Dr Halina Obuchowicz

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?	Requires improvement
Are services caring?	Requires improvement
Are services responsive to people's needs?	Requires improvement
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 Halina Obuchowicz practice on 22 June 2016. Overall the practice is rated as Inadequate.

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

- There was a system in place for reporting significant events.
- There were insufficient systems in place to discuss and communicate with all colleagues, information and learning from significant events, notifications of Medicines and Healthcare Products Regulatory Agency (MHRA) alerts, and all other updates.
- There were no measures in place to monitor the use of prescription pads.
- All recruitment checks had not been completed for all staff.
- Signed Patient Group Directions for the delivery of some immunisations were not in place.
- Patients Specific Direction were not in place.
- Patients said they were treated with compassion, dignity and respect.
- Information about services was available in patient waiting areas but there was no poster displayed advising that information was available in different languages and formats, for the benefit of the Eastern European community that used the practice.
- Information on how to complain was available from reception on request.
- Patients said they could make an appointment with a named GP, that there was some continuity of care, and urgent appointments were generally available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- Electronic patient records were correctly maintained. However the backlog of paper records of patients registering with the practice and note summarising was not being managed effectively.

Summary of findings

- There was a clear leadership structure. The practice sought feedback from staff and patients, but did not fully communicate to patients how they would make any required improvements.

There were areas where the provider must make improvements. The provider must:

- Have effective communications systems in place for sharing of alerts, updates and any findings from investigations.
- Ensure all recruitment checks as required by regulations, are in place for all staff and that information specified in schedule 3 is available in relation to all persons employed.
- Ensure there is a governance system in place to monitor the distribution and use of prescription pads.
- Ensure records relating the care and treatment of each person using the service are complete, legible, indelible, accurate and up to date, with no undue delays in adding and filing information.This includes addressing the backlog of patient note summarising.
- Do all that is reasonably practicable to mitigate risks. This includes ensuring that signed Patient Group Directions and Patient Specific Directions are in place and signed by the appropriate nurse delivering immunisations and vaccinations.
- Have systems and processes established to ensure that feedback provided by patients is used to continually evaluate and improve the service.

There were areas where the provider should make improvements. The provider should:

- Ensure all staff are aware of who the lead for safeguarding is within the practice.
- Have sufficient oversight in place so that they are aware of levels of exception reporting input by staff.
- Develop significant event reporting to provide details of learning from events and what steps are implemented to reduce the possibility of the event re-occurring.
- Develop audits to consist of a minimum of two cycles to provide a learning outcome and evidence improvement.

I am placing this service in special measures. Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate for any population group, key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

The service will be kept under review and if needed could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service by adopting our proposal to remove this location or cancel the provider's registration.

Special measures will give people who use the service the reassurance that the care they get should improve.

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.

- There was a system in place for reporting and recording significant events. However investigations lacked follow-up actions to prevent the re-occurrence of similar incidents.
- The practice had some systems, processes and practices in place that were designed to keep patients safe and safeguarded from abuse.
- Staff members were unable to explain to us the protocol they followed for the management of hypertension patients.
- Patient Group Directions (PGD's) were not all signed by the appropriate nurse delivering immunisations and vaccinations. These are a legal requirement.
- When we checked we saw that Patient Specific Directions (PSD's) were not being used but their introduction had been planned.
- We noted there was a backlog in note summarising of approximately six months; there was no plan in place to address this. Following inspection the provider submitted an action plan which described plans to address this.
- Staff recruitment checks were incomplete.
- There were insufficient systems in place to communicate changes, updates, and findings of investigations to clinical colleagues within the practice.

Are services effective?

Requires improvement

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

- Data from the Quality and Outcomes Framework (QOF) showed patient outcomes were at or above average compared to local and national averages. Levels of exception reporting were high in some key areas. The overall rate for exception reporting was 13%, compared to the CCG average of 7% and national average of 9%. The principal GP was unaware that exception reporting rates were this high.
- Staff assessed needs and delivered care in line with current evidence based guidance.
- The practice had taken part in audits undertaken by the CCG medicines management team. These had led to improvements in prescribing practices, for example, in antibiotic prescribing.

Summary of findings

- There was limited evidence of improvement in quality of patient care.
- The practice invited consultants from the local hospital to give training talks to GPs in the area, which were held at the practice.
- There was evidence of appraisals and personal development goals for staff.
- Staff worked with other health care professionals to understand and meet the range and complexity of patients' needs.
- Staff told us that interpreter services were always available via Language Line.

Are services caring?

Requires improvement

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

- Data from the national GP patient survey showed patients rated the practice lower than others for several aspects of care, although scores were still relatively high.
- Scores for patient satisfaction with nursing care and treatment were high.
- Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.
- Information for patients about the services available was easy to understand and accessible within the patient waiting and reception areas. However, there were no signs indicating that information was available in other languages and formats.
- A practice information leaflet was available on request from reception, but this was not immediately available in other languages.
- Information on how to make a complaint was available on request from reception staff.
- The practice said it was trying to form a Patient Participation Group (PPG). At the time of inspection there was still no PPG in place.
- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.

Are services responsive to people's needs?

Requires improvement

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

- Practice staff reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group to secure improvements to services where these were identified.

Summary of findings

- Patients said there was some continuity of care, with urgent appointments available the same day.
- The practice had introduced telephone triage by a GP, to give access to appointments based on need. Increased numbers of telephone consultations helped meet the needs of working age patients.
- The most recent data available showed that only 28% of patients were able to make an appointment with the GP they prefer. There had been no plan drawn up by the practice to try to improve on this score.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- Information about how to complain was available by asking at reception, and verbal complaints were recorded as well as written complaints.

Are services well-led?

Inadequate

The practice is rated as inadequate for being well-led.

- The practice had a vision to deliverevidence based medical care and health promotion to the local population.
- The practice staff had some understanding of how this would be achieved but lacked knowledge on how key parts of their role contributed to achieving this.
- There was a clear leadership structure and staff felt largely supported by management.
- The practice had a number of policies and procedures to govern activity. However staff were not familiar with key parts of these policies and there was a lack of regular clinical meetings to support clinical governance.
- Arrangements to monitor and improve quality of treatments was evidenced in the participation of the practice in local quality audits and initiatives, for example, in screening older patients for risk of frailty.
- The provider was aware of and complied with the requirements of the duty of candour.
- The practice sought feedback from staff and patients, through the Friends and Family Test. These results were available on the practice website, but they were not displayed in the practice reception and waiting areas for the benefit of those with no access to on-line facilities.
- The practice had been unable to form a patient participation group.
- There was evidence to suggest that greater delegation of practice managerial tasks to the practice manager would improve overall governance at the practice.

Summary of findings

- There was no evidence of sharing of issues, or clear identification of who was supposed to action any changes or follow-up actions identified.
- We found clerical staff were inputting exception reporting, and some areas of exception reporting were very high. This had not been picked up by the practice as an area requiring improvement.

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. There were aspects of the safe, effective, caring, responsive and well-led domains that affected all patient groups.

- The practice offered personalised care to meet the needs of the older people in its population.
- The practice was responsive to the needs of older people, and offered home visits and urgent appointments for those with enhanced needs.
- We noted that satisfaction scores in relation to continuity of care and being able to speak to a preferred GP were particularly low for the practice.
- The practice was signed up to a number of services that supported older patients, for example, the assessment of patients at risk of dementia and the assessment of patients at risk of frailty.
- The practice performance for the review of patients with dementia, in a face to face meeting in the past 12 months, was good at 90%, compared to a CCG average of 82% and national average of 84%. However the rate of exception reporting in this area was higher than local and national averages, at 17%. (CCG average 7%, England average 8%). The practice provided QOF information for 2015-16. For two out of three of the measurements of dementia care by GPs, exception reporting was 12% and over.

People with long term conditions

Inadequate

The practice is rated as inadequate for the care of people with long-term conditions. There were aspects of the safe, effective, caring, responsive and well-led domains that affected all patient groups.

- The practice nurse conducted reviews of patients with chronic diseases and patients at risk of hospital admission were identified as a priority.
- Some staff could not explain the protocol they followed for the management of patients with hypertension.
- Longer appointments and home visits were available when needed.
- All these patients had a named GP and a structured annual review to check their health and medicines needs were being met.

Summary of findings

- Achievement scores for QOF, for the management of patients with diabetes were high, although exception reporting in relation to indicators of diabetes management were higher than local and national averages.
- When we spoke with patients they told us if they really needed an appointment with a GP, they would be seen on the day. Patients expressed a high degree of satisfaction with nursing care.
- There practice nurse did not have clinical meetings with GPs, which could contribute to better management of patients with long term conditions.

Families, children and young people

Inadequate

The practice is rated as inadequate for the care of families, children and young people. There were aspects of the safe, effective, caring, responsive and well-led domains that affected all patient groups.

- There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances.
- Immunisation rates were relatively high for most standard childhood immunisations; a nurse from a neighbouring practice visits the surgery to deliver all baby immunisations.
- Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this.
- The practice rate for cervical screening in women aged 25-64 was 88%, compared to the CCG average of 81% and national average of 82%. However, exception reporting in this area was also high, with a practice value of 13%, compared to the local average of 6% and national average of 6%. The provider submitted QOF data for 2015-16, which is not yet published. This did not include data for public health initiatives such as cytology screening rates.
- Appointments were available outside of school hours and the premises were suitable for children and babies.
- We saw positive examples of joint working with midwives and health visitors.

Working age people (including those recently retired and students)

Inadequate

The practice is rated as inadequate for the care of working-age people (including those recently retired and students). There were aspects of the safe, effective, caring, responsive and well-led domains that affected all patient groups.

Summary of findings

- The practice demographic was slightly different than the rest of the Southport area, with higher numbers of working age patients.
- The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and could offer some continuity of care.
- The practice was not proactive in offering online services; only two appointments per day were bookable on line. There was evidence that this and other on-line services required better publicity to improve take-up.
- The practice took part in a range of health promotion and screening that reflects the needs for this age group, for example, levels of bowel cancer screening were in line with CCG and national averages. However, breast cancer screening was approximately 10% lower than local and national averages. We asked the provider to supply more up to date data, which they have access to but is not yet published. No data on breast cancer screening rates was provided.
- The practice had introduced telephone triage by a GP, to give access to appointments based on need. Increased numbers of telephone consultations helped meet the needs of working age patients.
- Approximately 12% of working age patients were from Eastern European countries. The practice employed two receptionists from Poland and the principal GP was Polish. However, the practice did not ask what language patients preferred to receive communications in . There were no notices in the surgery advising patients that information was available in other formats other than English.

People whose circumstances may make them vulnerable

Inadequate

The practice is rated as inadequatefor the care of people whose circumstances may make them vulnerable. There were aspects of the safe, effective, caring, responsive and well-led domains that affected all patient groups.

- The practice held a register of patients living in vulnerable circumstances including those with a learning disability.
- The practice offered longer appointments for patients with a learning disability.
- The practice worked with other health care professionals in the case management of vulnerable patients.
- The practice informed vulnerable patients about how to access various support groups and voluntary organisations.

Summary of findings

- Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff displayed an awareness of safeguarding.

People experiencing poor mental health (including people with dementia)

Inadequate

The practice is rated as inadequate for the care of people experiencing poor mental health (including people with dementia). There were aspects of the safe, effective, caring, responsive and well-led domains that affected all patient groups.

- 90% of patients diagnosed with dementia had their care reviewed in a face to face meeting in the last 12 months, which is better than the CCG and national average. However, exception reporting in this area was higher than local and national averages at 17%, compared to 7% and 8% respectively. The practice provided QOF information for 2015-16, which is not yet published. For two out of three of the measurements of dementia care by GPs, exception reporting was 12% and over.
- 90% of patients with schizophrenia, bipolar affective disorder and other psychoses, had a comprehensive, agreed care plan documented in their record, in the preceding 12 months, compared to the CCG average of 88% and national average of 88%.
- 94% of patients with schizophrenia, bipolar affective disorder and other psychoses had their alcohol consumption recorded in the preceding 12 months, compared to the CCG average of 86% and the national average of 90%.
- The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those with dementia.
- The practice carried out advance care planning for patients with dementia.
- The practice told patients experiencing poor mental health about how to access various support groups and voluntary organisations.
- The practice had a system in place to follow up patients who had attended accident and emergency where they may have been experiencing poor mental health.
- Staff had a good understanding of how to support patients with mental health needs and dementia

Summary of findings

What people who use the service say

The national GP patient survey results were published in January 2016. Other than for making telephone contact, the results showed the practice was performing in line with or below local and national averages. 301 survey forms were distributed and 113 were returned. This represented the views of 3% of the practice's patient list.

- 74% of patients found it easy to get through to this practice by phone compared to the local CCG average of 67% and the national average of 73%.
- 59% of patients were able to get an appointment to see or speak to someone the last time they tried compared to the local CCG average of 79% and the national average of 76%.
- 82% of patients described the overall experience of this GP practice as good compared to the local CCG average of 89% and the national average of 85%).
- 70% of patients said they would recommend this GP practice to someone who has just moved to the local area compared to the local CCG average of 84% and the national average of 79%.

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 all positive about the standard of care received.

We spoke with seven patients during the inspection. Some patients said they were satisfied with the care they received and thought staff were approachable, committed and caring. Some patients (three) said they had never received invitations to attend various health screening projects that they were aware of and that this concerned them. One patient we spoke to said they had never been offered interpreting services, or information and correspondence in an alternative language.

Areas for improvement

Action the service MUST take to improve

- Have effective communications systems in place for sharing of alerts, updates and any findings from investigations.
- Ensure all recruitment checks as required by regulations, are in place for all staff and that information specified in schedule 3 is available in relation to all persons employed.
- Ensure there is a governance system in place to monitor the distribution and use of prescription pads.
- Ensure records relating the care and treatment of each person using the service are complete, legible, indelible, accurate and up to date, with no undue delays in adding and filing information.This includes addressing the backlog of patient note summarising.
- Do all that is reasonably practicable to mitigate risks. This includes ensuring that signed Patient Group Directions and Patient Specific Directions are in place and signed by the appropriate nurse delivering immunisations and vaccinations.
- Have systems and processes established to ensure that feedback provided by patients is used to continually evaluate and improve the service.

Action the service SHOULD take to improve

- Ensure all staff are aware of who the lead for safeguarding is within the practice.
- Have sufficient oversight in place so that they are aware of levels of exception reporting input by staff.
- Develop significant event reporting to provide details of learning from events and what steps are implemented to reduce the possibility of the event re-occurring.
- Develop audits to consist of a minimum of two cycles to provide a learning outcome and evidence improvement.

Dr Halina Obuchowicz

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector**.** The team included a GP specialist adviser, and an Expert by Experience.

Background to Dr Halina Obuchowicz

The practice of Dr Halina Obuchowicz, also known as Kew Surgery, is based in Kew, Southport and sits within Southport and Formby Clinical Commissioning Group (CCG). The practice is run by Dr Halina Obuchowicz, supported by two long term locum GPs, a locum advanced nurse prescriber and a practice nurse. The combination of hours of the principal GP, the two part time locum GPs and the part time advanced nurse prescriber gives the equivalent of 2.0 working time equivalent GPs. The practice serves the Kew, Halsall and Scarisbrick areas of Southport. The patient list size of the practice is approximately 3,700 patients.

The practice has a slightly different demographic than most other surgeries in the area, in that it has higher than average numbers of working age patients, and lower than average numbers of older patients.

The clinical team is supported by a practice manager, three secretaries, five receptionists and one health care assistant. The practice is located in a single storey purpose built facility, which is fully accessible for those patients with limited mobility and for parents with prams and pushchairs. The premises provide seven clinical consulting rooms, one of which is suitable for performing surgical procedures and has a recovery room attached. There are two sets of patient toilets, one of which has baby changing facilities. There is also an interview room which can be used by patients who need greater privacy to discuss their needs with reception staff.

The practice is open from 8am to 6.30pm each weekday, with extended opening hours on Tuesday of each week until 8pm. Surgeries are run each morning and afternoon, but start and end at differing times each day. Pre-bookable appointments are available from 9 or 9.30am each weekday morning until 10.50 or 11.50 with the exception of Thursday morning, when an early surgery is available, from 8am. Afternoon surgeries also start and end at different times each day; generally, afternoon appointments are available from 2pm or 2.30pm to 4.20pm or 4.45pm each day, with the exception of Monday and Tuesday each week. Monday afternoon surgery is from 4pm to 5.50pm and Tuesday afternoon surgery is from 5.30pm to 7.40pm. The advanced nurse practitioner delivers a morning surgery on Friday of each week from 9am to 10.50pm and an afternoon surgery on Thursday of each week from 4pm to 5.50pm. Combined, these surgeries yield approximately 227 appointments each week. All appointments are ten minute consultations but patients can book double appointments when their needs require. Practice nurse appointments range from ten minutes to up to an hour for a full healthcare review for patients with long term conditions. Appointments can be booked up to six week in advance.

All services are delivered under a Personal Medical Services contract. Out of hours services are delivered by a different provider. When the surgery is closed, patients are diverted to the NHS 111 service. If patients need the services of a GP they are referred by NHS111 to the locally appointed out of hours service provider Go to Doc.

Detailed findings

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. The inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 22 June 2016.

During our visit we:

- Spoke with a range of staff including the principal GP, the practice nurse, the health care assistant, and three receptionist and administrative staff.
- Observed how staff interacted with patients in the reception and waiting areas and how they talked with carers and/or family members
- Reviewed an anonymised sample of the personal care or treatment records of patients.
- Reviewed comment cards where patients and members of the public shared their views and experiences of the service.
- Spoke with seven patients.

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

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

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

- Older people
- People with long-term conditions
- Families, children and young people
- Working age people (including those recently retired and students)
- People whose circumstances may make them vulnerable
- People experiencing poor mental health (including people with dementia).

Please note that when referring to information throughout this report, for example any reference to the Quality and Outcomes Framework data, this relates to the most recent information available to the CQC at that time.

Inadequate

Are services safe?

Our findings

Safe track record and learning

There was a system in place for reporting and recording significant events. Staff told us they would inform the practice manager of any incidents. Staff we spoke to said that there was a recording form available on the practice's computer system. The system to deal with significant events did not include the assignment of follow-up actions, designed to prevent the incident happening again and did not record learning points from the event.

We saw evidence that when things went wrong with care and treatment, patients were informed of the incident, received support, truthful information, and were told about any actions to improve processes to prevent the same thing happening again. There was no mechanism in place to share findings from significant events with locum GPs and the locum advanced nurse prescriber.

There was no system in place for the sharing of safety alerts, for example from the Medicines and Healthcare products Regulatory Agency (MHRA); the lack of regular practice clinical meetings, that included locum GPs, the locum advanced nurse prescriber and the practice nurse meant opportunities to discuss alerts and other clinical updates were limited.

We found the health care assistant at the practice was unclear in terms of clinical protocols that governed some of the duties they performed. For example, when asked, they could not demonstrate or refer to a protocol they followed when measuring patients' blood pressure.

Overview of safety systems and processes

The practice had systems, processes and practices in place to keep patients safe and safeguarded from abuse. However these were not embedded and fully understood by all staff. Processes included:

- Arrangements in place to safeguard children and vulnerable adults from abuse. These arrangements reflected relevant legislation and local requirements. Policies were accessible to all staff. The policies outlined who to contact for further guidance if staff had concerns about a patient's welfare.
- A lead member of staff for safeguarding. However, some staff were confused as to who the practice lead on safeguarding was. GPs provided reports where necessary for other agencies.
- Staff we spoke with said they understood their responsibilities and all had received training on safeguarding children and vulnerable adults relevant to their role.
- GPs were trained to child protection or child safeguarding level three. The practice nurse had been trained to safeguarding level two.
- When asked we were told that there were very few patients on the safeguarding register, which we confirmed. We did not see a culture where it is good to question things or to raise any concerns in relation to any safeguarding matter. This poses a risk of any safeguarding concerns not being followed up.
- There was conflicting information on whether reception staff performed chaperone duties. We were told some administrative staff had performed this duty.
- We saw that reception and administrative staff had not received a Disclosure and Barring Service (DBS) check. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable). There was no risk assessment in place in relation to administrative staff doing chaperone duties, in the absence of a DBS check. This poses the risk that staff who may be unsuitable, are carrying out these duties.

Some arrangements for managing medicines, including emergency medicines and vaccines, in the practice kept patients safe (including obtaining, prescribing, recording, handling, storing, security and disposal). However there were also areas of concern.

- We saw that processes were in place for handling repeat prescriptions which included the review of high risk medicines. However, hypnotic prescribing remained higher than local and national averages and there was no effective plan in place to address this.
- There was no effective systematic review of high risk patients by the practice, so the opportunity to spot any errors in treatment were limited. We saw, that as a result of the mental health team spotting a discrepancy in a

patients treatment, all mental health patients had been reviewed and the local consultant for mental health had worked with the practice to strengthen shared care agreements.

- Blank prescription forms and pads were securely stored. We did note that there was no system in place to monitor their use, for example prescription pads were not issued in numerical batches to GPs, so that they could be traced if required.
- The practice worked with the local CCG pharmacy teams, to ensure prescribing followed guidelines for safe prescribing.
- Although Patient Group Directions had been adopted by the practice to allow nurses to administer medicines in line with legislation, these were not signed by the nurse delivering, for example, baby immunisations.
- Patient Specific Directions were not being used, but their introduction was planned. Both Patient Group Directions and Patient Specific Directions are a legal requirement. The practice nurse was up to date with training to deliver other sorts of immunisations, for example, annual flu immunisations.

There were other areas where safety systems and processes were not working and this had not been addressed

.

- There was a backlog in note summarising of approximately six months; there was no plan in place to address this. This presents a risk that GPs do not have all the information they require to treat a patient safely and to provide continuity of care.
- We reviewed three personnel files and found they lacked the appropriate recruitment records. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service.

The practice maintained appropriate standards of cleanliness and hygiene. We observed the premises to be clean and tidy. The last infection control audit of the practice by Liverpool Community Health in May 2016, showed the practice achieved a score of 96%. The practice nurse was the infection control clinical 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 and staff had received up to date training.

Monitoring risks to patients

Risks to patients were assessed and managed, with the exception of those in relation to staff recruitment checks and risk assessements in relation to some staff duties.

- There were procedures in place for monitoring and managing risks to patient and staff safety. There was a health and safety policy available with a poster in the reception office which identified local health and safety representatives. The practice had up to date fire risk assessments and carried out regular fire drills. All electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly. The practice had a variety of other risk assessments in place to monitor safety of the premises such as control of substances hazardous to health and infection control and legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings).
- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs.

Arrangements to deal with emergencies and major incidents

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

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

Inadequate

Are services safe?

The practice had a 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

We saw evidence that the practice nurse and the principal GP assessed needs and delivered care in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines.

However, the practice did not have clearly defined systems in place to ensure all clinical staff kept up to date with latest guidance and best practice. Staff had access to guidelines from NICE via the practice computer system and used this information to deliver care and treatment that met patients' needs. However, there were no clinical practice meetings involving the practice nurse, the advanced nurse prescriber and the health care assistant, where updates or changes to protocol were discussed. This meant opportunites to discuss these changes were limited, which could impact on effective patient care.

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent published results showed the practice achieved 96% of the total number of points available. We did note that exception reporting in some key domains was significantly higher than CCG and national averages. (Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects). We asked the provider for their QOF results for 2015-16, which are not yet published. As a result we do not have comparator rates withCCG and national averages. Where we do have access to more up to date QOF data supplied by the provider, we have quoted this. The information we did received following inspection, did not provide an overall exception reporting rate for QOF 2015-16.

Overall rates per clinical domain showed:

The levels of exception reporting are set out below, alongside QOF achievement.

Data from QOF results for 2014-15 showed:

Performance for diabetes related indicators was in line with, or better than the national average:

- The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 64mmol/mol or less in the preceding 12 months was 92%, compared to the CCG average of 83% and national average of 78%. The exception reporting rate was 14% compared with a CCG average of 6% and a national average of 12%.
- The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80mmHg or less was 64%, compared to the CCG average of 79% and national average of 78%. The practice exception reporting rate was 18% compared to the CCG average of 6% and the national average of 9%.
- The percentage of patients with diabetes, on the register, who had an influenza immunisation in the preceding 1 August to 31 March (2014-15) was 100%, compared to the CCG average of 96% and national average of 94%. The practice exception reporting rate was 26%, compared to a CCG average of 15% and national average of 18%.
- The percentage of patients with diabetes, on the register, whose last measured total cholesterol (measured within the preceding 12 months) is 5mmol/l or less was 79% compared to the CCG average of 84% and national average of 81%. The practice exception reporting rate was 15%, compared to the CCG rate of 13% and national rate of 12%.
- The percentage of patients with diabetes, on the register, with a record of a foot examination and risk classification within the preceding 12 months was 93%, compared to the CCG average of 91% and national average of 88%. The practice rate of exception reporting was 24%, compared to the CCG rate of 10% and national rate of 8%.
- Data supplied by the provider following inspection, for QOF achievement in 2015-16 which is not yet published, showed exception reporting rates in the management of patients with diabetes, to be between 17% and 28%. We do not have a comparator exception reporting rate.

Requires improvement

Are services effective?

(for example, treatment is effective)

Performance for mental health related indicators was in line with or better than the local and national average. Other than in one area, the rate of exception reporting was in line with CCG and national averages. For example:

- The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who had a comprehensive, agreed care plan documented in their records, in the preceding 12 months was 90%, compared to the CCG average of 88% and national average of 88%. The rate of exception reporting for the practice was 9% compared to the CCG average of 7% and national average of 13%.
- The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses whose alcohol consumption had been recorded in the preceding 12 months was 94% compared to the CCG average of 86% and national average of 90%. The rate of exception reporting for the practice was below CCG and national averages. (Practice rate 3%, CCG average 8%, national average 10%).
- Data supplied by the provider following inspection, for QOF achievement in 2015-16 which is not yet published, showed exception reporting rates in the management of patients experiencing poor mental health to be between 10% and 17%. We do not have a comparator exception reporting rate.
- The percentage diagnosed with dementia whose care had been reviewed in a face to face review in the preceding 12 months was 90% compared to the CCG average of 82% and national average of 84%. The rate of exception reporting for the practice was 17% compared to the CCG average of 7% and national average of 9%.
- The practice provided QOF information for 2015-16. For two out of three of the measurements of dementia care by GPs, exception reporting was 12% and over. We do not have a comparator exception reporting rate.

The QOF scores for management of patients with long term respiratory conditions were comparable or slightly below that of CCG and national averages. For example:

- The percentage of patients with asthma, on the register, who had an asthma review in the preceding 12 months that included an assessment of asthma control using the 3 RCP questions was 68% compared to the CCG average of 74% and a national average of 75%. The rate of exception reporting for the practice was 5%. The CCG average was 8% and national average was 7%.
- Data supplied by the provider following inspection, for QOF achievement in 2015-16 which is not yet published, showed exception reporting rates in the management of patients with asthma were between 0% and 18%. We do not have a comparator exception reporting rate.
- The percentage of patients with COPD who had a review undertaken including an assessment of breathlessness using the Medical Research Council dyspnoea scale in the preceding 12 months was 87% compared to the CCG average of 86% and national average of 90%. The rate of exception reporting for the practice was 20%, compared to the CCG average of 11% and the national average of 11%.
- Data supplied by the provider following inspection, for QOF achievement in 2015-16 which is not yet published, showed exception reporting rates in the management of patients with COPD were between 14% and 31%. We do not have a comparator exception reporting rate.

When we spoke with the principal GP at the practice, we were told that they were not aware that exception reporting was this high in certain clinical areas but would focus on trying to reduce this. If patients with long term conditions are not reviewed regularly by a clinician, this could impact on their health and result in their condition being ineffectively managed.

There was some evidence of clinical audit, although these were not made up of two or more completed cycles.

- There had been three clinical audits initiated at practice level and completed in the last two years. These were single cycle audits that consisted of searches for patients on specific medicines.Two audits had been carried out following significant events, to ensure recommendations made were implemented. Without the benefit of a follow-up cycle of audit it was not possible to determine whether there had been a measureable improvement in quality of care and treatment.

Requires improvement

Are services effective?

(for example, treatment is effective)

- We did note that one of these audits had not been repeated as required, so there was no monitoring or evidence that improvements had been made in management of patients on a particular medicine.
- The practice participated in local audits with the medicines management team.
- Findings were used by the practice to improve prescribing and to adhere to new prescribing guidance.

We did note that the rate of prescribing of Hypnotics based medicines for this practice, was higher than both the CCG and national averages, with a practice value of 0.71, compared to a CCG value of 0.34 and national value of 0.26. We were told that this was historical although the principal GP at the practice has been in post for 15 years. This had been audited by the medicines management team over time but there has been no meaningful reduction in this prescribing rate. From the data supplied by the provider following the inspection, there were no figures on rates of hypnotic prescribing.

Effective staffing

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

- The practice had an induction programme for all newly appointed staff. This covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality.
- The practice could demonstrate how they secured role-specific training and updating for relevant staff such as the practice manager and the practice nurse.
- Staff administering vaccines and taking samples for the cervical screening programme had received specific training which had included an assessment of competence.Staff who administered vaccines could demonstrate how they stayed up to date with changes to the immunisation programmes, for example by access to on line resources, attendance at the annual immunisations update course and discussion at nurse forum meetings. The practice nurse working at the practice did not deliver any baby immunisations or vaccines; this work was carried out by a nurse at another practice.
- The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. The majority of staff had access to appropriate training to meet their learning needs and to cover the scope of their work. This included coaching and mentoring, clinical supervision and facilitation and support for revalidating GPs and nurses. All staff had received an appraisal within the last 12 months.
- Staff received training that included: safeguarding, fire safety awareness, basic life support and information governance. Staff had access to and made use of e-learning training modules and in-house training.

Coordinating patient care and information sharing

The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practice's patient record system and their intranet system.

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

Staff worked together and with other health and social care professionals to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. This included when patients moved between services, including when they were referred, or after they were discharged from hospital. Meetings took place with other health care professionals when care plans were routinely reviewed and updated for patients with complex needs. For example, multi-disciplinary team meetings for management of the care of palliative patients.

Consent to care and treatment

Staff sought patients' consent to care and treatment in line with legislation and guidance. We saw that when patients asked to have a chaperone present, this and the name of the chaperone was recorded in the consultation notes.

- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005. When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance.

Requires improvement

Are services effective?

(for example, treatment is effective)

- Where a patient's mental capacity to consent to care or treatment was unclear the GP or practice nurse assessed the patient's capacity and, recorded the outcome of the assessment.
- The process for seeking consent was monitored through checks on patient records.

Supporting patients to live healthier lives

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

- Patients receiving end of life care, carers, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation. Patients were signposted to the relevant service, or directed to information in the practice reception area, on how they could self refer to services .
- Smoking cessation advice was available from a local support group, and information on drop in sessions was available in the patient waiting area.
- Smoking cessation advice was available from the practice nurse and GPs.

The practice's uptake for the cervical screening programme was 88%, which was better than the CCG average of 81% and the national average of 82%, although rates of exception reporting at the practice were high at 13%, compared to the CCG average of 5% and the national average of 6% . There was a policy to offer telephone reminders for patients who did not attend for their cervical screening test. The practice had a register that was made up of 12% of patients from Eastern European countries.They were unable to demonstrate how they encouraged uptake of the screening programme by using information in different languages. They confirmed a female sample taker was available at all times. The practice had introduced an Informed Dissent form, which patients were asked to sign if they did not wish to take part in the cervical screening programme. The percentage of women aged 50-70 who were screened for breast cancer in the last three years was lower than expected, at 60%, compared to the CCG average of 71% and national average of 72%. When we asked the principle GP about this, we were told that many women from Eastern Europe, particularly Polish women, tend to go back to their home country for these health screening appointments. There had been no audit of the patients excepted in each category to see whether a broader use of other communication tools and different languages, would address this issue.

From the data supplied by the provider following the inspection, there were no figures on rates of public health screening such as cervical screening and breast screening for the year 2015-16.

Childhood immunisation rates for the vaccinations given were comparable to CCG averages for children under 12 months, but were below average for children up to 24 months . For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 75% to 86%, compared to the CCG average of between 81% and 96%. Immunisation rates for children under five were in line with CCG averages.

From the data supplied by the provider following the inspection, there were no figures on rates of childhood immunisation for 2015-16.

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. We saw that that the work of the practice nurse was well organised and the system of call and re-call was effective. Appropriate follow-ups for 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. Patients said they felt the practice offered a good service and staff were helpful, caring and treated them with dignity and respect.

We were able to speak with seven patients on the day of our inspection. They also told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. Comment cards highlighted that staff responded compassionately when patients needed help and provided support when required.

Results from the NHS England GP Patient Survey showed the majority of patients felt they were treated with compassion, dignity and respect. The practice was above average for its satisfaction scores on consultations with nurses, but below average for satisfaction scores for consultations with GPs and for the helpfulness of reception staff. For example:

- 80% of patients said the GP was good at listening to them compared to the clinical commissioning group (CCG) average of 93% and the national average of 89%.
- 82% of patients said the GP gave them enough time compared to the CCG average of 91% and the national average of 87%.
- 90% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 97% and the national average of 95%
- 75% of patients said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 90% and national average of 85%.
- 96% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 93% and national average of 91%.
- 83% of patients said they found the receptionists at the practice helpful compared to the CCG average of 88% and the national average of 87%.

Care planning and involvement in decisions about care and treatment

Patients told us they felt involved in making decisions 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 from the comment cards we received was also positive and aligned with these views.

Results from the national GP patient survey showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. However, results relating to GP consultations were slightly lower than local and national averages. Questions about consultations with nurses scored higher than local and national averages. For example:

- 74% of patients said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 89% and the national average of 86%.
- 74% of patients said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 86% and national average of 82%.
- 93% of patients said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average of 88% and national average of 85%.

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 saw notices in the reception areas informing

patients this service was available, but these were displayed in English only. This presented the risk that patients needs may not be fully met due to barriers to communication.

- Information leaflets could be produced in easy read format if required.

Patient and carer support to cope emotionally with care and treatment

Patient information leaflets and notices were available in the patient waiting area which told patients how to access a number of support groups and organisations. Information about support groups was also available on the practice website. We noted that other than a poster on smoking cessation in Polish and a poster on alcohol cessation in Russian, all leaflets and posters in the practice were in English only. There was no sign displayed saying all literature could be produced in alternative formats and languages. Approximately 12% of the practice population were from Eastern European countries but we saw no signs or leaflets displayed in other common languages of this patient group, for example, Polish.

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 59 patients who were carers, which is approximately 2% of the practice population. Some patients we spoke with were carers and confirmed that they were able to book longer appointments if they needed to. Written information was available to direct carers to the various avenues of support available to them.

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

The practice reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. For example, by offering 24 hour blood pressure monitoring, ECG monitoring, weight management services, spirometry and alcohol screening services.

- The practice offered early morning appointments each Thursday from 8am and late evening appointments each Tuesday, until 8pm.
- Results from the NHS England GP Patient survey, published in January 2016 and available to us at the time of the inspection, showed satisfaction scores in response to questions on how satisfied patients were with practice opening hours, were low at 66%, compared to the CCG average of 82% and national average of 78%. Updated results, published after the inspection showed this score has improved with 73% of patients being happy with the practice opening hours, but was still lower compared to the CCG average of 80% and national average of 76%.
- There were no plans in place to increase the length of surgeries, or to make start and finish times of surgeries uniform, to provide more consistency for ease of access.
- There were longer appointments available for all patients who required them including those with a learning disability.
- Home visits were available for older patients and those who were housebound. The practice identified all patients who may need more support and their initials and computer reference number where on a whiteboard in the staff administrative office.
- Same day appointments were available for children. GP triage had been introduced for those patients with medical problems that may require same day consultation. We noted that this did not increase routine access but did ensure urgent cases would be seen on the day.
- Patients were able to receive travel vaccinations available on the NHS.
- There were disabled facilities, a hearing loop and translation services available.
- The practice premises were set out on the ground floor and were fully accessible . There were clearly marked disabled parking bays close to the entrance to the building. Other reasonable adjustments were made and action was taken to remove barriers when patients find it hard to use or access services.

Access to the service

The practice was open between 8am and 6.30pm Monday to Friday, with extended opening hours on Tuesday evening until 8pm. Surgeries started and finished at different times each day. Generally the practice offered appointments from 9am or 9.30am to 11.40am each morning and from 2.30pm each afternoon, until 4.20pm. Surgeries on Wednesday and Thursday ran until 4.45pm, and on Tuesday afternoon surgery ran from 5.30pm to 7.40pm. In addition to pre-bookable appointments that could be booked up to six weeks in advance, urgent appointments were also available for people that needed them. The practice had increased the amount of telephone consultations available, which helped meet patient demand.

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

- 73% of patients being happy with the practice opening hours, but was still lower compared to the CCG average of 80% and national average of 76%.
- 76% of patients said they could get through easily to the practice by phone compared to the CCG average of 69% the national average of 73%.

There were no plans in place to increase access for patients by extending surgeries.

People told us on the day of the inspection that they were able to get appointments when they needed them.

Listening and learning from concerns and complaints

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

- Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England.
- There was a designated responsible person who handled all complaints in the practice.

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

- We saw that information was available to help patients understand the complaints system but this was only available from reception staff, which may deter some patients from raising a concern. We also noted that verbal complaints were logged and recorded by staff, which meant information that could be used as feedback, was systematically reviewed.
- We looked at a sample of complaints received in the last 12 months and found these had been handled and reviewed in line with the practice complaints policy. Lessons were learnt from individual concerns and complaints and discussed at practice meetings for non-clinical staff.

The lack of minutes of any clinical meetings meant the practice clinicians were unable to demonstrate that complaints were discussed.

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 a vision to deliver quality, evidence based medical care and health promotion to the local population.

- The practice staff had some understanding of how this would be achieved but lacked knowledge on how key parts of their role contributed to achieving this. For example, administrative staff who were exception reporting did not link this action with the impact this could have on patients health.
- The practice had a strategy and supporting business plans. However, there was insufficient evidence to support that these were effective.

Governance arrangements

The practice had an overarching governance framework, designed to support the delivery of services offered. This outlined procedures in place.

- There was a clear staffing structure and staff were aware of their own roles and duties.
- An understanding of the performance of the practice was shared with staff but some staff could not link how their role contributed to the overall performance of the practice, or how their actions ultimately impacted on patients health – for example, in exception reporting patients that failed to attend screening appointments.
- Staff placed greater importance on completion of Informed Dissent forms for those patients who failed to attend screening appointments, rather than investigating the cause of higher rates of patients not taking part in health screenings. Very high levels of exception reporting had not been picked up by staff or clinicians as an area that required improvement.
- There was some internal audit but this was incomplete; there was limited evidence of quality improvement.
- There were arrangements for identifying, recording and managing risks, issues and implementing mitigating actions. However, staff did not routinely follow policies and protocol. For example, staff checks were not completed as required for all staff working at the practice.
- Staff told us the practice held regular practice team meetings, which included the practice nurse.
- The health care assistant was unclear as to what their remit was and when they needed to escalate matters to the nurse or GP.
- The lack of delegation of duties that should fall to the practice manager, meant that some key aspects of governance were not followed, such as recruitment and succession planning.

Leadership and culture

On the day of inspection the principal GP did not evidence they had the experience, capacity and capability to run the practice safely and effectively. The lack of delegation of tasks, for example, to the practice manager, meant that some areas of the practice required attention. There were insufficient communication systems in place for clinicians, which meant the sharing of information and discussion of alerts, updates, changes to protocol and results of investigations was not taking place. The practice had failed to respond adequately to feedback from patients on access issues and that surgery times were inconvenient.

The provider was aware of and had systems in place to ensure compliance with the requirements of the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment). The practice had systems in place to ensure that when things went wrong with care and treatment:

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

There was a leadership structure in place.

- Staff told us there was an open culture within the practice and they had the opportunity to raise any issues at team meetings. However, we did not see a culture within the practice where it was good to report or raise concerns.
- Staff told us they felt respected, valued and supported.

Are services well-led?

Inadequate

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

- Staff said they were involved in discussions about how to run and develop the practice. However, we found the practice nurse had expressed interest in attending clinical meetings for some time, but this had not been facilitated.

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

The practice encouraged feedback from patients, the public and staff. It sought patients' feedback through distribution of survey forms and by running the Friends and Family test. However, there was no action plan produced in response to the findings of the last practice patient survey (2014-14). The practice were unable to demonstrate how they had responded to lower patient satisfaction rates identified in the NHS England GP Patient Survey. This data was published in January 2016.

The practice had not been able to form a patient participation group. We saw a poster in the reception area asking patients to join the group. Several patients we spoke with on the day told us they did not know what a patient participation group was.

- Results for the Friends and Family test were published on the practice website, and covered the months of May 2015 up to March 2016.
- The practice had conducted a patient survey in 2013-14 and the results of this were published on the practice website. The results of the survey did not state how many questionnaires were issued, how many were returned and what percentage of the practice population the views expressed represented. There was no action plan published to address some of the areas highlighted by patients as being less than satisfactory, such as, difficulty getting through to the practice by phone. The survey said that copies of the action plan would be made available on the website and in the patient reception and waiting areas. There was no copy of this in the reception and patient waiting areas when we visited the practice.
- The practice did not routinely gather feedback from staff ; the clinical team did not take part in the practice meetings. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with the practice manager. However, we found the practice managers role was limited to management of day to day events, rather than being involved in the long term planning and management of the practice.

Continuous improvement

The principal GP told us there was a focus on continuous learning and improvement at the practice, particularly in the area of medicines audit with the CCG medicines management team.

However, there were other areas where little improvement had been made, for example, in the prescribing of hypnotics. When we asked the principal GP, they could not show any plans in place to tackle this. There was evidence of a lack of clinical oversight, for example, the lack of knowledge about the rates of exception reporting being recorded by staff. No arrangements had been made for the practice nurse to take part in clinical meetings, which had been spoken about at the nurse's last appraisal.

The practice did not demonstrate that services for patients were improving or that access to GPs would be easier. There was a lack of focus on how career and succession planning could improve patients access to healthcare. There were no established priority areas for improvement, such as management of COPD or other chronic conditions. There was no plan in place to recruit for permanent GPs for the practice to replace long term locum GPs, which affected the ability of the practice to provide on-going continuity of care. There was limited evidence of the principal GP learning, sharing and implementing reflective improvement at the practice.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **How the regulation was not being met:** All required Patients Group Directions were not signed by the practice nurse belonging to a neighbouring practice, who delivered all childhood vaccinations and immunisations for the practice. Patient Specific Directions were not in place. This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed The provider did not have the information specified in Schedule 3 in relation to persons employed by the practice. This was a breach of Regulation 19(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider had not taken steps to deal with the six month backlog in summarising of patient records. The provider did not have effective communication systems in place to discuss and communicate with all colleagues, information and learning from significant events, notifications of Medicines and Healthcare Products Regulatory Agency (MHRA) alerts, and all other updates. There was no system in place to track and monitor the prescription pads issued to clinicians. Following patient surveys and the identification of areas that required improvement, there was no plan in place to support improvement required. This was a breach of Regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.