements were instigated on 27 January 2017.

Leadership and culture

On the day of inspection the leadership team did not consistently demonstrate they had the experience, capacity and capability to run the practice and ensure high quality care.

A partner GP did not have relevant knowledge to discharge their role as clinical infection control lead effectively, or to underpin appropriate management of staff. We found there were longstanding concerns with staff timekeeping and interpersonal or customer service skills that had not been managed.

Are services well-led?

Inadequate

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

There was evidence of divisions between staff and the leadership team. For example, several staff expressed dissatisfaction regarding the work performance or conduct of colleagues such as alleged unequal or unfair distribution of work, adopting strategies to avoid being unavailable whilst on duty, staff not talking to each other, receiving opposing guidance from different leaders or managers, important tasks left undone, and being shouted at or ignored. The partners told us they were united in their commitment to address staffing issues and there was evidence some initial steps had been taken to address some issues more formally.

The provider was aware of and had systems in place to ensure compliance with the requirements of the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).This included support training for all staff on communicating with patients about notifiable safety incidents. The partners encouraged a culture of openness and honesty between the practice and its patients, for example following complaints and significant events. The practice had systems in place to ensure that when things went wrong with care and treatment:

- The practice gave affected people reasonable support, truthful information and a verbal and written apology.
- The practice kept written records of verbal interactions as well as written correspondence.

There was leadership structure in place but staff did not feel supported by management.

- Staff told us the practice held regular team meetings but our interviews with staff indicated their morale was low.
- Staff did not feel valued, included or involved in discussions about how to run and develop the practice.
- No team away days or social events were held.

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

The practice encouraged and valued feedback from patients. It proactively sought patients' feedback and engaged them in the delivery of the service.

The practice had gathered feedback from patients through the patient participation group (PPG) and through surveys and complaints received. The PPG met regularly and submitted proposals for improvements to the practice management team. The practice used patients' feedback to make improvements. For example, it had improved the patient's notice board and including posting patients feedback on it and had also commenced a new weekly clinic on Wednesday mornings. PPG members were happy with the clinical care they received from GPs but raised concerns relating to leadership and governance at the practice. For example, they told us only one of the GP partners is involved with the PPG and they lack authority to make changes that are needed in the absence of agreement from the other GP partner who is never "present" for the PPG. The PPG said there was a lack of discipline within the practice and no-one was making difficult decisions that were necessary, some management and reception staff are very good but others are not, for example they are coming in late or have a disinterested or otherwise unsatisfactory working attitude which has not been dealt with. Shortages of staff had been discussed at PPG meetings along with discussions about whether there were enough staff. The PPG felt that some of the current staff were doing their best but a change in leadership was needed and a strong and professional practice management and administrative team.

Continuous improvement

Improvement focus at the practice was limited to some clinical audit and improvements following our previous inspection. However, several concerns had not been addressed effectively since the previous inspection and new concerns were identified.

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 Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **How the regulation was not being met:** The provider had failed to assess, monitor and mitigate risks to patients such as infection control, fire safety, and managing emails of absent staff. The provider had failed to assess, monitor and mitigate risks arising from cervical screening tests being carried out but test results not being received. The provider had failed to ensure effective systems for staff employment checks. The provider had failed to operate effective systems to monitor and improve the quality of services such patient care. This was in breach of Regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.