South Axholme 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?	Inadequate
Are services effective?	Requires improvement
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Requires improvement

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at South Axholme Practice on 2 February 2015. Overall the practice is rated as requires improvement.

Specifically, we found the practice to be inadequate for providing safe services and requires improvement for providing effective and well led services. The practice was good for caring and responsive services. It also required improvement for providing services for all of the six population groups based on the concerns identified under safe.

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

- Aspects of safe practice were not in place. For example, criminal record checks through the disclosure and barring service (DBS) were not always undertaken prior to staff commencing their employment. We also found that medicines were not always well managed.
- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed, although in one instance was not sustained.
- Data showed patient outcomes were mostly at or above average nationally. Staff referred to guidance from the National Institute for Health and Care Excellence and patient's needs were assessed and care was planned and delivered in line with current legislation. The practice was identified as high risk for the prescribing of one specific type of medicine and the practice was receiving external support to reduce this.
- Patients said they were mostly treated with compassion, dignity and respect. All patients said they were involved in their care, and decisions about their treatment.
- Information about services and how to complain was available.

Summary of findings

- The majority of patients were satisfied with the appointment system. Negative comments mostly related to the ability to see their GP of choice.
- The practice proactively sought feedback from staff and patients.
- Staff were supported to carry out their role. However, the nursing staff did not receive formal clinical supervision and the health care assistant did not have their delegated areas of responsibility competency assessed.

The areas where the provider must make improvements are:

- Ensure all necessary employment checks (including criminal records checks from the DBS) are obtained for staff before they commence work.
- Ensure risk assessments are undertaken for employee roles which do not require a criminal records check from the DBS.
- Ensure arrangements are in place for the safe management of medicines.

In addition the provider should:

- Ensure that systems are in place for the security of patient records when outside of the practice.
- Ensure that arrangements are in place for the nursing staff to receive formal clinical supervision and for the health care assistant to have their delegated areas of responsibility competency assessed.
- Ensure the practice participates in external peer review or benchmarking with practices, locally or nationally to compare the practices performance to others.
- Ensure that arrangements are in place for risk assessing legionella.
- Ensure arrangements are in place to check that measures introduced following incidents are maintained or evaluated for the effectiveness.
- Ensure that systems are in place to record and identify training that is due and overdue in order that all staff can complete mandatory training in a timely way.
- Ensure the practice acts on the advice of other agencies in a timely way.
- Ensure the practice management have an understanding of the Regulations relating to the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, replaced with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 from April 2015.

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

The practice is rated as inadequate for providing safe services and improvements must be made. Staff were clear about reporting incidents, near misses and concerns. Although the practice reviewed when things went wrong and lessons learned, we saw evidence that changes implemented after an incident to protect staff safety had not been maintained and the practice management were not aware. Patients were at risk of harm because systems had weaknesses and were not implemented in a way to keep them safe. Criminal record checks were not always undertaken prior to staff commencing their employment and repeat medicines were issued to patients before the repeat prescription had been signed. The failure to sign prescriptions prior to dispensing and supply is in contravention of relevant legislation and is an unsafe practice. We also learned that the way some medicines were supplied to patients using a patient group direction (PGD) did not meet legal requirements. The PGDs had not been checked by a pharmacist and additional healthcare professional or authorised by the local clinical commissioning group (CCG) or NHS England area team.

Are services effective?

Requires improvement

The practice is rated as requiring improvement for providing effective services. Data showed patient outcomes were mostly at or above average nationally. Staff referred to guidance from the National Institute for Health and Care Excellence and patient's needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff worked with multidisciplinary teams. There was evidence of appraisals and personal development plans for staff. However, we found the nursing staff were not receiving formal clinical supervision and the health care assistant who was delegated tasks by the nursing staff was not having their competencies assessed. The practice did not routinely compare its performance to others nationally.

Are services caring?

Good

The practice is rated as good for providing caring services. The majority of patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. The national GP survey showed 87% of patients said the GP and 92% said the nurse was good at listening to them. The

Summary of findings

survey also showed 89% said the GP and 95% said the nurse gave them enough time during their consultation. Some patients told us that conversations within patient waiting areas at South Axholme and one branch surgery could be overheard.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It 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. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. Learning from complaints was shared with practice staff.

Are services well-led?

Requires improvement

The practice is rated as requires improvement for being well-led. The practice proactively sought feedback from staff and patients, which it acted on. The virtual patient participation group (PPG) was active. Staff had received inductions and annual appraisals. The practice did not have arrangements in place for nursing staff to receive formal clinical supervision and for the health care assistant to have their delegated responsibilities competency assessed over time. Staff were clear about the vision to deliver high quality care to patients and their responsibilities in relation to this. The practice did not have a clearly defined vision that all staff were aware of and there was no strategy in place for the future of the practice. There was a leadership structure and staff felt supported by management; although there was no information available for patients about the leadership structure within patient waiting areas. There was information about GPs on the practice website but no information about the nursing staff. There were some systems in place to monitor and improve quality and identify risk. The management team did not demonstrate a clear understanding and knowledge of the regulations in relation to the safe recruitment of staff and management of medicines. They had also not addressed known risks in a timely way, for example legionella testing and advice from the fire service.

Summary of findings

The six population groups and what we found

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

Older people

Requires improvement

The practice is rated as requires Improvement for the care of older people. The provider was rated as good for caring and responsive overall and this includes for this population group. The provider was rated as inadequate for safe and requires improvement for effective and well-led. The concerns which led to these ratings apply to everyone using the practice, including this population group.

Staff recognised signs of abuse or neglect in older people and knew how to escalate or refer those concerns. We were provided with two examples where staff had acted on safeguarding concerns which resulted in a positive outcome for the patients. Carer status was recorded and when identified was recorded on patient notes and then invited for a health check. All patients over 75 years had a named GP and a care plan that was regularly reviewed. The practice had recently appointed an emergency care practitioner whose role was to support patients in this group. For example by undertaking home visits, visits to nursing and care homes and focussing on admissions avoidance to secondary care. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in dementia and end of life care.

People with long term conditions

Requires improvement

The practice is rated as requires Improvement for the care of people with long term conditions. The provider was rated as good for caring and responsive overall and this includes for this population group. The provider was rated as inadequate for safe and requires improvement for effective and well-led. The concerns which led to these ratings apply to everyone using the practice, including this population group.

The practice adopted a holistic approach to managing patients with long term conditions. Clinical staff had lead roles in chronic disease management and the management of patients at risk of hospital admission. Arrangements were in place to follow up patients who had accessed secondary care within 48 hours of the practice being made aware of their change in circumstances. Data showed outcomes for patients in this group were good. Patients were supported through the use of care plans which were reviewed regularly.

Summary of findings

Families, children and young people

Requires improvement

The practice is rated as requires improvement for the care of families, children and young people. The provider was rated as good for caring and responsive overall and this includes for this population group. The provider was rated as inadequate for safe and requires improvement for effective and well-led. The concerns which led to these ratings apply to everyone using the practice, including this population group.

Staff recognised signs of abuse or neglect in this group and knew how to escalate or refer those concerns. 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.

The practice provided a range of contraceptive, pre-conceptual, maternity and child health services with some clinical staff holding diplomas specific to family planning. The practice uptake of cervical smears was higher than the national average. The practice offered sexual health advice and had good relationships with health visitors and school nursing. The practice told us Child and Adolescent Mental Health Services (CAMHS) locally remained difficult to access despite new arrangements being put in place. The practice offered a full range of immunisations for children. Last year's performance for all immunisations was on average slightly below the average for the CCG.

Working age people (including those recently retired and students)

Requires improvement

The practice is rated as requires improvement for the care of working age people (including those recently retired and students). The provider was rated as good for caring and responsive overall and this includes for this population group. The provider was rated as inadequate for safe and requires improvement for effective and well-led. The concerns which led to these ratings apply to everyone using the practice, 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 and flexible. The practice was proactive in offering extended opening hours, although the practice closed every lunch time for one hour in the practices that opened in the afternoon. The practice was proactive in offering on line services for booking appointments and repeat prescriptions. The practice was in the initial stages of offering health checks for patients from 40 – 74 years.

Summary of findings

People whose circumstances may make them vulnerable

Requires improvement

The practice is rated as requires improvement for the care of people whose circumstances may make them vulnerable. The provider was rated as good for caring and responsive overall and this includes for this population group. The provider was rated as inadequate for safe and requires improvement for effective and well-led. The concerns which led to these ratings apply to everyone using the practice, including this population group.

The practice held a register of patients with a learning disability. Records showed 19 out of the 23 registered patients with a learning disability had received an annual physical health check and 10 had had a care plan review. The practice had identified patients who were over the age of 75 years who had not attended the practice for a significant amount of time to offer them an appointment for a health check as they may potentially be vulnerable. Patients who were identified as being within an 'at risk' group were offered further support in line with their needs. The practice regularly worked with the primary health care team (PHCT) in the case management of vulnerable people.

People experiencing poor mental health (including people with dementia)

Requires improvement

The practice is rated as requires improvement for the care of people experiencing poor mental health (including people with dementia). The provider was rated as good for caring and responsive overall and this includes for this population group. The provider was rated as inadequate for safe and requires improvement for effective and well-led. The concerns which led to these ratings apply to everyone using the practice, including this population group.

Data showed 93% of patients experiencing poor mental health had received a physical health check and 97% of patients had received an assessment for depression. The practice regularly worked with PHCT teams in the case management of people experiencing poor mental health, including those with dementia. It carried out advance care planning for patients with dementia.

Staff had received training on the Mental Capacity Act 2005. The practice had systems in place to follow up patients who had attended accident and emergency (A&E) where they may have been experiencing poor mental health.

Summary of findings

What people who use the service say

We spoke with six patients at South Axholme practice and two of the branch surgeries (Belton and Haxey) who were using the service on the day of our inspection and reviewed six completed CQC comment cards. The feedback we received was mixed. Most patients described most of the practice staff as helpful, caring and respectful. Staff told us appointments mainly ran to time and that they didn't feel rushed during their appointment. Some patients described the practice as excellent. We received some positive and some negative comments in relation to the appointment system. The negative comments related to being able to see their GP of choice.

National GP survey results published in July 2014 indicated that the practice was best in the following areas when compared to the local CCG average: ?

- 89% of respondents usually wait 15 minutes or less after their appointment time to be seen

Local (CCG) average: 64%

- 92% of respondents find it easy to get through to this surgery by phone

Local (CCG) average: 70%

- 94% of respondents would recommend this surgery to someone new to the area

Local (CCG) average: 77%

The national GP survey results published in July 2014 indicated that the practice could improve in the following areas when compared to the local CCG average:

- 48% of respondents with a preferred GP, usually get to see or speak to that GP

Local (CCG) average: 53%

- 87% of respondents say the last GP they saw or spoke to was good at listening to them

Local (CCG) average: 88%

- 96% of respondents had confidence and trust in the last nurse they saw or spoke to

Local (CCG) average: 97%

There were 254 surveys sent out, 138 returned giving a completion rate of 54%

Areas for improvement

Action the service MUST take to improve

- Ensure all necessary employment checks (including criminal records checks from the disclosure and barring service (DBS) are obtained for staff before they commence work.
- Ensure risk assessments are undertaken for employee roles which do not require a criminal records check from the DBS.
- Ensure arrangements are in place for the safe management of medicines.

Action the service SHOULD take to improve

- Ensure that systems are in place for the security of patient records when outside of the practice.
- Ensure that arrangements are in place for the nursing staff to receive formal clinical supervision and for the health care assistant to have their delegated areas of responsibility competency assessed.
- Ensure the practice participates in external peer review or benchmarking, to compare the practices performance to others.
- Ensure that arrangements are in place for risk assessing legionella.
- Ensure arrangements are in place to check that measures introduced following incidents are maintained or evaluated for the effectiveness.
- Ensure that systems are in place to record and identify training that is due and overdue in order that all staff can complete mandatory training in a timely way.
- Ensure the practice acts on the advice of other agencies in a timely way.

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- Ensure the practice management have an understanding of the Regulations relating to the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010

South Axholme 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 CQC pharmacist and three specialist advisors; a GP, a nurse and a practice manager.

Background to South Axholme Practice

South Axholme, 60 – 62 High Street, Epworth, DN9 1 EP is situated in Epworth, a small town and civil parish in the Isle of Axholme, North Lincolnshire. The practice also has four branch surgeries in nearby areas of Belton, Haxey, Owston Ferry and West Butterwick. The registered patient list size of the practice is 14,653. The overall practice deprivation is on the third least deprived decile. There is a mix of male and female staff at the practice. Staffing is made up of seven GP partners, two salaried and two registrars. The practice also employ one emergency care practitioner, two nurse practitioner/prescribers, specialist respiratory nurse practitioner, four practice nurses, four health care assistants, a range of administrative and reception staff along with a practice manager and deputy practice manager.

South Axholme is a training practice. The practice has a general medical service (GMS) Contract under section 84 of the National Health Service Act 2006.

The CQC intelligent monitoring placed the practice in band 6. The intelligent monitoring tool draws on existing national data sources and includes indicators covering a range of GP practice activity and patient experience including the Quality Outcomes Framework (QOF) and the National Patient Survey. Based on the indicators, each GP practice has been categorised into one of six priority bands, with band six representing the best performance band. This banding is not a judgement on the quality of care being given by the GP practice; this only comes after a CQC inspection has taken place.

Why we carried out this inspection

We inspected this service as part of our comprehensive inspection programme. We carried out the inspection under Section 60 of the Health and Social Care Act as part of our regulatory functions. This inspection was planned to check whether the provider was 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.

This practice had not been inspected before and was selected at random to be inspected under North Lincolnshire Clinical Commissioning Group (CCG).

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.

How we carried out this inspection

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?

Detailed findings

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

We also looked at how well services are provided for specific groups of people and what good care looks 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)

Before our inspection we reviewed a range of information we held about the practice and asked other organisations to share what they knew. We asked North Lincolnshire CCG to tell us what they knew about the practice and the service provided. We reviewed some policies and procedures and other information received from the practice prior to the inspection.

We carried out an announced inspection on 2 February 2015. During our inspection we spoke with 11 members of staff who were working in the main practice and three of the branch practices. This included three GP partners and one salaried GP, a nurse practitioner, an emergency care practitioner, two practice nurses, a health care assistant and the practice and deputy practice manager. We also spoke to six patients who attended the service that day for treatment. We reviewed comments from six CQC comments cards which had been completed.

We observed interaction between staff and patients in the waiting room.

Inadequate

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. For example we saw changes had been made to the process to ensure that fast track referrals were received by the hospital. We reviewed safety records, incident reports and minutes of meetings where these were discussed for the last 12 months. This showed the practice had managed these consistently over time and so could show evidence of a safe track record over the long term. The practice held an annual review of significant events.

Learning and improvement from safety incidents

The practice had a system in place for reporting and recording significant events, incidents and accidents. We were shown records of significant events that had occurred during the last 12 months. Significant events were reviewed at a quarterly meeting and a full review at the end of each year. Staff used incident forms to record significant events that were managed by the practice manager. We looked at the 23 recorded incidents and saw records were completed in a comprehensive and timely manner. We saw evidence of action taken as a result. For example arrangements had been put in place for checking the stock and expiry dates of emergency medicines. We were told about an example where the practice had put security arrangements in place to mitigate a risk following an incident; yet on the day of the inspection we identified the security measures were not being adhered to by staff and areas that should have been secured from unauthorised entry could easily be accessed. The practice had failed to identify that the action taken to prevent a reoccurrence of such an incident was not being adhered to.

National patient safety alerts were disseminated electronically or in paper format to practice staff. Staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for. They also told us alerts were discussed at practice meetings. We saw evidence that a recent alert relating to the use of a certain medicine used for urinary tract infections in some patients had been discussed and acted on.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed that most staff had received relevant role specific training on safeguarding. However, the training record showed one GP had not completed Level 3 safeguarding children training and one clinical member (non GP) of staff who had worked at the practice for four months had not completed safeguarding adults and children training and there was no record to show this was planned. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details were easily accessible. We were provided with two specific examples where practice staff had taken action when they had safeguarding concerns about their patients, which had led to positive outcomes for the patients.

The practice had appointed dedicated GPs as leads in safeguarding vulnerable adults and children. They had been trained and could demonstrate they had the necessary training to enable them to fulfil this role. All staff we spoke with were aware who the lead was and who to speak with in the practice if they had a safeguarding concern.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments; for example children subject to child protection plans. We were told GPs attended case conferences and where this was not possible then a report was submitted to the case conference. Some staff told us about the excellent links one GP had with attending case conferences. Staff also attended Primary Health Care Team and Partnership meetings where safeguarding was a standing agenda item for discussion.

There was a chaperone policy, which was visible in the waiting room. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). All administration staff had completed chaperone training and some of the clinical staff had also.

Inadequate

Are services safe?

Medicines management

Medicines were stored in a well organised way in the dispensaries at the main surgery and two branch surgeries we visited. However, access to the dispensary area was not restricted solely to dispensers and medically qualified staff. At the main surgery we noticed that it would be possible to take some medicines from open shelves by partly opening an unsecured inner door. This meant there was a risk of mishandling or misuse.

Controlled drugs for use in the practice were safely stored and recorded. (Controlled drugs are medicines that require extra checks and special storage arrangements because of their potential for misuse). Oxygen cylinders were kept safely. Medicines for emergency use were easy to access and their expiry dates were regularly checked. Blank prescription forms were kept safely.

The temperatures of medicine refrigerators in the dispensaries were monitored daily and medicines inside were kept at the right temperature. Vaccines were kept in separate, designated refrigerators which were checked using two thermometers. However, on a number of occasions the readings of the two thermometers were sometimes different and outside the correct temperature range for storing vaccines. Appropriate action had been taken on one but not all occasions which meant there was a risk of vaccines being less effective or even unsafe to use. Arrangements were in place to keep vaccines at the right temperature when transported from the main practice to the branch surgeries by staff, in their cars.

Standard operating procedures (SOPs) covering all aspects of dispensing and handling medicines were available to dispensary staff on the computers. Staff were trained to at least NVQ level 2 and had annual appraisals. The appraisal included a competency check for handling and dispensing medicines. All dispensed prescriptions were checked by a second dispenser before being given out. Errors found at the checking stage ('near misses') were recorded and later discussed as part of a learning process. As a result, very few errors were made.

One of the branch surgeries was equipped to dispense medicines into monitored dose system (MDS) packs. Patients who had difficulty remembering or understanding how to take their tablets could have MDS packs to help them take their medicines safely. Unwanted medicines that patients returned to the practice (including controlled drugs) were disposed of safely and promptly. This reduced the risk of harm from medicines.

GPs reviewed hospital discharge letters and other correspondence, and authorised changes to patients' medicines: An audit trail of the GP's instructions was created in the patient's record.

Prescriptions written by GPs during consultations (acute prescriptions) were sent electronically to the dispensary. Whilst it is preferable for such prescriptions to be printed and signed before medicines are dispensed, sending prescriptions electronically provides an audit trail confirming the GP has authorised the medicines.

Repeat prescriptions requested by patients were printed electronically by staff in the dispensary. We found that it was custom and practice for repeat prescriptions to be dispensed and the medicines given out to patients before prescriptions were signed by a GP. The failure to sign prescriptions prior to dispensing and supply is in contravention of relevant legislation and is an unsafe practice. We also learned that the way some medicines were supplied to patients using a patient group direction (PGDs) did not meet legal requirements. The PGDs had not been checked by a pharmacist and additional healthcare professional or authorised by the local clinical commissioning group (CCG) or NHS England area team.

Cleanliness and infection control

We observed the premises to be clean and tidy. We saw there were cleaning schedules in place. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

The practice had a lead for infection control. However, they had last completed infection control training 23 months ago which is not in line with Royal College of Nursing (RCN) guidelines. We saw evidence that audits for infection control were carried out and improvements identified for action were recorded.

An infection control policy and supporting procedures were available for staff to refer to. We saw personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these to comply with the

practice's infection control policy. There was a policy for needle stick injury and staff knew the procedure to follow in the event of an injury. The sample of single use instruments we looked at were within their sterile date.

Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms. The practice completed a hand hygiene audit and no concerns were identified in this audit. We noted the clinical rooms at the main practice at South Axholme did not have elbow taps. We were told there was a plan to replace these but no formal records were available to confirm this.

The practice had a policy for the management, testing and investigation of legionella (a bacterium that can grow in contaminated water and can be potentially fatal). However, we were told the practice was aware that South Axholme and the branches had never had legionella testing yet the practice had not risk assessed this.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. We saw evidence of calibration of relevant equipment; for example weighing scales and blood pressure measuring devices.

Staffing and recruitment

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. They told us about the arrangements for planning and monitoring the number of staff and mix of staff to meet patients' needs. Records confirmed that maintaining adequate staffing cover was discussed at practice meetings.

The practice had arrangements in place to assure them that the clinical staffs' professional registrations were up to date with the relevant professional bodies. The practice had a recruitment policy in place but this was not always being followed. We looked at three records relating to the most recently recruited clinical staff. We found the practice had not ensured that criminal records checks through the Disclosure and Barring Service (DBS) were carried out by the practice before clinical staff commenced work. We also found that references had not been obtained for some of these staff. Some staff who had access to medicines and who may act as a chaperone, for example dispensing and administration staff did not always have a DBS check or a risk assessment to show why they should not have a DBS check.

Monitoring safety and responding to risk

The practice had some systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included checks of the building, the environment, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy and health and safety information was displayed for staff to see. However, we identified the practice had failed to identify two areas relating to safety as well as areas of risk that the practice was aware of but had not acted on, for example, risk assessing legionella and frequency of fire evacuations.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support. Emergency equipment appropriate for children and adults was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, incapacity of staff, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff

Inadequate

Are services safe?

to refer to. For example, contact details of a heating company to contact if the heating system failed. The document was available electronically and in paper format which was stored off site.

The practice had a contract with an external company who managed some aspects of health and safety. A fire risk assessment was in place. Records showed the area fire service had visited the practice in January 2014 and concluded a satisfactory visit. However, we noted they had made recommendations for fire evacuations to take place annually. We noted the practice had not acted on this recommendation as the last fire drill was 18 months ago. Some staff had completed fire awareness training, some of which was almost four years ago. There were no designated staff to act as fire wardens nor had any staff training specific to this role.

Requires improvement

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We saw minutes of practice meetings where new guidelines were disseminated, the implications for the practice's performance and patients were discussed and required actions agreed. The staff we spoke with and the evidence we reviewed confirmed that these actions were designed to ensure that each patient received support to achieve the best health outcome for them. We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate.

Clinical staff led and were trained in specialist areas such as diabetes, heart disease, family planning and asthma. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support. Clinical staff told us they met regularly which enabled them to review and discuss new best practice guidelines. Minutes of staff meetings confirmed this.

The practice held a General Medical Services (GMS) contract with NHS England for delivering primary care services to their local community. As part of this contract, quality and performance was monitored using the Quality and Outcomes Framework (QOF). We looked at the QOF data for this practice which showed that for the most of QOF indicators, the practice was performing in line with the England average at 95.2%.

The practice had systems in place to review patients recently discharged from secondary care. We saw records to confirm patients were contacted as required and reviewed by members of the clinical staff, determined by need. Medicines were transcribed from secondary care discharge letters and reviews with the patient set based on need. Clinical staff confirmed they used national standards for the referral of patients with suspected cancers referred and seen within two weeks.

Discrimination was avoided when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were cared for and treated based on need and the practice took account of patient's age, gender, race and culture as appropriate.

Management, monitoring and improving outcomes for people

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included summarising patient records, safeguarding, recalls, family planning, management of long term conditions, supporting patients to remain at home and preventing patient admission to secondary care.

The practice showed us six clinical audits that had been undertaken in the last three years. Three of these were completed audits where the practice was able to demonstrate the changes resulting since the initial audit. For example, patients taking the medication Lithium had been audited and some resulting positive changes were seen for the patient. The other audits included the use of beta blockers in patients with COPD and the appropriate management and referral of patients with chronic kidney disease (CKD). The CKD audit identified some areas for improvement which the practice had acted on. For example, they had set up an identification, management and referral criteria based on current NICE guidelines.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. The data showed positive outcomes for patients. For example, the QOF data showed that patients with diabetes were managed in such a way that provided no evidence of risk. Data showed this practice was identified as being a risk for the prescribing of non-steroidal anti-inflammatory drugs (NSAIDS) but the practice had acted on this and was being supported by the CCG medicines management team to reduce their prescribing levels.

The team was making use of clinical audit tools, clinical supervision for some staff and staff meetings to assess the performance of clinical staff. The staff we spoke with discussed how, as a group, they reflected on the outcomes being achieved and areas where this could be improved. Staff spoke positively about the culture in the practice around quality improvement.

Requires improvement

Are services effective?

(for example, treatment is effective)

The practice had achieved and implemented the gold standards framework for end of life care. It had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss the care and support needs of patients and their families.

The practice reviewed their own referrals, for example they had reviewed ear/nose/throat (ENT) referrals and used best practice information that was shared with practices by the CCG. The practice received feedback of its performance at CCG level through GP representation at a CCG meeting. The practice did not take part in any formal external peer review or compare its performance nationally.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We noted a good skill mix among the clinical staff. GPs had additional diplomas in a range of areas; examples of which were sexual and reproductive healthcare (DFSRH), Royal College of Obstetricians and Gynaecologists (DRCOG) and Genitourinary Medicine (Dip GU Med). Nursing staff also had a range of additional qualifications; examples of which were diplomas in COPD and asthma. The practice had a record of what training had been completed but there was no system made available to us for identifying what training was required, planned or overdue. We found gaps in the completion of mandatory training, such as safeguarding and infection control.

All GPs were up to date with their yearly continuing professional development requirements and all either have been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

All staff received annual appraisals that identified learning needs from which action plans were documented. Our discussions with staff highlighted that whilst nursing staff were supported by the GPs; they were not receiving formal clinical supervision. The health care assistant had work delegated to them by the nursing staff and reported to a named nurse at the practice. They carried out a range of delegated duties from the nursing staff which included visiting patients who were housebound, venepuncture, Flu and B12 injections, ECG and general health checks. However we were told the HCA did not have their competencies assessed as required to ensure the HCA carried out the delegated tasks to meet required standards. Interviews with staff confirmed that they received protected learning time six times a year. We were told the practice was exploring the use of e-learning to allow the practice to access additional training electronically as there was not always enough time to complete training. As the practice was a training practice, doctors who were training to be qualified as GPs were offered support with their appointments and had the support of a named GP.

Records showed poor performance had been identified and appropriate action had been taken to manage this.

Working with colleagues and other services

The practice worked with other service providers to meet patients' needs and manage those of patients with complex needs. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. Systems were in place for ensuring that all information was looked at, reviewed and passed on to the appropriate person in a timely way.

The practice had signed up to a range of enhanced services. (Enhanced services require an enhanced level of service provision above what is normally required under the core GP contract). Examples include alcohol related risk reduction scheme, extended hours access, a range of vaccinations and avoiding unplanned admissions. We saw records to confirm the practice completed data returns to the CCG to demonstrate the delivery of enhanced services.

Clinical staff told us they had well established multi-disciplinary arrangements in place. We were told the practice was proud of the PHCT meeting arrangements they had in place. They said they communicated well with district nurses and health visitors but less so with midwives due to geography. The practice had good input from Social Services and links into school nursing, which the practice told us was helpful. They held regular palliative care meetings where patients on end of life care were discussed. Staff felt this system worked well and remarked on the usefulness of having established relationships with acute providers to help improve the patient experience.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was

Requires improvement

Are services effective?

(for example, treatment is effective)

a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. For example, we were told that once a patient was recognised as being on the end of life pathway this was shared with the GP out-of hours provider. Electronic systems were also in place for making referrals, and the practice was making referrals mostly via e-referral as this was the preferred method in the area.

The practice had implemented the Summary Care Record (SCR) which meant they uploaded any changes to a patient's summary information, at least daily. This meant anyone treating patients could have access to their full medical record. The practice had a system for identifying any patients who did not want to participate in SCR. The practice had also implemented GP2GP record transfers. The practice told us they continued to employ staff to summarise patients' records as a way of assuring themselves that all the correct information was on the patient's record when they joined the practice. GP2GP meant patients' electronic records would be transferred much sooner when patients moved between practices.

The practice had systems to provide staff with the information they needed, clinical and non-clinical. Staff used an electronic patient record, to coordinate, document and manage patients' care. Staff were trained to use the system and spoke positively about the benefits, for example flagging medicine contraindications. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference. The practice had a system in place for transporting patient information between the main practice and the branches. The information that was transported related to patient information received at the branches received from external sources such as Royal Mail that was then taken to the main practice for processing. Lloyd George patient records that had been delivered to the main practice were also transported to a branch surgery for summarising and storing in the secure records room. Whilst the practice had a system in place, the document bag used to transfer the records was not secure and could easily be opened during transfer.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice.

Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision. All clinical staff demonstrated a clear understanding of Gillick competencies. (These are used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions).

There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures, a patient's verbal consent was documented in the electronic patient notes with a record of the relevant risks, benefits and complications of the procedure. Staff gave examples that they also confirmed implied consent before commencing any physical interaction with the patient.

Health promotion and prevention

The practice offered health checks to all new patients registering with the practice. Any concerns identified at the health check were followed up in a timely way. We saw evidence that the practice was proactive in their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering opportunistic chlamydia screening to patients aged 18 to 25 years and offering smoking cessation advice to smokers. We saw evidence to confirm the practice was just starting to offer NHS Health Checks to all its patients aged 40 to 75 years.

The practice had numerous ways of identifying patients who needed additional support. For example, the practice kept a register of all patients with a learning disability. Data provided to us by the practice on the day of the inspection showed 19 out of the 23 registered patients with a learning disability had received an annual physical health check, although only 10 had had an annual care plan review. The practice had identified patients who were over the age of 75 years who had not attended the practice for a significant

Requires improvement

Are services effective?

(for example, treatment is effective)

amount of time to offer them an appointment for a health check as they may potentially be vulnerable. Patients who were identified as being within an 'at risk' group were offered further support in line with their needs.

Data from the general practice high level indicators (GPHLI) showed the practice's performance in a range of health prevention areas did not present a risk. The data showed the practice was either above, equal or slightly below for a range of areas. For example for cervical smear uptake and health checks for patients with mental illness was higher than the national average. Flu vaccinations for patients identified at risk or over 65 years of age was slightly lower than the national average. The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance for all immunisations was slightly below the average for the CCG. The practice had systems in place to remind patients who did not attend for certain appointments.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national GP patient survey in 2014 and the most recent practice survey completed from November to December 2014. The evidence from all these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the GPHLI showed the patient experience was 93% which was above the national average of 86%. The national GP survey showed 87% of patients said the GP and 92% said the nurse was good at listening to them. 89% said the GP and 95% said the nurse gave them enough time.

Patients completed six CQC comment cards to tell us what they thought about the practice. The majority were positive about the service experienced. Patients said they felt the practice offered a good service and staff were efficient, helpful and caring. They said most staff treated them with dignity and respect. Two comments were less positive which were related to the attitude of reception staff.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Disposable curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation / treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

We saw that most staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. The practice switchboard at South Axholme was in the main waiting area and was not shielded by glass partitions, conversations could be clearly heard although most staff were diligent not to divulge personal details during calls. However, we did hear mobile phone numbers being read out via the telephone on two occasions. We also identified issues with confidentiality in the waiting area at the Belton branch. We noted the music was particularly loud in some of the branches. Some patients told us that conversations could be overheard at South Axholme and the Belton branch. The practice had signs in place informing patients they could be seen in a private room if they so wished.

There was a clearly visible notice in the patient reception area stating the practice's zero tolerance for abusive behaviour, in the practice leaflet and on the practice website.

Care planning and involvement in decisions about care and treatment

Nationally reported data showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example, data from the national patient survey showed 88% of practice respondents said the GP involved them in care decisions and 92% felt the GP was good at explaining treatment and results. The practice's own satisfaction survey carried out in November 2014 showed the majority of responses were good or very good.

Patients told us that health issues were discussed with them and they felt involved in decision making and well informed about the care and treatment they received. Where applicable patients told us they were involved in choosing which hospital they would attend for further treatment. Patient feedback on the CQC comment cards we received was also positive and aligned with these views.

Staff told us that translation services were available for patients who did not have English as a first language. There was no information on the practice website or in the waiting areas about translation services available to patients.

Patient/carer support to cope emotionally with care and treatment

Data from the national GP survey showed 85% said the last GP and 93% said the last nurse they saw or spoke to was good at treating them with care and concern. The practice kept a list of patients who were also carers. Staff told us that if families had suffered bereavement; then a GP usually contacted them. We were given examples where only a named GP was involved in the care of a patient on the end of life pathway. The practice took a holistic approach to the management of patients with long term conditions, seeing the patient as a whole rather than as the disease itself. The new role of emergency care practitioner had helped provided continuity of care; in particular for older people.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patient's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered. For example the practice had employed an emergency care practitioner to further improve the care of the elderly and to avoid admissions to A&E. Data showed admissions to A&E were below the national average.

The NHS England Area Team and Clinical Commissioning Group (CCG) told us that the practice engaged regularly with them and attended meetings led by the CCG. The practice engaged the support of the CCG to improve their services, for example medicines management. The practice participated in providing data returns to the CCG and used this information to monitor and improve their performance. For example the practice had submitted actions plans to the CCG to reduce unplanned admissions to secondary care.

Tackling inequity and promoting equality

The practice had a very small population of patients who could not speak English though it could cater for other different languages through a translation service which was funded by the CCG. The practice did not provide specific equality and diversity training for staff; although staff were clear that all staff were treated equally. We saw no evidence of discrimination when making care and treatment decisions. Interviews with the clinical staff demonstrated that the culture in the practice was that patients were referred on need and that age, sex and race was not taken into account in this decision-making.

Physical access to services at South Axholme and the three branches we looked at were varied, some with services for patients provided across two floors and others on the ground floor only. The South Axholme building did not have a lift to the first floor. Staff told us that patients who could not use the stairs were seen on the ground floor. Most of the doors to the practices did not have automatic opening doors or door bells so patients may experience some difficulty opening doors. We saw that the waiting areas were large enough to accommodate patients with wheelchairs and prams and most corridors were wide to allow for easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients, although not all toilets had grab rail and emergency pull cords. None of the toilets had baby changing facilities.

The practice had a very small population of patients who could not speak English though it could cater for other different languages through a translation service which was funded by the CCG.

Access to the service

Appointments were available at South Axholme practice from Monday to Thursday 8am – 7pm and Friday from 8am to 6.30pm. Belton branch practice was open from Monday to Friday 8.30am to 12.30pm daily. Haxey surgery was open Monday to Wednesday 8.30am to 5.30pm, Tuesday until 8.15pm, Thursday and Friday to 12.30pm. Owston Ferry practice was open Monday 8.30am to 6.00pm and Tuesday to Friday 8.30am to 12.30pm. West Butterwick was open Monday, Wednesday and Friday from 08.30am to 12.00pm. Dispensing arrangements were available in the main surgery and three out of the four branches. All the practices, if open in the afternoon closed between 12:30pm and 1:30pm daily. The GP national survey data showed 86% of respondents were satisfied with the practice's opening hours compared to the national average of 75.7%.

Information was available to patients about making appointments on the practice website and practice leaflet, including how to request a home visit. Information about what number patients should call out of hours was shown on the practice website and practice leaflet. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients.

Longer appointments were also available for patients who needed them and those with long-term conditions. Home visits were made to local care homes, either by a GP or more recently the new emergency care practitioner. Visits were made to patients' homes when required.

From all the data we reviewed, the majority of feedback from patients about the appointment system was positive. The national GP survey results published in July 2014 showed that 93% of patients were able to get an appointment to see or speak to someone the last time they tried. 96% said the last appointment they got was convenient. 92% of respondents found it easy to get

Good

Are services responsive to people's needs?

(for example, to feedback?)

through to the surgery by phone. 89% of patients said they found the receptionists helpful. 88% described their experience of making an appointment as good compared to the national average of 73.8%. We saw evidence that the patient participation group had requested additional pre-bookable appointments to be made available following feedback from patients and this had been actioned. The practice had recently carried out their own survey from November 2014 to December 2014 which incorporated questions based on the appointment experience. 245 surveys had been returned and the responses largely reflected the feedback from the GP patient survey. Half of the patients (three) we spoke to on the day of the inspection provided negative comments about the sit and wait appointment system as they felt they could not see the GP of their choice and was normally seen by the nurse practitioner.

Listening and learning from concerns and complaints

The practice had a 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.

Basic information on how patients could make a complaint was displayed in waiting areas, the patient leaflet and the practice website. The majority of patients we spoke with were aware of the process to follow if they wished to make a complaint.

We looked at 37 complaints received in the last 12 months and found these were satisfactorily handled, dealt with in a timely way and were open and transparent with dealing with the complaint. We saw evidence where the practice had changed it policies and procedures as a result of complaints. The practice reviewed complaints annually to detect themes or trends.

Are services well-led?

Requires improvement

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

Our findings

Vision and strategy

The practice did not have a recorded vision and strategy. Included in the statement of purpose was an aim and objective 'To provide quality primary care medical services to its patient population'. The staff we spoke to had a clear vision to deliver high quality care and promote good outcomes for patients, although staff were not aware of a defined vision or values for the practice. There was no vision or values displayed in patient or staff areas. The practice did not have in place a business plan to show the practice's strategy for the future.

We spoke with 11 members of staff and they all spoke about delivering high quality patient care and what their responsibilities were in relation to this. We did not see nor were we shown any records to show that staff discussed the vision and values of the practice.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the practice. We looked at 10 of these policies and procedures and they were up to date. None of them had a record on them to confirm staff had read and signed them.

There was a leadership structure with named members of staff in lead roles. For example, there was a lead nurse for infection control and lead GPs for areas such as governance, QOF and safeguarding. This information was not made available to patients within patient waiting areas. There was information about the GPs on the practice website but no information about the nursing staff. We spoke with 11 members of staff and they were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed it was performing in line with national standards. We saw that QOF data was regularly discussed and action taken to maintain or improve outcomes.

The practice had completed a range of clinical audits and had a programme of re-audit in place for 2015. The audits were used to monitor quality and systems to identify where action should be taken.

The practice did not complete a central risk log for identifying, recording and managing risks. Some risks were highlighted as part of the significant event recording and discussions at practice meetings showed risks were discussed; for example staffing issues. Individual risk assessments were completed for a range of areas such as the environment, health and safety and fire. However, we noted a number of risks such as inadequate recruitment arrangements and medicine management had not been identified as risks. The practice management did not demonstrate an understanding of the associated regulations relating to compliance with these areas. We also found that other risks, such as the lack of legionella risk assessments had not been acted on and we found one example where the practice had not acted on the recommendation of the fire service.

The practice received feedback of its performance at CCG level through GP representation at a CCG meeting. The practice did not take part in any formal external peer review or compare its performance nationally. The practice did not hold formal governance meetings. However we found that performance, quality and risks were discussed at the routine practice meetings.

Leadership, openness and transparency

Records showed that team meetings were held regularly. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings.

The practice was supported by an external company to support the practice with some aspects of human resources. The practice had access and used the external company policies and procedures which had been adapted to the practice. These included disciplinary procedures, induction policy and a staff handbook. Staff had access to these policies and procedures to support them in their employment at the practice.

Seeking and acting on feedback from patients, public and staff

The practice had gathered feedback from patients through a patient survey. We viewed the most recent survey. The practice had made available electronic devices in waiting areas for patients to complete the survey. They also sent out surveys to patient homes in an attempt to obtain as much feedback as possible. We also saw the practice provided staff with the facility to complete the new Friends and Family test.

Are services well-led?

Requires improvement

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

The practice had a virtual patient participation group (PPG). The PPG had been involved in carrying out a recent survey relating to the use of telephone consultations. The action plan from this survey showed the practice would offer on-line booking facilities for patients, which was now in place. The practice had gathered feedback from staff through staff meetings, appraisals and discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

The practice had a whistleblowing policy which was available to all staff in the staff handbook and electronically on any computer within the practice.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at five staff files and saw that regular appraisals took place, although there were no systems in place to ensure nursing staff received formal clinical supervision and that HCAs had their competencies assessed. Staff told us that the practice was supportive of training, although some staff told us there was not enough time allocated to complete training.

The practice was a GP training practice. It had two GP leads for this area who were involved in the vocational training of fully qualified doctors who wished to enter general practice. Arrangements were in place for managing appointments with trainee GPs to ensure they received the appropriate support.

The practice had completed reviews of significant events and other incidents and shared with staff at meetings. The practice met regularly to review all significant events and complaints to look at how the events and complaints had been managed and any trends and action to be taken to ensure the practice improved outcomes for patients. The practice provided us with examples where the practice had implemented changes following events and complaints. However, we found one example where the changes the practice told us they had implemented were not working in practice on the day of our inspection and therefore the risk had not been mitigated. The practice had failed to identify that the action taken to prevent a reoccurrence of such an incident was not being adhered to.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed We found that the registered person had not protected people against the risk of unsafe recruitment of workers. This was in breach of regulation 21 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment We found that the registered person had not protected people against the risk of unsafe management of medicines. This was in breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12 (f) and (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.