Dr Tom Frewin

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Dr Tom Frewin, Clifton Village Practice on 15 April 2015. Overall the practice is rated as inadequate.

Specifically we found the practice inadequate for safe, effective, responsive and well led services. We found that services required improvement in respect of caring. Overall the practice was found to be inadequate for providing services for all population groups.

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

- Patients said they were treated with compassion, dignity and respect and they were involved in care and treatment decisions
- Patients were able to have appointments on the same day of them contacting the practice.
- Patients were at risk of harm because systems and processes were not in place in a way to keep them safe. Areas of concern were the lack of infection control audit and process, poor medicine management, the lack of consistent maintenance of equipment and insufficient monitoring of safety and responding to risk. The practice was working with the NHS England area team to ensure they took immediate corrective action, which would enable them to fulfil their basic functions safely. NHSE were also monitoring the concerns and issues within the practice.
- We saw no evidence that audit was driving improvement in performance to improve patient outcomes. We found there were no clinical audits or audits of the service provision to ensure patients safety and welfare were protected, such as infection control.
- There was a lack of nursing provision at the practice of systems for monitoring patients with long term conditions.

The areas where the provider must make improvements are:

Importantly, the provider must:

Summary of findings

- Not carry our minor surgery at the practice as they are not registered for this regulated activity. On 29 April 2015 we sent a section 64 letter to the provider in order to establish further information and to determine the level of risk to patients. The provider has been given until 13 May 2015 in which to provide a response to us.
- Ensure there are systems in place for monitoring patients with long term conditions, end of life care and patients identified as at risk.
- Ensure there is adequate clinical staff employed in the practice, at the right time and have the right skills to meet the needs of patients.
- Ensure there is a system in place to ensure that equipment used at the practice is safe
- Ensure it has the necessary equipment and medicines in accordance to the Resuscitation Council (UK) guidelines to respond to medical emergencies.
- Ensure that patients consent is obtained and recorded before treatment is provided
- Implement a safe system for medicines management including the management of vaccines, and the safe keeping of prescription pads and prescription printer paper.
- Undertake an infection control audit and have effective systems in place for the cleanliness and hygiene of the practice. To assess the risks of preventing the spread of infection including the safe storage of clinical waste and substances hazardous to health.
- Document all recruitment and employment information required by the regulations in all staff members' personnel files.
- Carry out risk assessments and document these to inform which members of staff required a DBS check and which staff did not.
- Implement a system to ensure all staff members receive regular supervision and training such as infection control and the Mental Capacity Act 2005.
- Provide clinical and operational business leadership and develop a clinical audit process and implement findings from audits.
- Develop and maintain a system to identify risks and improve quality in relation to patient safety. Undertake and record all relevant risk assessments in regard to the practice premises including fire safety.
- Take action to ensure all patients' records are updated with appropriate information and documents in relation to the care and treatment they have received. Records must be kept secure.
- Undertake a disability access risk assessment of the building to check that it was meeting current legislation requirements in accordance to the Equality Act 2010.

The areas where the provider should make improvement are:

- Introduce a legionella risk assessment and related management schedule.
- The practice should ensure that within the complaints policy and procedure patients are given the necessary information for the complaints ombudsman.

Where, as in this instance, a provider is rated as inadequate for one of the five key questions or one of the six population groups it will be re-inspected no longer than six months after the initial rating is confirmed. Being placed into special measures represents a decision by CQC that a service has to improve within six months to avoid CQC taking steps to cancel the provider's registration.

On the basis of the ratings given to this practice at this inspection, I am placing the provider into special measures. GP practices rated as inadequate for one or more of the five key questions or six population groups will be inspected no longer than six months after the initial rating is confirmed. Being placed into special measures represents a decision by CQC that a practice has to improve within six months to avoid having its registration cancelled.

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. The practice had a generic health and safety policy however it did not identify by name who was responsible for implementing the policy and was not fit for purpose as it did not scope the full risks at the practice. The policy was generic and did not relate to the practice. Staff were clear about reporting incidents, near misses and concerns. The practice reviewed when things went wrong, however safety was not always improved. For example a fire risk assessment highlighted the need to implement more fire extinguishers but these were not put in place. Patients were at risk of harm because systems and processes were not in place in a way to keep them safe. Areas of concern were the lack of infection control audit and process, poor medicine management, the lack of consistent maintenance of equipment and insufficient monitoring of safety and responding to risk. The practice did not have a policy for the management, testing and investigation of legionella (a germ found in the environment which can contaminate water systems in buildings). There was no risk assessment to determine if action was required to reduce the risk of legionella infection to staff and patients. We found all recruitment and employment information required by the regulations was not documented in all staff members' personnel files.

Are services effective?

Inadequate

The practice is rated as inadequate for providing effective services, as there are areas where improvements must be made. NHS England data showed patient outcomes were at or below average for the locality for childhood immunisations. The practice did not employ a permanent practice nurse and therefore there was an inconsistent approach to providing care and support to patients with long term health conditions. There were no completed audits of patient treatment outcomes. We saw no evidence that audit was driving improvement in performance to improve patient outcomes. Multidisciplinary working was taking place but was generally informal and record keeping was limited or absent. Consent was not routinely recorded and this meant there was no evidence that treatment was provided with the consent of the patient.

Are services caring?

Requires improvement

The practice is rated as requiring improvement for providing caring services. NHS England data showed that patients rated the practice higher than others for several aspects of care. We saw positive

Summary of findings

comments on NHS Choices website. However, there were four negative comments made during the last 12 months where patients expressed unhappiness about their support, delivery of the service, meeting appointment times and processing referrals to external health providers. The practice was accessible via six steps up from street level and external steps down to the basement level. There was a consulting room, reception, waiting room and office on the ground floor. A further consulting/meeting room was on the first floor. A consulting room, treatment room and meeting room was situated in the basement. There was no lift. The patient toilet was not suitable for visitors who had poor mobility, used walking aids or required support from a carer. The provider had not carried out a disability access risk assessment of the building to check that it was meeting current legislation requirements in accordance to the Equality Act 2010.

Patients said in comment cards received by the CQC they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information to help patients understand the services available was easy to understand. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Are services responsive to people's needs?

Inadequate

The practice is rated as inadequate for providing responsive services. Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day. The practice had the minimum of the necessary facilities and was equipped to treat patients and meet their needs. The practice had a register of patients who were receiving palliative care. There was no formal system or register of patients with learning disabilities or those who had long term conditions such as diabetes or asthma. There was no organised system for patient recall for health checks for long term conditions.

Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. There was evidence there was learning from complaints and actions were put to improve the service to prevent them reoccurring.

Are services well-led?

Inadequate

The practice is rated as inadequate for being well-led. It had an ethos for providing responsive and good care however it did not have a strong strategy to meet this vision. Staff we spoke with were not always clear about their responsibilities in relation to the vision or strategy of the practice. There was a leadership structure which

Summary of findings

consisted of the principal lead who was also the registered provider. Staff told us they felt supported by the provider. The practice had a number of policies and procedures to govern activity, but there were key policies and procedures not in place and others were not always followed, such as infection control and recruitment. There was not a clear system for monitoring and managing test results such as blood and urine samples. There was not a safe system for managing information received in from hospital or other health providers at the practice. The practice did not hold regular governance meetings and issues were discussed at ad hoc meetings. Meetings and strategic planning discussions for the service were not recorded. The practice had not proactively sought feedback from staff or patients and did not have a patient participation group (PPG). There was no website for the practice.

Staff told us they had recently received appraisals but did not have clear objectives. The long term locum did not have clinical supervision as the principal lead was not in the position to provide this. The principal lead was not providing any clinical activity at the practice. However, they had continued working at the practice in the capacity of day to day management.

Summary of findings

The six population groups and what we found

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

Older people

Inadequate

The practice is rated as inadequate for the care of older people. We saw evidence which showed that basic care and treatment requirements were met. We found that the safety of care for older people was not a priority and there were limited attempts at measuring safe practice. There were risks to patients' safety and a lack of evidence to show the service was safe and well led in all population groups.

The care of older people was not managed in a holistic way. Little attempt had been made to respond to older people's needs and access for those with poor mobility or who were housebound was limited. Services for older people were reactive, and there was a limited attempt to engage this patient group to improve the service.

Patients over the age of 75 years did not have a named GP. Influenza vaccinations were provided on an ad hoc basis as there was no planned approach to patients care in this age group. There was a lack of care plans for older people preventing hospital admission.

People with long term conditions

Inadequate

The practice is rated as inadequate for the care of people with long-term conditions. There were risks to patients' safety and a lack of evidence to show the service was safe and well led in all population groups.

Longer appointments and home visits were available when patients needed them. Areas of concern in regard to safety were recruitment, infection control, medicine management, management of equipment and the monitoring of safety and responding to risk. Concerns about record keeping and governance, including clinical governance showed the service was not well led. Patients did not have a named GP and for patients who had long term conditions there were very few personalised care plans as the provider had just commenced developing them. For patients with long term health conditions there was evidence from QOF that the needs were not met or managed. For example, the practice had achieved managing the health care of 88% patients identified with hypertension, 86% patients with asthma and just under 91% of patients with diabetes.

Structured annual reviews were not always undertaken to check that patients' health and care needs were being met as there was no planned programme to identify and provide them. For example there were no dedicated clinics for patients with diabetes, cardiovascular or respiratory problems. There was no practice nurse

Summary of findings

to lead in the delivery of on-going care and treatment for patients with long-term conditions. The practice did not have a robust recall system for patients' long- term conditions to have monitoring checks. When medication and health checks were carried out patient's records and test results were not processed and reviewed in a timely way. Therefore there was a risk that there was a delay in patients' receiving the care and support they required.

Families, children and young people

Inadequate

The practice is rated as inadequate for the care of families, children and young people. There were risks to patients' safety and a lack of evidence to show the service was safe and well led in all population groups.

Immunisation rates were relatively low for a number of the standard childhood immunisations. For example the practice's achievement for Meningitis C was just below 77%; Bristol Clinical Commissioning Group (CCG) was just above 94.7%. For the pre-school booster vaccine for five year olds, the practice had achieved 66.7%, Bristol's CCG average was 88.1%. There were no systems to identify and follow up patients in this group who were living in disadvantaged circumstances and who were at risk.

Working age people (including those recently retired and students)

Inadequate

The practice is rated as inadequate for the care of working-age people (including those recently retired and students). The age profile of patients at the practice is mainly those of working age or recently retired. There were risks to patients' safety and little evidence to show the service was well led in all population groups.

There were some extended opening hours for patients. Patients were provided with appointments up to 6pm four days per week. There was no an online appointment booking system and repeat prescription and appointments could only be booked by telephone or attending the practice.

People whose circumstances may make them vulnerable

Inadequate

The practice is rated as inadequate for the care of people whose circumstances may make them vulnerable. There were risks to patients' safety and a lack of evidence to show the service was safe and well led in all population groups. The practice did not hold a register of patients living in vulnerable circumstances. There was no system to identify or monitor patients who were in vulnerable circumstances that they had received an annual health check.

Summary of findings

Staff knew how to recognise signs of abuse in vulnerable adults and children and aware of their responsibilities regarding information sharing and how to contact relevant agencies out of normal working hours.	
People experiencing poor mental health (including people with dementia) The practice is rated as inadequate for the care of people experiencing poor mental health (including people with dementia). The practice did not carry out advanced care planning for patients with dementia. Information about support groups was made available in the practice for patients with mental health needs. There were risks to patients' safety and a lack of evidence to show the service was safe and well led in all population groups.	**Inadequate** 

Summary of findings

What people who use the service say

We spoke with two patients during the day. We received information from the 37 comment cards completed by patients.

Patients said they had very positive experiences of care and support from the practice and the staff. Patients said staff treated them with dignity and respect and empathy. Patients had found the staff helpful and caring.

Patients we spoke with and who wrote in the comment cards said they had found the practice clean, tidy and comfortable. Patients had commented they had found the practice environment hygienic and told us they had no concerns about infection control.

Patients told us that consent was asked for routinely by staff when carrying out an examination or treatment. They also told us that staff always waited for consent or agreement to be given before carrying out a task or making personal contact. Patient's also told us that if they declined an examination or treatment this was listened to and respected.

Patients told us they felt listened to and supported by staff and said they had been given sufficient time during consultations in order to make an informed decision about the choice of treatment they wished to receive. This was reflected in the 37 comment cards we received and was in addition to the many personal reflections patients had made about the valued care and treatment they had from individual GPs at the practice.

We saw positive comments on NHS Choices website. However, there were four negative comments made during the last 12 months where patients expressed unhappiness about their support, delivery of the service, meeting appointment times and processing referrals to external health providers.

Areas for improvement

Action the service MUST take to improve

- Not carry our minor surgery at the practice as they are not registered for this regulated activity. On 29 April 2015 we sent a section 64 letter to the provider in order to establish further information and to determine the level of risk to patients. The provider has been given until 13 May 2015 in which to provide a response to us.
- Ensure there are systems in place for monitoring patients with long term conditions, end of life care and patients identified as at risk.
- Ensure there is adequate clinical staff employed in the practice, at the right time and have the right skills to meet the needs of patients.
- Ensure there is a system in place to ensure that equipment used at the practice is safe
- Ensure it has the necessary equipment and medicines in accordance to the Resuscitation Council (UK) guidelines to respond to medical emergencies.
- Ensure that patients consent is obtained and recorded before treatment is provided
- Implement a safe system for medicines management including the management of vaccines, and the safe keeping of prescription pads and prescription printer paper.
- Undertake an infection control audit and have effective systems in place for the cleanliness and hygiene of the practice. To assess the risks of preventing the spread of infection including the safe storage of clinical waste and substances hazardous to health.
- Document all recruitment and employment information required by the regulations in all staff members' personnel files.
- Carry out risk assessments and document these to inform which members of staff required a DBS check and which staff did not.
- Implement a system to ensure all staff members receive regular supervision and training such as infection control and the Mental Capacity Act 2005.
- Provide clinical and operational business leadership and develop a clinical audit process and implement findings from audits.

Summary of findings

- Develop and maintain a system to identify risks and improve quality in relation to patient safety. Undertake and record all relevant risk assessments in regard to the practice premises including fire safety.
- Take action to ensure all patients' records are updated with appropriate information and documents in relation to the care and treatment they have received. Records must be kept secure.
- Undertake a disability access risk assessment of the building to check that it was meeting current legislation requirements in accordance to the Equality Act 2010.

Action the service SHOULD take to improve

- Introduce a legionella risk assessment and related management schedule.
- The practice should ensure that within the complaints policy and procedure patients are given the necessary information for the complaints ombudsman.

Dr Tom Frewin

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 second CQC inspector and two specialist advisors: a GP and Practice Nurse.

Background to Dr Tom Frewin

Dr Tom Frewin, Clifton Village Practice is situated in a residential area of the city of Bristol. The practice had approximately 2,981 registered patients from the Clifton area. Based on information from Public Health England the practice patient population were identified as having a low level of deprivation. The practice did not support any patients living in a care or nursing homes.

The practice is located in a Victorian adapted large private residence. The practice is accessible via six steps up from street level. There are four floors within the building and a basement. There is a consulting room, reception, waiting room and office on the ground floor. A further consulting/ meeting room is on the first floor. A consulting room, treatment room and meeting room is situated in the basement. There is no lift. The practice is on a primary medical service contract with Bristol Clinical Commissioning Group.

Dr Tom Frewin, services provided at Clifton Village Practice are only provided from one location:

52 Clifton Down Road

Clifton

Bristol

Avon

BS8 4AH

The practice had patients registered from all of the population groups such as older people, people with long-term conditions, mothers, babies, children and young people, working-age population and those recently retired; people in vulnerable circumstances who may have poor access to primary care and people experiencing poor mental health.

Over 65.6% of patients registered with the practice were working aged from 15 to 44 years, 20.4% were aged from 45 to 64 years old. Just above 5% were over 65 years old. Around 1.8% of the practice patients were 75-84 years old and just over 1.2% of patients were over 85 years old. Just below 6% of patients were less than 14 years of age, 2.1% of these were below the age of 4 years. Information from NHS England showed that 4.9% of the patients had long standing health conditions, which was below the national average of 54%. The percentage of patients who had caring responsibilities was just over 8% which is below the national average of 18.5%. Of the working population 4.1% were unemployed which is below the national average of 6.2%.

The practice consists of an individual GP who is registered as the provider. They had engaged a full time locum GP, both GPs were male. At the time of the inspection there was also a female locum GP who worked at least one day a week and a locum practice nurse who provided sessions three times per week. At the time of the inspection visit the provider/ individual GP was not providing any clinical activity, which left the regular locum GP providing clinical care with the support of locum GPs.

The practice was open to patients from 9am to 12.00pm and then 2pm to 6:00pm, Monday, Tuesday, Thursday and Friday. Wednesday the practice was open 9am to 12pm and on occasions if there was the demand they would open an afternoon surgery session, appointments only. The

morning surgery session was an open session where patients could attend without a prior appointment and be seen. The practice referred patients to another provider, Brisdoc for an out of hour's service to deal with any urgent patient needs when the practice was closed. Details of what the practice provided were included in their practice leaflet. The provider did not have a website to inform patients of the out-of-hours arrangement.

Why we carried out this inspection

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. This 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. This service was inspected under our pilot methodology in 2013.

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

We obtained information from other organisations, such as the local Healthwatch, the Bristol Clinical Commissioning Group (CCG), and the local NHS England team. We looked at recent information left by patients on the NHS Choices website.

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

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

We also looked at how well services were provided for specific groups of people and what good care looks like for them. The population groups were:

- Older people
- People with long-term conditions
- Mothers, babies, children and young people
- The working-age population and those recently retired
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing poor mental health.

During our visit we spoke with the registered provider and one of the locum GPs. We also spoke with the practice manager, deputy practice manager and the reception and administration staff on duty. We spoke with two patients in person during the day. We reviewed the 37 comment cards where patients and members of the public shared their views and experiences of the service.

On the day of our inspection we observed how the practice was run, such as the interactions between patients, staff and the overall patient experience.

Inadequate

Are services safe?

Our findings

Safe track record

Staff do not assess, monitor or manage risks to patients who use the services.

We spoke with one locum GP and the provider and reviewed information about both clinical and other incidents that had occurred at the practice. We were given information about nine incidents which had occurred during the last 12 months. These had been reviewed under the practices significant events analysis process.

Where events needed to be raised externally, such as with other providers or other relevant bodies, this was done and appropriate steps were taken,

National patient safety alerts and other safety guidance such as Medicines and Health Regulatory Agency alerts went to the practice manager and were then forwarded to the provider. There was no system to record that these had been appropriately dealt with. Regular meetings were not held to review and monitor risks and where we had been told that meetings had taken place minutes of these meetings had not been recorded. This showed the practice was not routinely managing safety and risk consistently over time and therefore were unable to demonstrate a safe track record. The practice manager told us how comments, complaints and compliment received from patients were responded to. Staff we spoke to were aware of their responsibilities to raise concerns, and how to report incidents or events.

The practice had not raised any safeguarding alerts within the last year.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events. The records we reviewed showed that each clinical event or incident was analysed and discussed by the provider and senior members of the practice management.

We saw from summaries of the analysis of the events and complaints which had been received that the practice put actions in place in order to minimise or prevent reoccurrence of events. For example, a patient made a complaint that they wished to see a female GP instead of a male, staff made alternative arrangements to ensure a female GP was available. Since this complaint staff ensured patients were aware of what these post natal examination checks entail so that alternative GPs are provided if requested.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We asked members of medical and administrative staff about their most recent training. Practice records showed non-clinical staff at the practice had been provided with level one training for both safeguarding of vulnerable adults and children. The provider took the lead for all safeguarding at the practice and had completed training to level three. There was no detail available about the training for safeguarding that the regular locum GP who worked at the practice. The locum on duty on the day of the inspection told us they had no specific training for safeguarding vulnerable adults and been trained to level three for safeguarding children.

Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities share information, record information about safeguarding concerns. Staff told us they knew how to contact the relevant agencies, both in working and out of normal hours, and were confident about making referrals if patients were thought to be at risk. Contact details were easily accessible. All staff we spoke to were aware of who the lead for safeguarding was and knew 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. Staff were alerted with 'pop ups' of flags when patients records were accessed.

Regular discussions took place with health visitors in regard to children identified as at risk. Staff told us that patients at risk were discussed and information shared appropriately with other staff at the practice. We asked for information to evidence that this was happening, however, there were no records available to support this.

The practice had a chaperone policy, which was visible on the waiting room and in consulting rooms. The practice manager had been trained as a chaperone but did not have a Disclosure and Barring Service (DBS) check in place. There was no assessment of risk for this decision to use a member of staff without a DBS check for this role.

Inadequate

Are services safe?

Medicines management

We looked at the systems for medication used at the practice and the safe keeping of prescription pads and prescription printer paper. Blank prescription forms were not handled in accordance with national guidance as these were not tracked through the practice and kept securely at all times. We found that prescription pad numbers and printer paper serial numbers were not recorded by the practice and there was no audit trail for prescriptions. We saw that the prescription pads and blank prescription forms were not stored securely, and there were no systems in place to prevent the stationary being accessed by unauthorised people. We also found that 'blue' prescriptions (drug misuse instalment prescription) were not tracked through the practice, although the practice did record where prescriptions had been sent i.e. to the pharmacy or to a patient's home address. We also saw that written prescriptions for collection were left on the desk at reception which was contrary to practice procedure.

There was no system in place for the management of high risk medicines, which included regular monitoring in line with national guidance.

All prescriptions were reviewed and signed by a GP before they were given to the patient. There was no schedule or planned programme for patient's medicines reviews.

Staff told us that the medicines used by the practice were stored in medicine refrigerators held in the treatment room on the basement level and in the consulting room on the basement level. We found the refrigerators had a lockable facility but were unlocked. There was a system for ensuring that medicines, such as vaccines, were kept at the required temperatures. We saw records that temperatures were checked regularly and the fridges were calibrated by an external provider. We were told by the practice staff there was no policy for vaccine management or cold chain. We were told that vaccines were administered by GPs only. Processes were in place to check medicines were within their expiry date and suitable for use. No records were kept of medicines used at the practice including stock levels and disposal or use. No controlled medicines were kept in the practice.

Cleanliness and infection control

Patients had commented to us that they had found the practice environment hygienic and had no concerns about infection control. However, patients had only visited the waiting room and one consulting room, located on the ground floor. The provider has not risk assessed the premises were fit for purpose.

We found that areas of the premises cleanliness and infection control were not well managed. Some rooms had high levels of dust, with this clearly evident on areas such as the skirting boards. Some walls were grubby and marked, with finger marks on light switches and door handles. Sinks away from patient areas were dirty. The vaccine fridge in the basement treatment room had mould around the edges of the door seal. A food fridge in the ground floor office was in urgent need of defrosting and cleaning. The treatment room had been identified by the NHS England monitoring visit in February 2015 as being inadequate for managing infection control. We saw that some steps to improve facilities had taken place. For example removing an examination couch in poor condition and a new one on order. The vinyl flooring had been identified as not meeting Department of Health Guidelines as it was not sealed at the edges and the skirting was wood. We were told by the practice manager that the treatment room used by the locum nurses had been identified as in need of refurbishment. There was no schedule to when this would be completed. Offices used by staff were untidy and cluttered.

There were no cleaning schedules in place. There was a cleaner employed once a week and a contractor that was employed to undertake a deep clean at the practice every six weeks. We asked the practice manager if there were any cleaning audits and were informed that audits were not undertaken. This did not meet the Department of Heath guidance relating to cleanliness of GP practices.

The provider was the lead for infection control at the practice. We saw that there was an infection control policy that set out staff's responsibilities including the undertaking of planned audits. The policy had identified training for staff to complete. We found that this infection control policy had not been implemented at the practice. An infection control audit had not been completed or planned for. Staff had not undertaken infection control training. We observed that bins were not foot operated and had no lids; there were no feminine hygiene waste bins; the baby changing area was cleaned with baby wet wipes and not an antibacterial cleaner. Nappy disposal was into an open bin which staff emptied. 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. There were disposable gloves and aprons available in the practice. All but one of the privacy screens in consulting rooms were not made of a suitable material which could be easily cleaned. There was no system in place for cleaning screens in the consulting rooms. The practice manager told us they steam cleaned the cloth curtains in the treatment room. There were no records to evidence this.

The practice had no system in place to ensure reusable equipment such as sphygmomanometer cuffs, oximeter, or thermometers, was routinely cleaned. We saw the ECG machine was dirty and there was a multiplicity of refrigerators in the building some of which were dirty, for example, we observed mould around the seal of one of the vaccines refrigerators.

There were systems in place for managing clinical waste. An external contractor was engaged to remove and dispose of clinical waste at the practice. The clinical waste and sharps boxes, when full, were stored in an unsecured cupboard which could be accessed by patients. There was a system and instruction given to staff for the receiving and handling of specimens brought to the practice and sent from the practice to the local laboratory.

The practice did not have a policy for the management, testing and investigation of legionella (a bacterium that can grow in contaminated water and can be potentially fatal). There was no risk assessment to determine if action was required to reduce the risk of legionella infection to staff and patients.

Safe systems and guidance were unavailable for staff in regard to chemicals and cleaning fluids that should be kept in accordance to the Control of Substances Hazardous to Health Regulations 2002. Items were stored away from patient areas but were stored in an unlocked cupboard.

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. We saw that some equipment had been calibrated. We were told by staff that other equipment (which had not been calibrated in the practice) was not in use. The practice told us they would remove these un-calibrated pieces of equipment. The practice had no system to check equipment used by locum GPs had been calibrated, we found the locum GP working in the practice during our visit had un-calibrated equipment, a sphygmomanometer, for blood pressure testing in their bag which they used for home visits. There was no testing of portable electrical equipment however this had been booked for 27 April 2015.

Staffing and recruitment

The practice had a recruitment policy that set out the standards to follow when recruiting clinical and non-clinical staff. However, the assistant practice manager confirmed their policy had not been followed.

We looked at documents relating to the recruitment and employment of two most recently appointed staff. These staff had been recruited since the practice had been registered with the CQC in 2013. Records did not contain evidence to demonstrate that recruitment checks had been undertaken prior to employment. For example, such as, proof of identification, references, and qualifications. We were told that registration checks for locum GPs were carried out with the General Medical Council but these checks had not always been recorded. Criminal records checks through the Disclosure and Barring Service had not been undertaken for all staff.

No nursing staff were employed to provide on-going care and treatment for patients with long term conditions. There were some arrangements for planning and ensuring the number of staff and mix of staff needed to meet patients' needs was met. The practice employed GP and nurse locums when they identified greater demand for appointments. However, there was no recorded method of identifying increased demand or risks. There were designated roles for administration staff. Some administration staff had multiple roles to support the staff team and had replaced or supported reception staff when required.

Monitoring safety and responding to risk

The practice did not have systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. There were no regular checks of the building and the environment. For example fire, water and the chemicals used at the practice. There was no regular servicing of equipment such as the gas boilers and no

evidence the gas boilers had been serviced since fitted. Carbon monoxide sensors had not been fitted, particularly in the office on the ground floor and the treatment room in the basement area. The practice had not fully evaluated potential risks posed to patients and staff. For example, there was not a completed risk assessment for fire safety, or a risk assessment outlining the control of substances hazardous to health (COSHH), furthermore there was no overall health and safety risk assessment in place and no disability access assessment .

The practice had a generic health and safety policy however it did not identify by name the person who was responsible for implementing the policy and was not fit for purpose as it did not scope the full risks at the practice. The policy was generic and did not relate to the practice, for example, it made references to department managers of which there are none.

There no were systems for monitoring patients with long term conditions, end of life care and patients and families who were identified as at risk in regard to safeguarding and abuse. These meant patients may not have received the care and treatment they needed and they were not always protected from possible harm or abuse.

Arrangements to deal with emergencies and major incidents

The practice had some arrangements in place to manage emergencies. However, the practice had not carried out a risk assessment to establish the limitations of emergency support they would provide to patients should a life threatening event occur at the practice.

Records showed that staff had received training in basic life support. Their emergency equipment in place was an automated external defibrillator and one adult face mask.

When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked annually. Emergency medicines were available for anaphylaxis only. This did not meet the Resuscitation Council Guidance which includes providing emergency drugs or oxygen to respond to life threatening events such as a heart attack and medical emergencies. There was no assessment of the potential of risk for agreeing to host the counselling service for patients using the Bristol Drug Project.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Such as power failure, adverse weather, and unplanned sickness. The practice had a fire risk assessment which was unsigned, undated and was not attributed to the practice. There were no records to show that staff were up to date with fire training or that they practised regular fire drills. There were no records that the fire safety system or fire points had been tested. We saw from the undated, unsigned risk assessment that it had identified that additional fire extinguishers were needed in the practice. There were five 600g hand held extinguishers, one of which had expired in 2004 and another in 2008. There was limited signage to fire exits. There were no fire extinguishers in any of the corridors or landings to protect the fire escape route from upper floors. We saw that there was a fire notice by each fire alarm point which referred to use of extinguishers which were not in place. There was no fire evacuation plan which identified the layout of the building or directed patients and staff to their nearest fire exits. We found there were sources of ignition within the building such as cookers, microwave and tumble driers without suitable fire safety measures in place. Following the inspection visit we made our concerns known to the local fire brigade.

Inadequate

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

A locum GP and the provider we spoke with on the day of the inspection told us about their approaches to providing care, treatment and support to their patients. They were not fully familiar with current best practice guidance such as the National Institute for Health and Care Excellence (NICE) and from local commissioners. There was evidence they did not follow NICE guidance in regard to the management of patients with long term conditions such as diabetes and COPD (lung disease).

The practice staff assessed and identified high risk patients, such as those who misuse substances, and patients requiring palliative care. The practice staff participated in partnership working with other health and social care professionals and services such as to avoid patients unplanned hospital admissions. Care plans were being implemented for patients who had long term care or complex health needs.

We looked at information available about the practice from the NHS Quality and outcomes Framework (QOF). QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures for maintaining patient health. We also looked at recent information provided from an NHS contract monitoring visit in February 2015. Information from the NHS contract monitoring visit showed that there were a complete absence in the management of patients with long term health conditions. There was no regular practice nurse employed or a system to ensure that patients in this population group had regular health screening. Where screening had taken place there were a lack of information in how the information was used to develop a plan of care or ensure patients had the treatment they required.

Management, monitoring and improving outcomes for people

People receive ineffective care or there was insufficient assurance in place to demonstrate otherwise. There was very limited or no monitoring of patient's outcomes of care and treatment, including no clinical audit. Patient's outcomes were very variable or significantly worse than expected when compared with other similar services. Necessary action was not taken to improve people's outcomes.

The named GP, the provider, with responsibility for patients over 75 years of age was not providing clinical care. We were unable to obtain information about how patients care and treatment needs were reviewed and assessed as the regular locum GP who provided the clinical care was unavailable. We were provided with copies of clinical audits undertaken by NHS England and we looked at Quality Outcomes Framework (QOF) information available for the practice to check how the practice was performing and meeting patient's needs.

The information collected for the QOF and performance against national screening programmes to monitor outcomes for patients such as childhood vaccinations did not meet local expected targets. For example the practice's achievement for Meningitis C was just below 77%; Bristol Clinical Commissioning Group was just above 94.7%. For the pre-school booster vaccine for five year olds, the practice had achieved 66.7%, Bristol's CCG average was 88.1%. Likewise, the detail for the influenza vaccine 2013/2014 campaign showed the update was much lower than average, where vaccination is offered ad hoc and there are no influenza clinics in place. There was no clinical leads, method of identify patients needs or planned programme to provide immunisations to the practice patients. For patients with long term health conditions there was evidence that the needs were not met or managed. For example, the practice had achieved managing the health care of 88% patients identified with hypertension, 86% patients with asthma and just under 91% of patients with diabetes.

The practice had a palliative care register and had multidisciplinary meetings to discuss the care and support needs of patients and their families. We did not see records of these meetings and we were told patients' individual needs were recorded in their care records.

The practice worked in conjunction with the local drug service, Bristol Drug Project, supporting and caring for patients with drug and alcohol addictions.

We found no evidence of completed clinical audit cycles in the last two years. A clinical audit is a process or cycle of events that help ensure patients receive the right care and

Inadequate

Are services effective?

(for example, treatment is effective)

the right treatment. This is done by measuring the care and services provided against evidence base standards, changes are implemented to narrow the gap between existing practice and what is known to be best practice

Effective staffing

We found there was no practice nurse employed and locum GPs provided clinical care. The practice nurse post had been vacant since before the CQC inspection visit in June 2013. This meant that patients with long term conditions did not have the regular health care checks as regular health clinics were not run and there was not a schedule of checks carried out. There were no staff training records or evidence of a training plan, but saw from an invoice that staff were up to date with basic life support. We found that the one locum GP we spoke with was up to date with their yearly continuing professional development requirements. We saw no other information about the other GPs at the practice relating to 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).

We saw information to confirm what staff had told us, in that they had an annual appraisal of their performance.

Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and to work in a coordinated way to manage the needs of patients with complex needs. The practice had attached staff such as health visitors, midwife's and the community nursing team. The practice hosted other health care provider's services such as those from the Bristol Drug Project.

There was multidisciplinary team working for patients identified as 'at risk' through age, social circumstances and multiple healthcare needs. We were told by staff that regular meetings with other professionals such as the assistant community matron, district nursing teams, health visitors and palliative care team took place. However, there were no records of these meetings held by the practice.

Information sharing

The practice used electronic systems to communicate with other providers. Such as blood results, X-ray results, letters from hospital accident and emergency and outpatients and discharge summaries, the 111 service were received electronically and by post. There was a shared system with the local GP out of hour's provider to enable patient data to be shared in a secure and timely manner.

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record called EMIS. All staff were fully trained on the system. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

There was a system for receiving pathology and test results. Correspondence, such as hospital discharge letters and outcomes of consultations and treatment with other providers such as hospitals were also managed in the same way. We were shown different aspects of how the information was received and addressed. Electronic and paper information was reviewed by three members of staff as it was received into the practice. There was a method of triage of the information with staff, none who had previous clinical training, where they placed clinical coding on the information as they judged to be appropriate, before it was flagged up to the GPs. We were told that normal expected results were not routinely forward to GPs. We were told all documents were scanned and placed on the electronic patient record system EMIS. We observed that approximately 25 test results/ letters dating back over the last two weeks were waiting archiving in this way. There was a concern this had not been looked at and patients care needs responded to in a timely way.

Consent to care and treatment

Patients told us that consent was asked for routinely by staff when carrying out an examination or treatment. They also told us that staff always waited for consent or agreement to be given before carrying out a task or making personal contact. They also confirmed that if patient's declined this was listened to and respected.

We found when looking at patient records for example, for joint injections, that consent had not been recorded. We asked if there was a practice policy for documenting consent for specific interventions including a patient's verbal consent, to be recorded in the electronic patient notes. We were told there was not a consent policy and the practice were unaware of their responsibilities to obtain verbal and written consent.

Inadequate

Are services effective?

(for example, treatment is effective)

Clinical staff demonstrated an 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). We saw the practice had 'Do Not Attempt Resuscitation' decision tools in place for some patients and were able demonstrate a good understanding of how and for whom these decision were appropriate. We were told the practice referred patients to the local Memory Nurse if they had concerns, rarely did they undertake an assessment themselves at the practice. Staff were unable to give details of how many patients who had been assessed and diagnosed with dementia. There was no information available in regard to how many patients with learning difficulties were registered at the practice. This meant there were no systems in place to ensure their needs were being met.

Health promotion and prevention

New patients registering with the practice were offered a health check and those under the age of 24 were also offered sexual health screening. Through this process patients' health concerns were identified and arrangements made to add them into any long term health monitoring processes such as the asthma or heart conditions reviews. However, there was no schedule or programme for regular reviews and checks were carried out on an ad hoc basis. The practice provided information and support to patients to help maintain or improve their mental, physical health and wellbeing. The practice offered NHS Health Checks to all its patients aged 40 to 75 years, and could refer to a weight management service.

The practice offered a full range of immunisations for children, travel vaccines and influenza vaccinations in line with current national guidance. Last year's performance for all immunisations was below for the CCG targets. There was no clear policy for following up for patients who did not-attend appointment. For example the practice's achievement for Meningitis C was just below 77%; Bristol Clinical Commissioning Group (CCG) was just above 94.7%. For the pre-school booster vaccine for five year olds, the practice had achieved 66.7%, Bristol's CCG average was 88.1%.

The practice implemented combined six week baby and post natal check to ensure that patient's needs were met in one appointment.

The practice did not have a website, however, advice and information was available in the practice about a wide range of topics from health promotion to support and advice.

Requires improvement

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent information available for the practice on patient satisfaction from the friends and family test. Patients participating in this survey gave positive comments about the staff and the level of care received. We saw positive comments on NHS Choices website. However, there were four negative comments made during the last 12 months where patients expressed unhappiness about their support, delivery of the service, meeting appointment times and processing referrals to external health providers.

There were 37 patients who completed CQC comment cards to tell us what they thought about the practice. We also spoke with two patients on the day of our inspection. Patients said they had very positive experiences of care and support from the practice and the staff. Patients said staff were treated with dignity and respect and empathy. Patients told us that they had found the staff helpful and caring.

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

The practice is located in a Victorian adapted large private residence. The practice was accessible via six steps up from street level and external steps down to the basement level. There were four floors within the building and a basement. There was a consulting room, reception, waiting room and office on the ground floor. A further consulting/meeting room was on the first floor. A consulting room, treatment room and meeting room was situated in the basement. There was no lift. The patient toilet was not suitable for visitors who had poor mobility, used walking aids or required support from a carer. The provider had not carried out a disability access risk assessment of the building to check that it was meeting current legislation requirements in accordance to the Equality Act 2010.

We saw that staff followed the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private.

Care planning and involvement in decisions about care and treatment

The feedback from patients showed patients experienced being involved in planning and making decisions about their care and treatment and generally felt the practice did well in these areas. Patients we spoke with confirmed their GP involved them in care decisions and they also felt the staff were good at explaining treatment and results.

Patients told us on the day of our inspection that they felt listened to and supported by staff and told us that they had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. This was reflected in the 37 comment cards in addition to the many personal reflections patients had made about the valued care and treatment they had from individual GPs at the practice. It was clear from comments that if patients decided to decline treatment or a care plan this was listened to and acted upon.

Patient/carer support to cope emotionally with care and treatment

Patients we spoke with were very positive about the emotional support provided by the practice staff. For example, we were told by one patient how they and their family were supported during a life threatening event and with their on-going long term care. They told us their treatment and care was explained to them, their options were discussed with them and the decisions they made were supported. They had found they were able to speak to the GPs who answered their questions well, were supportive of their family's needs and provided the reassurance they needed.

There were notices in the patient waiting room on how to access a number of support groups and organisations external to the practice. The practice's electronic patient record system alerted GPs and other staff if a patient was also a carer. There was a carer's register so that all staff were aware of those patients who were also carers. The practice provided influenza vaccinations for carers.

Inadequate

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 not responsive to patients' needs and the needs of the practice population for those with a long term health condition or those with specialist needs such as those people with a learning disability or dementia. There were not systems were in place to address their on-going healthcare needs. There was no formal system or register of patients with learning disabilities or those who had long term conditions such as diabetes or asthma. There was no organised system for patient recall for health checks for long term conditions. The practice did not offer special clinics for influenza vaccinations.

One GP provided support to patients with drug and alcohol addictions and worked with external services to ensure their needs were met. Patients told us there was a good system for referral to secondary care. The practice had a register of patients who were receiving palliative care. Patients and staff told us that all patients who requested urgent attention were always seen on the day of their request this included patients requiring home visits. The practice had implemented combined appointment systems for new mothers which ensured their babies first health check was carried out with their post natal check.

There was no online repeat prescription service for patients. Patients could drop in repeat prescription forms to the surgery to get their medications. There was no website for patient information or to provide an additional system to book appointments.

The practice did not have a Patient Participation Group (PPG), patients were able to provide feedback through NHS Choices, the Friends and Family test and the national patient survey.

Tackling inequity and promoting equality

The practice had recognised they needed to support people of different groups in the planning and delivery of its services. They had made some arrangements to meet the needs of patients with mobility problems by ensuring they could be seen in the consulting room on the ground floor. Alternative arrangements for home visiting were put in place when patients could not physically access the practice for appointments. Patient areas were all on the basement, ground and first floor level. There was no level access to the building and there was no lift. The building was not accessible or suitable for wheel chair users and people with limited mobility.

There was a main waiting area on the ground floor which was large enough to accommodate patients with pushchairs and allowed for access to the treatment and consultation rooms. There was a small waiting area on the basement floor for the visiting practitioner's services such as the Bristol Drug Project and immunisation clinics. A toilet was available for all patients attending the practice although it was not suitable for wheel chair users or people using walking aids. Baby changing facilities were available in the public foyer, this area was not clean and did not provide any privacy.

The staff had access to a translating service should it be required. However, we were told this had not been required for a long period of time.

Access to the service

The practice was open to patients from 9am to 12.00pm and then 2pm to 6:00pm, Monday, Tuesday, Thursday and Friday. Wednesday the practice was open 9am to 12pm and on occasions if there was the demand they would open an afternoon surgery session. The practice referred patients to another provider Brisdoc for an out of hour's service to deal with any urgent patient needs when the practice was closed.

The practice provided extended hours surgery's appointments to enable the working population to access appointments. Housebound patients and others who were unable to attend the practice premises received home visits.

Information was available to patients about the opening times and appointments in the patient leaflet and these were also available on display in the practice waiting areas and were provided to patients when they registered with the practice. This information included how to arrange urgent appointments, home visits and how to book appointments. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave patients the telephone number they should ring for the out of hour's service.

Inadequate

Are services responsive to people's needs?

(for example, to feedback?)

Patients were very satisfied with the appointments system. They confirmed that they could see a GP on the same day if they needed to. They also said they could see another GP if there was a wait to see the GP of their choice. Comments received from patients showed that patients in urgent need of treatment were able to either speak to a GP or attend appointments on the same day of contacting the practice.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its complaints policy and procedures did not have full information for patients, such as referral to the Ombudsman should they not be satisfied with the outcome of an investigation into a complaint. There was a designated responsible person, the practice manager, who handled all complaints in the practice.

Information was available to help patients understand the complaints system. It was included in the practice information leaflet, on display in the patient areas. The information contained details of how the complaints process worked and how they could complain outside of the practice if they felt their complaints were not handled appropriately. The 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 the information about the five complaints the practice had received in the 12 months 2014/2015, and found they dealt with in a timely way. The complaints ranged from a variety of issues, some were in regard to dealing with a patient with mental health needs, access to a GP of choice and a patient missing their appointment slot. We saw that from the complaints we reviewed that the complainant had been kept informed and the practice had looked at how it could improve and avoid patients raising similar complaints in the future. Verbal comments made were managed in a similar way to complaints, investigated, assessed and feedback provided to the person making the comment.

Are services well-led?

Inadequate

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

Our findings

Vision and strategy

The practice had an ethos to deliver responsive quality care and promote good outcomes for patients. The practice told us their ethos was 'a traditional family practice with patients at the heart of everything they do.' This was in the information provided to patients in information leaflets and in their Statement of Purpose.

When we spoke with the GPs and other staff on duty they all understood what the values were of the practice. There was a focus of providing a community service for the local people.

The practice were not able to provide a written business or strategic plan for the future of the practice. We were told that they had business meetings about the service provision where planning and delivery of the service was discussed. However, these meetings were not recorded.

Governance arrangements

The practice had policies and procedures in place to govern how services were provided however there was limited evidence to provide the assurance that they were followed. For example, we asked if the practice were undertaking minor surgery and were told that they only undertook joint injections. We found equipment which suggested that minor surgery to remove skin legions had taken place such as open packets of sutures, dermal curettage tools and histology sample pots. This was attributed to the regular locum GP who was unavailable.

There was a structure with named members of staff in lead roles. For example, there was a practice manager who led the day to day running of the service. The provider was the named lead for clinical governance; however this was not effective as there was no planned programme of audits in place and no governance arrangements. All of the members of staff we spoke with understood their own roles and responsibilities. They told us they felt they were supported well and valued for the work they undertook at the practice. Staff knew who to go to in the practice with any concerns or suggestions.

There were identified gaps in provision highlighted by the Quality Outcomes Framework (QOF) results for 2013/2014. For example the practice's achievement for Meningitis C was just below 77%; Bristol Clinical Commissioning Group (CCG) was just above 94.7%. For the pre-school booster vaccine for five year olds, the practice had achieved 66.7%, Bristol's CCG average was 88.1%. For patients with long term health conditions there was evidence that the needs were not met or managed. For example, the practice had achieved managing the health care of 88% patients identified with hypertension, 86% patients with asthma and just under 91% of patients with diabetes.

The practice had no arrangements for identifying, recording and managing risks, including risk assessments relating to the environment and safe delivery of the service, for example, review of test results. There was no overall health and safety risk assessment process in the practice, which protected patients.

We asked the practice about governance meetings and business meetings where issues were discussed and plans put in place to develop the service, we were told although the issues are discussed the meetings, outcomes and actions were not recorded.

The practice used both electronic and paper record systems for patient records. Current patients' paper records were stored in filing cabinets in the ground floor office near the reception area. These were not locked. Archived patient records were kept in unlocked filing cabinets, boxes and left on work surfaces in a room upstairs which was not secure. The paper records for the day's surgery were left in an open box on the reception desk easily observed and accessible to people standing in the reception area.

Pathology results and letters pertaining to patients' personal information were in open trays in offices on the ground, first and second floor. There was not a safe system of receiving pathology and test results and of being reviewed by GPs in a timely way. These were not secure areas as there were no physical restrictions to people accessing all parts of the building. We saw a SMART card (electronic access key) left in a computer station unattended. This meant there was a risk that unauthorised access could occur and patient information was not kept confidential.

Leadership, openness and transparency

The delivery of high-quality care is not assured by the leadership, governance or culture in place. When the provider was absent there was no contingency or leadership to cover their absence.

Are services well-led?

Inadequate

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

We heard from staff at all levels that team meetings were held but not recorded. Staff told us they had the opportunity to and felt comfortable raising issues.

The practice employed a practice manager to enable the business and administration of the service to be run effectively. Their responsibilities included the recruitment and management of staff and complaints management. We reviewed a number of policies, such as those for employing and supporting new staff and found they were up to date and contained the required information, but not always implemented. Staff we spoke with knew where to find these policies if required.

Seeking and acting on feedback from patients, public and staff

The practice had gathered feedback from patients through patient surveys, compliments and complaints received. We looked at the results of the patient surveys and saw that patients had highlighted a range of issues that they thought could be improved. We found the practice had been responsive and made required changes.

The practice had gathered feedback from staff through informal meetings, appraisals and discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. The practice did not have a patient participation group.

Management lead through learning and improvement

We saw the practice supported staff to maintain their clinical professional development through training and mentoring. Staff confirmed that regular appraisals took place.

The practice had completed reviews of significant events and other incidents and shared with staff to ensure the practice improved outcomes for patients.

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 Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect · Patients/service users must be treated with dignity and respect, having due regard to meeting the Equality Act 2010. Regulation 10.1, 2(c).

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent · Patients/service users consent must be obtained and recorded before treatment is provided. Regulation 11.

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment · The practice must have effective systems in place for the cleaning of the practice. Regulation 15.1 (a).

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing · Persons employed by the service must receive appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out their duties they are employed for. Regulation 18.2(a)

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing · There must be adequate clinical staff employed to meet the needs of patients/service users. Regulation 18.1.
Diagnostic and screening procedures Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed · There must have safe recruitment practices to ensure that persons providing the care, treatment and support to patients have the competencies, qualifications and skills to do so. Regulation 19.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment · There must be systems for assessing the risk of and preventing the spread of infection including safe storage for clinical waste and substances hazardous to health. Regulation 12.2(h). · There must be systems in place to manage and monitor risks to patients in regard to the practice premises including fire safety. Regulation 12.2(d). · There must be systems in place for monitoring service users with long term conditions, end of life care and patients identified as at risk. Regulation 12.2(a). · The practice must ensure it has the necessary equipment and medicines in accordance to the Resuscitation Council (UK) guidelines to respond to medical emergencies. Regulation 12.2(b).

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance · There must be a safe system that reduces the risk of abuse or harm to patients for medicines management including the management of vaccines and for the safe keeping of prescription pads and printer paper. Regulation 17.2.(b). · There must be a safe system that reduces the risk of abuse or harm to patients for medicines management including the management of vaccines and for the safe keeping of prescription pads and printer paper. Regulation 17.2.(b).

This section is primarily information for the provider

Enforcement actions

· There must be a safe system that reduces the risk of abuse or harm to patients for medicines management including the management of vaccines and for the safe keeping of prescription pads and printer paper. Regulation 17.2.(b).

· Records must be managed safely and kept securely to ensure they are accurate and not accessible to unauthorised persons. Regulation 17.2(c).