Cressex Health Centre

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Cressex Health Centre on 18 August 2016. Overall the practice is rated as requires improvement.

Specifically, we found the practice to be inadequate for safe service. It was require improvement for provision of effective, caring, responsive and well led services. The concerns which led to these ratings apply to all population groups using the practice.

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

- We noted the current provider had inherited number of challenges when they took over the practice in July 2015. We saw the practice had developed comprehensive action plans, implemented changes and shown improvements in number of areas. However, they were required to make further improvements.
- There were inconsistent arrangements in how risks were assessed and managed. For example during the inspection we found risks relating to management of legionella, medicines management, safeguarding adults and children training and management of blank prescription forms for use in printers which had not been monitored appropriately.
- Monitoring of fire safety, infection control procedures, record keeping, management of health and safety issues at the branch practice and Disclosure and Barring Service (DBS) checks for non-clinical staff undertaking clinical duties were not always managed appropriately.
- Patients said they were not satisfied with the appointment booking system; they had to wait a long time to get through to the practice by phone and found it difficult to make an appointment with a named GP.
- We found that completed clinical audits were driving positive outcomes for patients.
- Staff assessed patients' needs and delivered care in line with current evidence based guidance.
- Staff had the skills, knowledge and experience to deliver effective care and treatment. However, some staff had not received annual appraisals and undertaken training relevant to their role.

Summary of findings

- Data from the national GP patient survey and national screening programme showed patient outcomes were low compared to others in locality and the national average.
- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses.
- Information about services and how to complain were available and easy to understand. However, information about a translation service was not displayed in the reception areas and there were limited information posters and leaflets available in other languages.
- There was a clear leadership structure and staff felt supported by management. The practice sought feedback from staff and patients, which it acted on.
- The provider was aware of and complied with the requirements of the Duty of Candour.

The areas where the provider must make improvements are:

- Further review, assess and monitor the governance arrangements in place to ensure the delivery of safe and effective services. For example, medicines management, the management of blank prescription forms and improve record keeping of medicine, fridge temperature and cleaning checks.
- Ensure effective monitoring of health and safety of the premises such as fire safety, management of legionella and infection control.
- Ensure effective monitoring of health and safety of the branch surgery premises and ensure it is suitable for the purpose for which they are being used and properly maintained.
- Ensure to carry out a Disclosure and Barring Scheme (DBS) check or a risk assessment for non-clinical staff undertaking chaperoning duties to ensure risks are managed appropriately.
- Ensure all staff receive an annual appraisal and undertake training relevant to their role including safeguarding children and adults, fire safety, basic life support, health and safety, infection control, mental capacity, and equality and diversity.
- Consider patient feedback about the appointment system. Review the appointments booking system and the waiting time it takes to get through to the practice by telephone. Improve the availability of non-urgent appointments with a named GP.
- Review and improve the systems in place to effectively monitor and improve patient outcomes for patients on the learning disabilities register, patients experiencing poor mental health, and promote the benefits of cervical, breast and bowel screening to increase patient uptake. Review and improve the national GP patient survey results.

The areas where the provider should make improvements are:

- Review the system in place to further improve the patient outcomes for patients with asthma and rheumatoid arthritis (inflammation and pain in the joints).
- Ensure information about a translation service is displayed in the reception area informing patients this service is available. Ensure information posters and leaflets are available in multi-languages.
- Consider staff feedback, and continue to review and improve the staffing levels to ensure the smooth running of the practice and keep patients safe.
- Consider installing a hearing induction loop at reception and improve access at the branch practice (Lynton House).

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 as there are areas where it must make improvements.

- Although risks to patients who used services were assessed, the systems and processes to address these risks were not always implemented to ensure patients were kept safe. For example, monitoring and record keeping of vaccine fridge temperature and medicines checks, infection control procedures, management of legionella and management of blank prescription forms were not always managed appropriately.
- We found a fire safety risk assessment had not been carried out at the branch practice (Lynton House) and the practice had only addressed some issues identified during previous fire risk assessment at the main premises (Cressex Health Centre).
- We noted number of health and safety issues at the branch surgery premises and it was not properly maintained.
- Disclosure and Barring Scheme (DBS) checks or risk assessments were not carried out for non-clinical staff undertaking chaperoning duties to ensure patients safety.
- There was a lead for safeguarding adults and child protection. However, some staff had not completed safeguarding adults and children training relevant to their role.
- There was an effective system in place for reporting and recording significant events. Lessons were learnt from significant events and staff we spoke with informed us that significant events were discussed during the practice meetings.
- When there were safety incidents, patients received reasonable support, truthful information, a verbal and written apology and are told about any actions to improve processes to prevent the same thing happening again.

Are services effective?

Requires improvement

The practice is rated as requires improvement for providing effective services as there are areas where it must make improvements.

- Data from the Quality and Outcomes Framework (QOF) in 2015-16 showed patient outcomes were comparable to the local Clinical Commissioning Group (CCG) and to the national average.
- The practice had demonstrated significant improvements in reducing exception reporting in QOF data for 2015-16, however,

Summary of findings

they were required to make further improvements. For example, in 2015/16, the practice exception reporting for asthma related indictors had increased from 11% to 15% compared to the previous year's data.

- Staff had the skills, knowledge and experience to deliver effective care and treatment. However, some staff had not received annual appraisals and undertaken role specific training including safeguarding children and adults, fire safety, basic life support, health and safety, infection control, mental capacity, and equality and diversity.
- The practice's uptake of the national screening programme for cervical, bowel and breast cancer screening were below national average. For example, bowel cancer screening uptake was 38%, which was below the national average of 58%.
- The practice was required to review and improve the systems in place to effectively monitor care plans and health checks for patients with learning disabilities and patients experiencing poor mental health.
- Staff assessed need and delivered care in line with current evidence based guidance.
- Clinical audits demonstrated quality improvement.
- Staff worked with multidisciplinary teams to understand and meet the range and complexity of patient's needs.

Are services caring?

Requires improvement

The practice is rated as requires improvement for providing caring services as there are areas where it must make improvements.

- Data from the national GP patient survey showed that patient outcomes were below average compared to others in locality for many aspects of care.
- Patients said they were treated with compassion, dignity and respect. However, not all felt cared for, supported and listened to.
- Information for patients about the services was available. However, the practice had a high proportion of their population from a culture where English was not their first language, yet there were limited information posters and leaflets available in other languages.
- We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Are services responsive to people's needs?

Requires improvement

The practice is rated as requires improvement for providing responsive services as there are areas where it must make improvements.

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- We found that patients were not satisfied with the appointments booking system and the practice was not offering extended hours appointments due to capacity and recruitment issues.
- Feedback from patients reported that access to a named GP and continuity of care was not always available quickly. However, urgent appointments were available the same day.
- The patients' feedback we received on the day of inspection was in line with national survey results findings that patients had to wait long time in the waiting area after their appointment time and had to wait long time to get through to the practice by phone.
- We checked the online appointment records of three GPs and noticed that the next pre-bookable appointments with named GPs were available within four to five weeks and a duty GP within three to four weeks.
- It 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.
- Information about how to complain was available and easy to understand and evidence showed the practice responded quickly to issues raised.
- The practice worked closely with other organisations and with the local community in planning how services were provided to ensure that they met patients' needs.

Are services well-led?

Requires improvement

The practice is rated as requires improvement for being well-led as there are areas where it must make improvements.

- The practice had a governance framework. However, governance monitoring of specific areas required improvement, such as management of legionella, fire safety, record keeping of fridge temperature and medicines checks, and management of health and safety issues at the branch practice were putting patients safety at risk.
- Monitoring of appointment booking system, uptake of the national screening programme and management of blank prescription forms for use in printers were not always managed appropriately.
- We noted the practice had implemented changes and shown improvements in number of areas. We observed with the staffing issues stabilising, the practice was concentrating on further improving the service.

Summary of findings

- There was a clear vision and strategy to deliver high quality care and promote good outcomes for patients. For example, we saw the practice had developed a comprehensive business plan supported by number of risk assessments and action plans to address the challenges inherited from the previous provider when they took over the practice in July 2015.
- NHS England had contacted Care Quality Commission before the inspection to explain the challenges practice was facing and the significant improvements current provider had made since July 2015.
- There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings.
- The practice was aware of and complied with the requirements of the Duty of Candour. The practice sought feedback from staff and patients and there was an active patient participation group.

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 all of the population groups. The provider was rated as inadequate for safe and requires improvement for effective, caring, responsive and well led services. The concerns which led to these ratings apply to everyone using the practice, including this population group.

However, there were areas of good practice.

- The practice offered proactive, personalised care to meet the needs of the older patients in its population.
- It was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs.
- There was a register to effectively support patients requiring end of life care.
- There were good working relationships with external services such as district nurses.
- The premises were accessible to those with limited mobility. However, we noted the front door used to enter the practice did not have an automatic door activation system or doorbell at the branch practice (Lynton House).

People with long term conditions

Requires improvement

The practice is rated as requires improvement for all of the population groups. The provider was rated as inadequate for safe and requires improvement for effective, caring, responsive and well led services. The concerns which led to these ratings apply to everyone using the practice, including this population group.

However, there were areas of good practice.

- There were clinical leads for chronic disease management and patients at risk of hospital admission were identified as a priority.
- Longer appointments and home visits were available when needed.
- All patients with long term conditions had a named GP and the practice carried out a structured annual review to check that 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

Requires improvement

The practice is rated as requires improvement for all of the population groups. The provider was rated as inadequate for safe and requires improvement for effective, caring, responsive and well led services. The concerns which led to these ratings apply to everyone using the practice, including this population group.

However, there were areas of good practice.

- There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young patients who had a high number of A&E attendances.
- Immunisation rates were high for all standard childhood immunisations.
- Patients told us that children and young patients were treated in an age-appropriate way and were recognised as individuals.
- The practice's uptake for the cervical screening programme was 78%, which was lower than the national average of 82%.
- Appointments were available outside of school hours and the premises were suitable for children and babies.
- We saw good examples of joint working with midwives, health visitors and school nurses.

Working age people (including those recently retired and students)

Requires improvement

The practice is rated as requires improvement for all of the population groups. The provider was rated as inadequate for safe and requires improvement for effective, caring, responsive and well led services. The concerns which led to these ratings apply to everyone using the practice, including this population group.

However, there were areas of good practice.

- The needs of the working age population, those recently retired and students had been identified but the practice had not always adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care.
- For example, the practice did not offer extended hours appointments due to capacity and recruitment issues. However, the practice informed us they had recruited new salaried GPs and was planning to offer extended hours appointments from September/ October 2016.
- Health promotion advice was offered but there was limited health promotion material available in multi-languages.

Summary of findings

People whose circumstances may make them vulnerable

Requires improvement

The practice is rated as requires improvement for all of the population groups. The provider was rated as inadequate for safe and requires improvement for effective, caring, responsive and well led services. The concerns which led to these ratings apply to everyone using the practice, including this population group.

However, there were areas of good practice.

- The practice held a register of patients living in vulnerable circumstances including homeless patients, travellers and those with a learning disability.
- It offered annual health checks for patients with learning disabilities. Health checks were completed for three patients out of 57 patients on the learning disability register. Care plans had not been completed for none of those 57 patients on the learning disability register.
- Longer appointments were offered to patients with a learning disability.
- The practice regularly worked with multi-disciplinary teams in the case management of vulnerable patients.
- It had told 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)

Requires improvement

The practice is rated as requires improvement for all of the population groups. The provider was rated as inadequate for safe and requires improvement for effective, caring, responsive and well led services. The concerns which led to these ratings apply to everyone using the practice, including this population group.

However, there were areas of good practice.

- Data from 2014-15 showed, performance for dementia face to face reviews was above the clinical commissioning group and national average. The practice had achieved 89% of the total number of points available, compared to 86% locally and 84% nationally.
- 69% of patients experiencing poor mental health were involved in developing their care plan in last 12 months. Health checks were completed for 51% of patients experiencing poor mental health.

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 had told patients experiencing poor mental health how to access various support groups and voluntary organisations.
- Systems were in place to follow up patients who had attended accident and emergency, when experiencing mental health difficulties.
- 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 published on 7 July 2016 showed the practice was performing below the local and the national averages. Three hundred and sixty-six survey forms were distributed and 105 were returned (a response rate of 29%). This represented 1.30% of the practice's patient list.

- 51% of patients found it easy to get through to this practice by phone compared with a clinical commissioning group (CCG) average of 73% and a national average of 73%.
- 75% of patients were able to get an appointment to see or speak to someone the last time they tried compared with a CCG average of 88% and a national average of 85%.
- 67% of patients described the overall experience of their GP practice as good compared with a CCG average of 86% and a national average of 85%.
- 52% of patients said they would definitely or probably recommend their GP practice to someone who has just moved to the local area compared with a CCG average of 80% and a national average of 78%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received seven comment cards which were positive about the standard of service experienced. We spoke with 12 patients and a patient participation group (PPG) member during the inspection. The patients we spoke with on the day highlighted some concerns about the appointment booking system, availability of appointments with named GPs and the waiting time in the waiting area after their appointment time. They said staff treated them with dignity and their privacy was respected. They also said they always had enough time to discuss their medical concerns.

We saw the NHS friends and family test (FFT) results for last five months and 45% patients were likely or extremely likely to recommend this practice.

Cressex Health Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a GP specialist advisor and an Expert by Experience. This is a person who has personal experience of using or caring for someone who uses this type of service.

Background to Cressex Health Centre

Cressex Health Centre is situated in High Wycombe, Buckinghamshire within a purpose built premises at the main practice and converted premises at the branch practice with car parking for patients and staff. All patient services are offered on the ground floor at both locations.

Services are provided via an Alternative Provider Medical Services (APMS) contract. (APMS contracts are provided under Directions of the Secretary of State for Health.APMS contracts can be used to commission primary medical services from traditional GPpractices). APMS contract is awarded to Chiltern Vale Health (2012) LLP (current provider also known as CV Health) in July 2015. CV Health established Better Health Bucks Community interest Company (BHB CiC) in 2015 to develop a transparent relationship with the patients and NHS England. BHB has three directors who run the service.

The management team informed us this practice had faced significant difficulties until it was taken over by CV Health. In July 2015, the CV Health started with a salaried GP and no practice manager in post. They inherited number of issues including recruitment challenges and limited governance arrangements. They carried out comprehensive risk assessment to identify all issues they inherited from the previous provider and developed an action plan to implement a number of measures to mitigate the challenges during this period of transition.

The practice has shown significant improvements in number of areas. However, the practice recognised that there is more work to do to improve, monitor and review the quality of service.

There are five salaried GPs and a locum GP at the practice. Three GPs are male and three female. The practice employs a nurse practitioner, a practice nurse, an emergency care practitioner and a health care assistant. The practice manager is supported by an assistant practice manager, an IT manager, a team of administrative and reception staff.

The practice has core opening hours from 8am to 6.30pm Monday to Friday. The practice offers a range of scheduled appointments to patients every weekday from 8am to 5.30pm including open access appointments with a duty GP throughout the day. The practice does not offer extended hours appointments.

The practice has a patient population of approximately 8,300 registered patients. The practice population of patients aged between 0 to 9 and 20 to 44 years old is higher than the national average and there are lower number of patients aged above 45 years old compared to national average.

Ethnicity based on demographics collected in the 2011 census shows the patient population is predominantly White British and 35% of the population is composed of patients with an Asian, Black or mixed background. The practice is located in a part of High Wycombe with the low levels of income deprivation in the area.

Detailed findings

Services are provided from following main location and the branch practice, and patients can attend any of the two practice premises. We visited both premises during this inspection.

Cressex Health Centre (the main practice),

Hanover House,

Coronation Road,

Cressex Business Park,

High Wycombe,

Buckinghamshire,

HP12 3PP.

Lynton House (the branch practice),

43 London Road,

High Wycombe,

Buckinghamshire,

HP11 1BP.

The practice has opted out of providing out of hours services to their patients. Out of hours services are provided during protected learning time by Harmony Primary Care service or after 6:30pm, weekends and bank holidays by calling NHS 111.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme.

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory 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, (Regulated Activities) Regulations 2014, 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

Prior to the inspection we contacted the Chiltern Clinical Commissioning Group (CCG), NHS England area team and local Healthwatch to seek their feedback about the service provided by Cressex Health Centre. NHS England had contacted Care Quality Commission before the inspection to explain the challenges practice is facing and the significant improvements the current provider has made since July 2015.

We also spent time reviewing information that we hold about this practice including the data provided by the practice in advance of the inspection.

The inspection team carried out an announced visit on 18 August 2016. During our visit we:

- Spoke with 12 staff (included four GPs, a nurse practitioner, a practice nurse, a practice manager, an assistant practice manager, an IT manager and three administration staff), 12 patients and a patient participation group (PPG) member who used the service.
- Collected written feedback from five staff.
- Observed how patients were being cared for and talked with carers and/or family members.
- Reviewed 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 are provided for specific groups of patients and what good care looks like for them. The population groups are:

- Older people.
- People with long-term conditions.
- Families, children and young people.

Detailed findings

- 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

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 also 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.
- We reviewed records of 22 significant events and incidents that had occurred during the last year. There was evidence that the practice had learned from significant events and change was implemented. For example, following a significant event the practice had revised their repeat prescribing protocol and reminded all staff to carry out blood tests of all patients requiring regular monitoring of their conditions before prescribing the medicines again.
- Staff we spoke with informed us that significant events were discussed during the practice meetings and staff were reminded to read detailed notes of significant events on the shared drive online. The practice carried out a thorough analysis of the significant events.
- We saw safety records, incident reports, patient safety alerts and minutes of meetings where these were discussed.

Overview of safety systems and processes

The practice had systems, processes and practices in place to keep patients safe and safeguarded from abuse, however improvements were required.

- Arrangements were in place to safeguard children and vulnerable adults from abuse that reflected relevant legislation and local requirements and policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. There was a lead member of staff for safeguarding. The GPs attended safeguarding meetings when possible and always provided reports where necessary for other agencies. Staff demonstrated they understood their responsibilities but some staff had not received all the appropriate levels of safeguarding training relevant to their role. For example, three out of six GPs and a health care assistant were not trained to safeguarding children level three and safeguarding adults training. Two administrations staff had not completed safeguarding children training and adults training.
- A notice was displayed in the waiting room and consulting rooms, advising patients that clinical staff would act as a chaperone, if required. All staff who acted as a chaperone were trained for the role but non-clinical staff had not received a Disclosure and Barring Service (DBS) checks. (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 had not undertaken a risk assessment for the non-clinical staff undertaking chaperoning duties to determine whether a DBS check was required to ensure risks were managed appropriately. On the day of inspection the practice confirmed they would not allow staff to undertake chaperone duties until a DBS check had been received.
- A practice nurse was the infection control lead who liaised with the local infection prevention teams to keep up to date with best practice. There was an infection control protocol in place but most staff (including three GPs, a health care assistant and most administration staff) had not received up to date infection control training. Annual infection control audits were undertaken and we saw evidence that action was taken to address most improvements areas identified as a result. However, we observed that appropriate standards of cleanliness and hygiene were not always followed and some areas of the practice were not clean. Written cleaning checklists were not maintained and regular spot checks were not carried out by the practice.
- We checked the arrangements for managing medicines (including obtaining, prescribing, recording, handling,

security and disposal). Processes were in place to check medicines were within their expiry date and suitable for use. However, we noted written records were not maintained.

- Processes were in place for handling repeat prescriptions which included the review of high risk medicines. Regular medicine audits were carried out to ensure the practice was prescribing in line with best practice guidelines for safe prescribing.
- Records showed fridge temperature checks were not carried out daily at both locations. This meant we could not be sure that vaccines were stored within the recommended temperature ranges to be safe and effective to use. There was a policy for ensuring that medicines were kept at the required temperatures, which also described the action to take in the event of a potential failure.
- Patient Group Directions (PGDs) had been adopted by the practice to allow nurses to administer medicines in line with legislation. Health Care Assistants was trained to administer vaccines and medicines against a patient specific prescription or direction from a prescriber.
- Blank prescription forms for use in printers were not handled in accordance with the national guidance as these were not tracked through the practice. On the day of inspection we found blank prescription forms for use in printers were stored in locked cabinet but the staff we spoke with were not able to find the written monitoring records at the main premises (Cressex Health Centre) and records were not maintained at the branch location (Lynton House).
- Recruitment checks were carried out and the three staff files we reviewed showed that appropriate checks had been undertaken prior to employment. For example, proof of identification, references, qualifications and registration with the appropriate professional body.

Monitoring risks to patients

Risks to patients were assessed and well managed, however improvements were required.

- There were procedures in place for monitoring and managing risks to patient and staff safety. The practice had a health and safety policy and carried out health and safety risk assessments for both premises for suitability of premises to ensure patient safety. The practice had identified high health and safety risks in some areas at the branch practice premises and displayed notices to alert staff not to enter in the high risk areas of the premises. The practice applied to NHS England in April 2016 to close Lynton House branch surgery because they felt the premises did not meet the quality standards required for modern general practice. Prior to submitting their application, the practice carried out a consultation with patients and local stakeholders on their proposal. The consultation raised concerns about access to GP services in the area of High Wycombe should the branch close. NHS England and Chiltern Clinical Commissioning Group (CCG) agreed that the decision about the closure of Lynton House should be postponed until Chiltern CCG considered the options for the continued provision of GP services. This resulted in NHS England asking Cressex Health Centre to continue providing services whilst Chiltern CCG explored these options. A refurbishment plan is in place to improve Lynton House surgery and address the issues raised about quality standards.
- A fire safety risk assessment had been carried out at the main premises (Cressex Health Centre) on 11 December 2015. We noted the practice had taken some actions but not addressed all issues identified during the previous fire risk assessment. A fire safety risk assessment had not been carried out at the branch practice (Lynton House). The practice was carrying out regular fire safety checks which included carrying out regular smoke alarm checks. The practice had carried out last fire drill on 12 July 2016 and electronic fire system was serviced on 9 May 2016.
- Legionella (a bacterium which can contaminate water systems in buildings) risk assessment was carried out by an external contractor at the main premises (Cressex Health Centre) but on the day of inspection we found it was expired on 1 July 2015. However, we noted regular monthly water sample analysis had been undertaken by an external contractor. Legionella risk assessment was carried out a week before the inspection at the branch practice (Lynton House) and the practice was still waiting for the written report.
- All electrical and clinical equipment was checked to ensure it was safe. The practice also had a variety of other risk assessments in place to monitor safety of the premises such as control of substances hazardous to health and infection control.
- 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.

However, some staff raised concerns regarding appropriate staffing levels of non-clinical staff. The practice manager showed us records to demonstrate actual staffing levels and skill mix. The practice informed us they had advertised to recruit two additional administration staff.

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 mask. A first aid kit and accident book 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 fit for use. Staff we spoke with informed us that regular checks had been carried out to check medicines were within their expiry date and suitable for use. However, we noted written records were not maintained.
- 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.

Requires improvement

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice assessed needs and delivered care in line 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 and random sample checks of patient records.

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality 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). In 2014-15, the practice had achieved 92% of the total number of points available, compared to 97% locally and 95% nationally, with 11% exception reporting. The level of exception reporting was above the clinical commissioning group (CCG) average (8%) and the national average (9%). Exception reporting is the percentage of patients who would normally be monitored but had been exempted from the measures. These patients are excluded from the QOF percentages as they have either declined to participate in a review, or there are specific clinical reasons why they cannot be included.

The high exception reporting indicated that high numbers of patients had not received appropriate reviews or an annual check-up for their long term condition.

GPs and the management team explained that this was due to known documented challenges within the practice population and vast numbers of patients not attending for long term condition reviews. We noted that the practice followed the national QOF protocol for inviting patients three times for the review of their long term conditions and all potential exceptions of the patient from the recall programme were reviewed by a GP. The practice had a highly transient patient population; patients were often outside of the country for long periods and patients registering at the practice were often only in the area for short, temporary amount of time. This had an impact on screening and recall programmes.

Furthermore, the GPs and management team reflected the recruitment challenges and the changes within staff team in the past 14 months and inherited a practice in July 2015 with no recall systems and limited governance arrangements which had an effect on the systems for recalls and patient outcomes.

The practice had identified the high levels of exception reporting as an area for improvement and formulated action plans to reduce exception reporting. In 2015-16, the practice had achieved 96% of the total number of points available. We saw the exception reporting was regularly reviewed by a dedicated member of staff and the practice had demonstrated significant improvements in reducing exception reporting in QOF data for 2015-16. For example:

- In 2014/15, exception reporting for cancer related indictors was 33%. This was higher than the CCG average (14%) and national average (15%). In 2015/16, the practice exception reporting for cancer related indictors was 0%. This was a 33% reduction from the previous year's data.
- In 2014/15, exception reporting for dementia related indictors was 20%. This was higher than the CCG average (10%) and national average (8%). In 2015/16, the practice exception reporting for dementia related indictors was 4%. This was a 16% reduction from the previous year's data.
- In 2014/15, exception reporting for mental health related indictors was 27%. This was higher than the CCG average (10%) and national average (11%). In 2015/16, the practice exception reporting for mental health related indictors was 15%. This was a 12% reduction from the previous year's data.
- In 2014/15, exception reporting for heart failure related indictors was 12%. This was higher than the CCG average (8%) and national average (9%). In 2015/16, the practice exception reporting for heart failure related indictors was 0%. This was a 12% reduction from the previous year's data.

However, not all areas of clinical care had seen improvement. For example:

Requires improvement

Are services effective?

(for example, treatment is effective)

- In 2014/15, exception reporting for asthma related indictors was 11%. This was higher than the CCG average (6%) and national average (7%). In 2015/16, the practice exception reporting for asthma related indictors was 15%. This was a 4% increase from the previous year's data.
- In 2014/15, exception reporting for rheumatoid arthritis (inflammation and pain in the joints) related indicators was 24%. This was higher than the CCG average (7%) and national average (7%). In 2015/16, the practice exception reporting for rheumatoid arthritis related indictors was 51%. This was a 27% increase from the previous year's data.

With the recent appointment of three salaried GPs, two clinical pharmacists and staffing issues stabilising, the practice was concentrating on further improving QOF for 2016/17. The two clinical domain indicator groups the practice aimed to reduce exception reporting were asthma indicators and rheumatoid arthritis (inflammation and pain in the joints) indicators.

Data from 2014-15 showed;

- Performance for diabetes related indicators was worse than the CCG and national average. The practice had achieved 80% of the total number of points available, compared to 93% locally and 89% nationally. The practice had shown significant improvements in 2015-16 and achieved 90% of the total number of points available.
- The percentage of patients with hypertension having regular blood pressure tests was worse than the CCG and national average. The practice had achieved 73% of the total number of points available, compared to 84% locally and 84% nationally. The practice had shown significant improvements in 2015-16 and achieved 85% of the total number of points available.
- Performance for mental health related indicators was better than the CCG and national average. The practice had achieved 100% of the total number of points available, compared to 97% locally and 93% nationally.

However, in 2015-16;

- The practice had carried out health checks for 51 out of 101 patients experiencing poor mental health. The practice had completed care plans for 70 out of 101 patients experiencing poor mental health.
- The practice had carried out health checks for three out of 57 patients with learning disabilities. The practice had not completed care plans for any patients on the learning disability register.

Clinical audits were carried out to demonstrate quality improvement and all relevant staff were involved in improving care and treatment and patient outcomes.

- The practice had made improvements and carried out number of clinical audits. We checked six clinical audits undertaken in the last 14 months, one of these was completed audit where the improvements made were implemented and monitored. We noticed three clinical audit cycles were in progress and the practice had a comprehensive audit plan in place to carry out future audits.
- The practice participated in applicable local audits, national benchmarking and accreditation.
- Findings were used by the practice to improve services. For example, we saw evidence of repeated audit cycle of end of life care patients.
- The aim of the audit was to identify and ensure all patients on the palliative care register and the end of life care register had comprehensive care plans in place to deliver high quality personalised healthcare and to avoid unplanned admission to the hospital. The first audit in March 2016 demonstrated that seven patients were on the palliative care register and no end of life care plan was in place. The practice had reviewed their protocol and redesigned personalised care plan template and invited patients for reviews. We saw evidence that the practice had carried out follow up audit in August 2016 which demonstrated improvements in patient outcomes and found 43 patients were on the palliative care register and 39 patients were on the end of life care register with comprehensive end of life care plan in place.

Effective staffing

Staff had the skills, knowledge and experience to deliver effective care and treatment. However, records demonstrated that some staff had not received annual appraisals and completed training that was relevant to their role.

- The learning needs of some staff were identified through a system of appraisals, meetings and reviews of practice development needs. Staff had access to

appropriate training to meet these learning needs and to cover the scope of their work. This included ongoing support during one-to-one meetings, appraisals, coaching, mentoring, clinical supervision and facilitation and support for the revalidation of doctors. Eight administration staff and a health care assistant had not received an appraisal within the last 12 months. However, the practice manager had implemented a revised appraisal process in April 2016 and had completed an appraisal for seven staff.

- Some staff had not received training that included: safeguarding children and adults, fire safety, basic life support, health and safety, infection control and equality and diversity. 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.

- 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 services to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. This included when patients moved between services, including when they were referred, or after they were discharged from hospital. The practice had identified 130 patients who were deemed at risk of admissions and 87% of these patients had care plans created to reduce the risk of these patients needing hospital admission. We saw evidence that multi-disciplinary team meetings took place on a monthly basis and that care plans were routinely reviewed and updated.

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. However, most of the staff had not received mental capacity training at a level appropriate to their role.
- When providing care and treatment for children and young patients, 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, where appropriate, recorded the outcome of the assessment.
- The provider informed us that verbal and written consents were taken from patients for routine examinations and minor procedures as per general medical council (GMC) guidelines. The provider informed us that written consent forms were completed for more complex procedures.

Supporting patients to live healthier lives

Patients who may be in need of extra support were identified by the practice.

- These included patients receiving end of life care, carers, those at risk of developing a long-term condition and those wishing to stop smoking. Patients were signposted to the relevant external services where necessary such as local carer support group.
- The practice was offering opportunistic smoking cessation advice and patients were signposted to a local support group. For example, information from Public Health England showed 91% of patients (15+ years old) who were recorded as current smokers had been offered smoking cessation support and treatment in last 24 months. This was higher than the CCG average (87%) and to the national average (86%).

The practice's uptake for the cervical screening programme was 78%, which was below the national average of 82%. There was a policy to offer text message reminders for patients about appointments. The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening. In total 38% of patients eligible had undertaken bowel cancer screening and 66% of patients eligible had been screened for breast cancer, compared to the national averages of 58% and 72% respectively.

Requires improvement

Are services effective?

(for example, treatment is effective)

Childhood immunisation rates for the vaccines given were good but the CCG data was not available for comparison. For example:

- Childhood immunisation rates for the vaccines given to under two year olds were 97%, these were above the national averages which ranged from 85% to 95%. CCG data was not available for comparison.
- Childhood immunisation rates for vaccines given to five year olds were 93%, these were comparable to the national averages which ranged from 87% to 95%. CCG data was not available for comparison.

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 on the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.

Requires improvement

Are services caring?

Our findings

Kindness, dignity, respect and compassion

We observed members of staff were courteous and very helpful to 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.

All of the seven patient Care Quality Commission comment cards we received were positive about the service experienced. We also spoke with 12 patients and a member of the patient participation group (PPG). They also told us their dignity and privacy was respected. However, patients feedback highlighted some concerns about the appointment booking system, availability of appointments with named GPs and the waiting time in the waiting area after their appointment time. Comment cards highlighted that staff responded compassionately when they needed help and provided support when required.

Results from the national GP patient survey showed less patients felt they were treated with compassion, dignity and respect. The practice was below the clinical commissioning group (CCG) average and the national average for most of its satisfaction scores on consultations with GPs and nurses. For example:

- 89% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 96% and national average of 95%.
- 87% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 91% and national average of 91%.
- 80% of patients said they found the receptionists at the practice helpful compared to the CCG average of 86% and national average of 87%.
- 75% of patients said the GP gave them enough time compared to the CCG average of 88% and national average of 87%.
- 70% of patients said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 87% and national average of 85%.
- 81% of patients said the GP was good at listening to them compared to the CCG average of 90% and national average of 89%.

Care planning and involvement in decisions about care and treatment

Patients we spoke with told us that health issues were discussed with them and 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. Patient feedback on the comment cards we received was also positive and aligned with these views.

Results from the national GP patient survey we reviewed showed less patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and results were below the CCG average and the national average. For example:

- 77% of patients said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average of 85% and national average of 85%.
- 66% of patients said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 83% and national average of 82%.
- 80% of patients said the last nurse they saw was good at explaining tests and treatments compared to the CCG average of 90% and national average of 90%.
- 69% of patients said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 87% and national average of 86%.

The practice was aware of poor national survey results and informed us that with staffing issues stabilising, they would be able to focus on improving in these areas.

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

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

Requires improvement

Are services caring?

- Information leaflets were available in easy read format. However, the practice had a high proportion of patients from a culture where English was not their first language, yet there were limited information posters and leaflets available in other languages.

Patient and carer support to cope emotionally with care and treatment

Notices in the patient waiting room told patients how to access a number of support groups and organisations.

The practice's computer system alerted GPs if a patient was also a carer. There was a practice register of 101 patients (1.2% of the practice patient population list size) who were carers and they were being supported, for example, by offering health checks and referral for social services support. Written information was available for carers to ensure they understood the various avenues of support available to them. The practice website also offered additional services including counselling. Comment cards highlighted that staff responded compassionately when patients needed help and provided support when required.

Staff told us that if families had suffered bereavement, their usual GP contacted them or sent them a sympathy card. 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

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 demands of the practice population were understood and systems were in place to address identified needs in the way services were delivered. Many services were provided from the practice including diabetic clinics, mother and baby clinics and a family planning clinic. The practice worked closely with health visitors to ensure that patients with babies and young families had good access to care and support. Services were planned and delivered to take into account the needs of different patient groups and to provide flexibility, choice and continuity of care. For example;

- There were longer appointments available for patients with a learning disability.
- Home visits were available for older patients and patients who would benefit from these.
- Same day and urgent access appointments were available for children and those with serious medical conditions.
- The practice had installed a touch screen self check-in facility at the Hanover House and Lynton House to reduce the queue at the reception desk. However, the self check-in screen was faulty at the branch practice (Lynton House) on the day of inspection.
- The practice was offering services to a care home including a weekly round by one of the GPs.
- Patients were able to receive travel vaccines.
- There were disabled facilities and translation services available. However, we noted a hearing induction loop was not available at the branch practice (Lynton House). The practice did not provide a low level desk at the front reception at the branch practice (Lynton House).
- The practice installed an automatic floor mounted blood pressure monitor in the waiting area for patients to use independently.
- The practice website was well designed, clear and simple to use featuring regularly updated information. The website also allowed registered patients to book online appointments and request repeat prescriptions.

Access to the service

The practice was open from 8am to 6.30pm Monday to Friday. The practice was closed on bank and public holidays and patients were advised to call NHS 111 for assistance during this time. The practice offered a range of scheduled appointments to patients every weekday from 8am to 5.30pm including open access appointments with a duty GP throughout the day. In addition to pre-bookable GPs appointments that could be booked up to five weeks in advance, urgent appointments were also available for patients that needed them.

The practice had not offered extended hours appointments due to capacity and recruitment issues. However, the practice informed us they had recruited new salaried GPs and was planning to offer extended hours and web GP (online consultations) from September/ October 2016.

- We checked the online appointment records of three GPs and noticed that the next pre-bookable appointments with named GPs were available within four to five weeks and a duty GP within three to four weeks. Urgent appointments with GPs or nurses were available the same day.
- The patients' feedback we received on the day of inspection was in line with national survey results findings that patients had to wait long time in the waiting area after their appointment time, patients found it difficult to make an appointment with a named GP and patients had to wait long time to get through to the practice by phone. Staff we spoke with recognised that there was more work to do to monitor and review appointments booking system.

Results from the national GP patient survey showed that patient's satisfaction with how they could access care and treatment were below the CCG average and the national average. For example:

- 63% of patients were satisfied with the practice's opening hours compared to the CCG average of 73% and national average of 76%.
- 51% of patients said they could get through easily to the practice by phone compared to the CCG average of 73% and national average of 73%.
- 75% of patients said they were able to get an appointment to see or speak to someone the last time they tried compared to the CCG average of 88% and national average of 85%.

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

- 59% of patients described their experience of making an appointment as good compared to the CCG average of 75% and national average of 73%.
- 39% of patients said they always or almost always see or speak to their preferred GP compared to the CCG average of 63% and national average of 59%.

The practice was aware of poor national survey results and they had taken steps to address the issues. For example;

- The practice had reviewed appointment booking system in May 2016, introduced telephone consultation with GPs, offered two 'sit and wait' clinics between 9.40am and 12pm Monday to Friday and pre-bookable GPs appointments were available to book online with most GPs.
- The practice had recruited four salaried GPs since taking over in July 2015 and employed a new practice manager in January 2016.
- The practice had recruited two new clinical pharmacists, who were focusing on medicines reviews, repeat prescriptions and monitoring prescribing cost.
- The practice had upgraded telephone system in July/ August 2016 but still facing some teething issues.

The practice had a system in place to assess:

- whether a home visit was clinically necessary; and
- the urgency of the need for medical attention.

The practice operated a triage system for urgent on the day appointments. Patients were offered an urgent appointment, telephone consultation or a home visit where appropriate. In cases where the urgency of need was so great that it would be inappropriate for the patient to wait for a GP home visit, alternative emergency care arrangements were made.

Listening and learning from concerns and complaints

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

- The 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. The complaints procedure was available from reception, detailed in the patient leaflet and on the patient website. Staff we spoke with were aware of their role in supporting patients to raise concerns. Patients we spoke with were aware of the process to follow if they wished to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice.

We looked at 43 complaints received in the last 12 months and found that all written complaints had been addressed in a timely manner. When an apology was required this had been issued to the patient and the practice had been open in offering complainants the opportunity to meet with either the manager or one of the GPs. We saw the practice had included necessary information of the complainant's right to escalate the complaint to the Ombudsman if dissatisfied with the response. The Ombudsman details were included in complaints policy, on the practice website and a practice leaflet.

Lessons were learnt from concerns and complaints and action was taken to as a result to improve the quality of care.

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 had a clear vision to deliver high quality care and promote good outcomes for patients.

- The practice had a vision statement which included the delivery of a compassionate and innovative healthcare service through effective leadership, shared knowledge and effective teamwork.
- The practice had a good strategy and supporting business plans which reflected the vision and values and were regularly monitored.
- The management team informed us that they had taken over this practice in July 2015 and inherited a number of issues including the recruitment challenges and limited governance arrangements. We saw the practice had implemented a number of measures to mitigate the challenges during this period of transition. NHS England and the clinical commissioning group had provided additional support to the practice.
- We observed with the appointment of three salaried GPs, two clinical pharmacists and a practice manager, the practice aspired to improve the service. We noted and recognised that there was more work to do to improve, monitor and review the quality of service.

Governance arrangements

On the day of inspection we observed that the practice had a governance framework. However, governance monitoring of specific areas required improvement, for example:

- There was a clear staffing structure and that staff were aware of their own roles and responsibilities. However, some staff had not completed role specific training to enable them to carry out the duties they were employed to do.
- We noted some staff had not received annual appraisals in the last 12 months.
- There were some arrangements for identifying, recording and managing risks, issues and implementing mitigating actions. However, monitoring of specific areas required improvement, such as, the practice's uptake of the national screening programme was below average compared to the local and national averages. For example, the practice's uptake for the bowel cancer screening programme was 38%, which was below the national average of 58%.
- Disclosure and Barring Service (DBS) checks for non-clinical staff undertaking clinical duties and effective management of health and safety issues at the branch practice were not always carried out to ensure risks were managed appropriately.
- Monitoring and record keeping of vaccine fridges temperature and medicines checks, monitoring of fire safety, infection control procedures, management of legionella and management of blank prescription forms were not always managed appropriately.
- Patients we spoke with on the day of inspection informed us they were not satisfied with the appointments booking system. For example, the practice was not offering extended hours appointments due to capacity and recruitment issues.
- A programme of clinical and internal audit was used to monitor quality and to make improvements.
- Practice specific policies were implemented and were available to all staff.

Leadership and culture

The directors and GPs in the practice were visible in the practice and staff told us that they were approachable and always took time to listen to all members of staff. Staff told us there was an open and relaxed atmosphere in the practice and there were opportunities for staff to meet for discussion or to seek support and advice from colleagues. Staff said they felt respected, valued and supported, particularly by the partners and management in the practice.

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

When there were significant safety incidents:

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

There was a clear leadership structure in place and staff felt supported by management.

- Staff told us that the practice held regular team meetings.

Are services well-led?

Requires improvement

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

- Staff told us that there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and confident in doing so and felt supported if they did.
- Staff said they felt respected, valued and supported, particularly by the management in the practice. All staff were involved in discussions about how to run and develop the practice, and the partners encouraged all members of staff to identify opportunities to improve the service delivered by the practice.

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

The practice encouraged and valued feedback from patients, proactively gaining patients' feedback and engaging patients in the delivery of the service.

- The practice had established a new patient participation group (PPG) in November 2015. It had gathered feedback from patients through the PPG and through surveys including friends and family tests and complaints received. There was an active PPG which met on a regular basis, supported patient surveys and submitted proposals for improvements to the practice management team. For example, the practice appointment system had been reviewed and patients' consultations were organised in collaboration with the PPG to collect feedback about closing the branch practice and find out the demand of the extended hours appointments.
- The practice had also gathered feedback from staff through staff meetings, appraisals and discussion. We saw that some staff appraisals were not completed in the last 12 months. Staff told us they felt involved and engaged to improve how the practice was run.

Continuous improvement

- There was a focus on continuous learning and improvement within the practice, however we found some gaps in staff training.
- We saw practice nurses attended regular training sessions organised by the CCG and had completed further training in asthma, diabetes and minor illness.
- We noticed two salaried GPs had completed joint injections training and all GPs were entitled to take five study days per year.
- The practice offered all non-clinical staff to undertake National Vocational Qualifications (NVQs) in administration management.
- The practice was in discussion with Diabetes UK to run a joint project to improve the outcomes for diabetic patients.
- The practice was in discussion with CCG to run a pilot project to reduce prescribing cost.

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 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2014 Safe care and treatment** **How the regulation was not being met:** **We found the registered person did not have suitable arrangements in place for assessing and managing risks in order to protect the welfare and safety of service users and others who may be at risk from the carrying on of the regulated activity. For example:** **Ensure effective monitoring of safety of the premises such as fire safety, management of legionella and infection control.** **Regulation 12(1)(2)**

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment **Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2014 Premises and equipment** **How the regulation was not being met:** **We found the registered person did not have suitable arrangements in place to protect the welfare and safety of service users and others who may be at risk from the carrying on of the regulated activity. For example:** **Ensure effective monitoring of health and safety of the branch surgery premises and ensure it is suitable for the purpose for which they are being used and properly maintained.** **Regulation 15(1)(e)**

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2014 Good Governance How the regulation was not being met: We found the registered person did not have effective governance, assurance and auditing processes and they were required to further review, assess and monitor the governance arrangements in place to ensure the delivery of safe and effective services. For example, medicines management, the management of blank prescription forms and improve record keeping of medicine, fridge temperature and cleaning checks. Consider patient feedback about the appointment system. Review the appointments booking system and the waiting time it takes to get through to the practice by telephone. Improve the availability of non-urgent appointments with a named GP. Review and improve the systems in place to effectively monitor and improve patient outcomes for patients on the learning disabilities register, patients experiencing poor mental health, and promote the benefits of cervical, breast and bowel screening to increase patient uptake. Review and improve the national GP patient survey results. Regulation 17(1)(2)

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2014 Staffing. How the regulation was not being met: We found the registered person did not operate effective systems to ensure staff received appropriate support, annual appraisal and training including safeguarding

This section is primarily information for the provider

Requirement notices

children and adults, fire safety, basic life support, health and safety, infection control, mental capacity, and equality and diversity to enable them to carry out the duties they were employed to do.

Regulation 18(2)

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed Regulation 19 HSCA 2008 (Regulated Activities) Regulations 2014 Fit and proper person employed How the regulation was not being met: We found the registered person did not have robust recruitment procedures including undertaking appropriate pre-employment checks to ensure persons employed for the purposes of carrying out regulated activity are of good character, such as; Ensure to carry out a Disclosure and Barring Scheme (DBS) check or a risk assessment for non-clinical staff undertaking chaperoning duties to ensure risks are managed appropriately. Regulation 19(1)