Leyton Green Neighbourhood HS

Inspection 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 location	Inadequate
Are services safe?	Inadequate
Are services effective?	Requires improvement
Are services caring?	Good
Are services responsive?	Requires improvement
Are services well-led?	Inadequate

Overall summary

This practice is rated as inadequate overall. (Previous inspection 11 2015 – *Good*)

The key questions are rated as:

Are services safe? – *Inadequate*

Are services effective? – *Requires Improvement*

Are services caring? – *Good*

Are services responsive? – *Requires Improvement*

Are services well-led? – *Inadequate*

We carried out an announced comprehensive inspection at Leyton Green Neighbourhood HS on 26 April 2018 as part of our inspection programme.

At this inspection we found:

- The practice did not have clear systems to manage risk so that safety incidents and significant events were less likely to recur. When incidents did happen, the practice did not effectively learn from them and improve their processes.
- The practice did not routinely review the effectiveness and appropriateness of the care it provided.
- Learning and outcomes from complaints was not shared with all relevant staff members.
- There was no evidence of quality improvement work being carried out.
- The practice did not provide appointments outside or core working hours for patients who could not attend during working hours and the practice was closed for two hours each day during lunch.
- Not all staff members had received the training required to carry out their roles effectively, for example safeguarding, infection and prevention control, fire safety and chaperone training.
- Emergency equipment was not sufficiently maintained as resuscitation equipment did not include a baby mask and had a missing valve.
- There was no documented approach to manage pathology results.
- There was no failsafe system to ensure the practice received results for all cytology samples taken.
- There were no systems to enable the process for seeking consent to be monitored appropriately.
- Home visit documentation completed by the nurse was not always comprehensive.
- Systems to ensure that electrical equipment was safe and in good working order was not effective.
- Staff involved and treated patients with compassion, kindness, dignity and respect.
- The practice had an approach for identifying and providing support to patients with caring responsibilities and had identified 2% of patients as a carer.
- Quality and Outcomes Framework achievement was in line with local and national averages.

The areas where the provider **must** make improvements as they are in breach of regulations are:

- Ensure care and treatment is provided in a safe way to patients.
- Establish effective systems and processes to ensure g good governance in accordance with the fundamental standards of care.
- Ensure recruitment procedures are established and operated effectively to ensure only fit and proper persons are employed.

The areas where the provider **should** make improvements are:

- Ensure all premises and equipment used by the service provider is fit for use.

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

Population group ratings

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

Our inspection team

Our inspection team was led by a CQC lead inspector**;** the team included a GP specialist advisor and a practice nurse specialist adviser.

Background to Leyton Green Neighbourhood HS

Leyton Green Neighbourhood HS is located in a residential area in east London based in a converted house. There are approximately 3700 patients registered with the practice where approximately 30% of whom do not have English as a first language and required an interpreter. The practice scored three on the index of multiple deprivation score where a score of one represents the most deprived and 10 is the least deprived.

The practice has two female GP partners and one female and two male regular locum GPs who complete a total of 13 sessions per week; there was also one female practice nurse and one female nurse prescriber who complete a total of 12 sessions per week. The practice has one practice manager and six reception/administrator staff members.

The practice is a training practice for medical students but did not have any students at the time of inspection. The practice operates under a General Medical Services Contract (a contract between NHS England and general practices for delivering general medical services and is the commonest form of GP contract).

The practice is open Monday to Friday between 9am and 6:30pm except for Thursdays when the practice closed at 1pm. The practice also closed each day between 12:30pm and 2:30pm and extended hours appointments were not offered. Telephone calls are answered from 9am to 12:30pm and 2:30pm to 6:30pm and appointment times are as follows:

- Monday 9am to 12:15pm and 3pm to 5pm.
- Tuesday 9:30am to 12:30pm and 3pm to 6pm.
- Wednesday 9am to 11:20am and 3pm to 5:20pm.
- Thursday 9:30am to 12:20pm.
- Friday 9:30am to 12:20pm and 3:15pm to 6pm.

The locally agreed out of hours provider covers calls made to the practice when the practice is closed and the practice is a part of a local HUB, which provides GP and nurse appointments to patients on weekday evenings and weekends when the practice is closed.

Leyton Green Neighbourhood HS operates regulated activities from one location and is registered with the Care Quality Commission to provide treatment of disease, disorder or injury, diagnostic and screening procedures, maternity and midwifery services and family planning.

Inadequate

Are services safe?

We rated the practice as inadequate for providing safe services.

The practice was rated as inadequate for providing safe services because:

- *The systems to keep patients safe and safeguarded from abuse was not effective.*
- *Staff had not completed or were not up to date with mandatory training required for them to carry out their role effectively.*
- *Facilities and equipment were not effectively checked to ensure they were in good working order and emergency equipment did not include all the necessary parts.*
- *Systems to record, act on and share learning from significant events was not effective.*

Safety systems and processes

The practice systems to keep people safe and safeguarded from abuse did not minimise risk.

- The practice did not have appropriate systems to safeguard children and vulnerable adults from abuse. Not all staff members had received up-to-date safeguarding (including to the appropriate level) and safety training appropriate to their role. For example one of the nurses was the safeguarding lead but was only trained to child safeguarding level two, the two most recently employed non-clinical staff members had not completed any safeguarding training and the practice was unable to evidence safeguarding training for another non-clinical staff member. The practice was also unable to evidence any vulnerable adults training for locum GPs, a practice nurse and non-clinical staff members. Reports and learning from safeguarding incidents were discussed at clinical meetings, but the practice was unable to demonstrate how learning from safeguarding issues were shared with non-clinical staff members.
- Staff who acted as chaperones were not trained for their role but had received a 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.)
- Staff took steps, including working with other agencies, to protect patients from abuse, neglect, harassment, discrimination and breaches of their dignity and respect.
- The practice did not carry out appropriate staff checks at the time of recruitment and on an ongoing basis. We found that there were no references for locum GPs that worked at the practice.
- There was a lead member of staff for infection and prevention control and the practice had completed an infection and prevention control audit where all issues identified had been actioned. However no staff member with the exception of the practice lead had completed infection control training and this was not included in the staff induction.
- The practice did not have effective arrangements to ensure that facilities and equipment were safe and in good working order.
- Arrangements for managing waste and clinical specimens kept people safe.

Risks to patients

There were not adequate systems to assess, monitor and manage risks to patient safety.

- We were told arrangements were in place for planning and monitoring the number and mix of staff needed to meet patients' needs, including planning for holidays, sickness, busy periods and epidemics. However there were no risk assessments or formal documented discussions to mitigate against potential risks associated with the practice closing for two hours each afternoon and not participating in extended hours appointments.
- The practice had completed a fire risk assessment but none of the staff members had completed fire safety training.
- There was no induction process for temporary staff and the induction process for permanent staff was not tailored to their role as it did not ensure that key training modules were completed.
- The practice was not well equipped to deal with medical emergencies as resuscitation equipment had no baby mask and a missing valve. The practice could not evidence that staff were all suitably trained in emergency procedures. For example the most recently employed non-clinical staff member had not received basic life support training, the practice was unable to evidence that basic life support training had been

completed by one of the GP partners and some non-clinical staff members. The last training that had taken place was out of date by two months. However we did see evidence that training was booked for May 2018.
- Staff mostly understood their responsibilities to manage emergencies on the premises and to recognise those in need of urgent medical attention, however reception staff we spoke with was unable to describe symptoms of sepsis and therefore how they would deal with it. Clinicians knew how to identify and manage patients with severe infections including sepsis.
- When there were changes to services or staff the practice did not assess and monitor the impact on safety.

Information to deliver safe care and treatment

Staff did not have the information they needed to deliver safe care and treatment to patients.

- The care records we saw showed that information needed to deliver safe care and treatment was available to staff. There was no documented approach to managing test results.
- Home visit documentation completed by the nurse was not comprehensive.
- The practice had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.
- Clinicians made timely referrals in line with protocols.

Appropriate and safe use of medicines

The practice had reliable systems for appropriate and safe handling of medicines.

- The systems for managing and storing medicines, including vaccines, emergency medicines and equipment, minimised risks.
- Staff prescribed, administered or supplied medicines to patients and gave advice on medicines in line with current national guidance. The practice had reviewed its antibiotic prescribing and taken action to support good antimicrobial stewardship in line with local and national guidance.
- Patients' health was monitored in relation to the use of medicines and followed up on appropriately. Patients were involved in regular reviews of their medicines.

Track record on safety

The practice did not have a good track record on safety.

- There were no comprehensive risk assessments in relation to safety issues.
- The practice did not monitor and review activity to help it to understand risks and give a clear, accurate and current picture of safety that leads to safety improvements.

Lessons learned and improvements made

The practice did not effectively learn and make improvements when things went wrong.

- The practice did not have a significant event policy or reporting form and staff did not understand their responsibility to report certain incidents to external bodies such as the Care Quality Commission.
- Systems for reviewing and investigating when things went wrong were not adequate. Significant events were completed by the GPs as a part of their appraisal process and were not always shared with the wide practice and there was no central system for reporting or recording or saving significant events.
- The practice did not always learn and share lessons, identify themes or take action to improve safety in the practice. We saw that there was no definition in the practice of what a significant event was and events were not always shared with all the necessary staff members in the practice and actions and learning pointes were not always identified.
- The practice acted on and learned from external safety events as well as patient and medicine safety alerts.

Please refer to the Evidence Tables for further information.

Requires improvement

Are services effective?

We rated the practice as requires improvement for providing effective services overall and across all population groups.

The practice was rated as requires improvement for providing effective services because:

- Evidence of quality improvement was limited.
- Not all relevant staff had completed relevant training required for their role.
- There was no failsafe system for cytology.

(Please note: Any Quality Outcomes (QOF) data relates to 2016/17. QOF is a system intended to improve the quality of general practice and reward good practice.)

Effective needs assessment, care and treatment

The practice had systems to keep clinicians up to date with current evidence-based practice. We saw that clinicians assessed needs and delivered care and treatment in line with current legislation, standards and guidance supported by clear clinical pathways and protocols.

- Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.
- We saw no evidence of discrimination when making care and treatment decisions.
- Staff did not have access to tools to assess the level of pain in patients but would ask patients to describe how severe their pain was.
- Staff advised patients what to do if their condition got worse and where to seek further help and support.

Older people:

- The practice was unable to evidence that all staff members involved in assessments of vulnerable patients had received vulnerable adults training.
- The practice used an appropriate tool to identify patients aged 65 and over who were living with moderate or severe frailty. Those identified as being frail had a clinical review including a review of medication.
- Patients aged over 75 were invited for a health check. If necessary they were referred to other services such as voluntary services and supported by an appropriate care plan.
- The practice followed up on older patients discharged from hospital. It ensured that their care plans and prescriptions were updated to reflect any extra or changed needs.
- The practice was unable to demonstrate that all necessary staff had the appropriate training and knowledge of how to treat older people including their psychological, mental and communication needs.

People with long-term conditions:

- Patients with long-term conditions had a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- Staff who were responsible for reviews of patients with long term conditions had received specific training.
- GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.
- The practice had arrangements for adults with newly diagnosed cardiovascular disease including the offer of high-intensity statins for secondary prevention, people with suspected hypertension were offered ambulatory blood pressure monitoring and patients with atrial fibrillation were assessed for stroke risk and treated as appropriate.
- The practice was able to demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension).

Families, children and young people:

- Childhood immunisations were carried out in line with the national childhood vaccination programme. Uptake rates for the vaccines given to children aged below one year were above the target percentage of 90% at 100% and vaccines given to children aged two years were in line with the target percentage of 90% ranging between 82% and 83%.
- The practice told us they had arrangements to identify and review the treatment of newly pregnant women on long-term medicines. These patients were provided with advice and post-natal support in accordance with best practice guidance.
- The practice had arrangements for following up failed attendance of children's appointments following an appointment in secondary care or for immunisation.

Requires improvement

Are services effective?

Working age people (including those recently retired and students):

- The practice's uptake for cervical screening was 62%, which was in line with the CCG average of 68% but below the 80% coverage target for the national screening programme. The practice was aware of their low uptake and told us that this was because of their mobile population and population demographic but could not evidence what they had done to improve this.
- The practices' uptake for breast and bowel cancer screening was in line the national average.
- The practice was unable to describe their system to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40-74. There was appropriate follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.

People whose circumstances make them vulnerable:

- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.

People experiencing poor mental health (including people with dementia):

- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder by providing access to health checks, interventions for physical activity, obesity, diabetes, heart disease, cancer and access to 'stop smoking' services. There was a system for following up patients who failed to attend for administration of long term medication.
- When patients were assessed to be at risk of suicide or self-harm the practice had arrangements in place to help them to remain safe.
- 100% of patients diagnosed with dementia had their care reviewed in a face to face meeting in the previous 12 months. This is above the CCG and the national average.
- 85% of patients diagnosed with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive, agreed care plan documented in the previous 12 months. This is comparable to the CCG and the national average.
- The practice specifically considered the physical health needs of patients with poor mental health and those living with dementia. For example 87% of patients experiencing poor mental health had received discussion and advice about alcohol consumption. This is comparable to the national average.
- Patients at risk of dementia were identified and offered an assessment to detect possible signs of dementia. When dementia was suspected there was an appropriate referral for diagnosis.
- The practice offered annual health checks to patients with a learning disability.

Monitoring care and treatment

The practice did not have a comprehensive programme of quality improvement activity and did not routinely review the effectiveness and appropriateness of the care provided. For example, we were provided with a second audit cycle for an audit relating to asthma but when asked we were not provided with the first cycle of this audit to demonstrate whether improvements had been made.

- The practice did not effectively use information about care and treatment to make improvements.
- Some staff told us they were not provided with protected time to carry out audits to review the effectiveness of the care they provided.
- The practice was not actively involved in quality improvement activity. However, clinicians sometimes took part in local improvement initiatives. For example the practice ran a computer search to find out how many patients who were coded as having chronic obstructive pulmonary disease (COPD) to see whether their smoking status had been recorded and an annual review had been carried out. This had not been repeated to see whether any actions taken impacted on the care of patients with COPD.

Requires improvement

Are services effective?

- Post inspection the practice informed us that they will formalise reception staff information sharing and do this via email and not verbally.

Effective staffing

Staff had the skills, knowledge and experience to carry out their roles. However not all staff training was up to date.

- Staff had appropriate knowledge for their role, for example, clinical staff attended regular updates to carry out reviews for people with long term conditions, older people and people requiring contraceptive reviews.
- Staff whose role included immunisation and taking samples for the cervical screening programme had received specific training and could demonstrate how they stayed up to date. However there were no processes in place to ensure the practice received the results for all cervical screening samples taken. Post inspection the practice told us that there was an administrative member of staff who monitors this but did not provide any evidence in support of this.
- The practice understood the learning needs of staff. Some staff members told us they were not provided with protected time to complete the required training and clinical audits. Up to date records of skills, qualifications and training were not maintained and there was little management oversight into the training completed by clinical staff members.
- The practice provided staff with support. This included an induction process appraisals and support for revalidation. The practice did not have processes to ensure the competence of staff employed in advanced roles, for example by audit of their clinical decision making, including non-medical prescribing.
- There was no clear approach for supporting and managing staff when their performance was poor or variable.

Coordinating care and treatment

Staff worked together and with other health and social care professionals to deliver effective care and treatment.

- We saw records that showed that all appropriate staff, including those in different teams and organisations, were involved in assessing, planning and delivering care and treatment.
- The practice shared clear and accurate information with relevant professionals when deciding care delivery for people with long term conditions and when coordinating healthcare for care home residents. The shared information with, and liaised, with community services, social services and carers for housebound patients and with health visitors and community services for children who have relocated into the local area.
- Patients received coordinated and person-centred care. This included when they moved between services, when they were referred, or after they were discharged from hospital. The practice worked with patients to develop personal care plans that were shared with relevant agencies.
- The practice ensured that end of life care was delivered in a coordinated way which took into account the needs of different patients, including those who may be vulnerable because of their circumstances.

Helping patients to live healthier lives

Staff were consistent and proactive in helping patients to live healthier lives.

- The practice identified patients who may be in need of extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.
- Staff encouraged and supported patients to be involved in monitoring and managing their own health, for example through social prescribing schemes.
- Staff discussed changes to care or treatment with patients and their carers' as necessary.
- The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns, tackling obesity.

Consent to care and treatment

The practice obtained consent to care and treatment in line with legislation and guidance.

- Clinicians understood the requirements of legislation and guidance when considering consent and decision making.
- Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.
- The practice did not have systems to enable the process for seeking consent to be monitored.

Requires improvement

Are services effective?

Please refer to the Evidence Tables for further information.

Good

Are services caring?

We rated the practice as good for caring.

The practice was rated as good for caring because:

- *Staff treated patients with dignity and respect.*
- *The practice identified 2% of patients as a carer.*

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- Feedback from patients was positive about the way staff treat people.
- Staff understood patients' personal, cultural, social and religious needs.
- The practice gave patients timely support and information.

Involvement in decisions about care and treatment

Staff helped patients to be involved in decisions about care and treatment. They were aware of the Accessible Information Standard (a requirement to make sure that patients and their carers can access and understand the information that they are given.)

- Staff communicated with people in a way that they could understand, for example, communication aids and easy read materials were available.
- Staff helped patients and their carers find further information and access community and advocacy services. They helped them ask questions about their care and treatment.
- The practice proactively identified carers and supported them.

Privacy and dignity

The practice respected patients' privacy and dignity.

- Reception staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private area to discuss their needs.
- Staff recognised the importance of people's dignity and respect. They told us they would challenge behaviour that fell short of this.

Please refer to the Evidence Tables for further information.

Requires improvement

Are services responsive to people's needs?

We rated the practice, and all of the population groups, as requires improvement for providing responsive services .

The practice was rated as requires improvement for responsive because:

- Appointment times and practice opening hours did not reflect the needs of the local population.
- The complaints system was not effective.

Responding to and meeting people's needs

The practice did not organise services to meet patients' needs. It did not take account of patient needs and preferences.

- The practice understood the needs of its population but did not effectively tailor services in response to those needs.
- Telephone consultations were available with the nurse but not readily available with GPs for patients who were unable to attend the practice during normal working hours. Post inspection the practice informed us that the GPs carry out a large number of telephone consultations for any patient who request them.
- The facilities and premises were appropriate for the services delivered.
- The practice made reasonable adjustments when patients found it hard to access services.
- The practice provided effective care coordination for patients who are more vulnerable or who have complex needs. They supported them to access services both within and outside the practice.
- Care and treatment for patients with multiple long-term conditions and patients approaching the end of life was coordinated with other services.

Older people:

- All patients had a named GP who supported them in whatever setting they lived.
- The practice offered home visits and urgent appointments for those with enhanced needs. The GP and practice nurse also accommodated home visits for those who had difficulties getting to the practice due to limited local public transport availability.
- Appointments during extended hours were not available for patients who could not attend the practice during normal working hours.
- There was a medicines delivery service for housebound patients.

People with long-term conditions:

- Patients with a long-term condition received an annual review to check their health and medicines needs were being appropriately met. Multiple conditions were not always reviewed at one appointment.
- Consultation times were not flexible to meet each patient's specific needs.
- The practice discussed and managed the needs of patients with complex medical issues with community services.

Families, children and young people:

- We found there were systems 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 accident and emergency (A&E) attendances. Records we looked at confirmed this.
- All parents or guardians calling with concerns about a child under the age of five were offered a same day appointment when necessary.
- There were appointments available outside of school opening hours but these were not able to be booked during lunch time hours due to the practice being closed. Post inspection the practice informed us that the practice nurse runs special half term clinics for at risk children to receive the flu vaccination and also asthma clinics for children.

Working age people (including those recently retired and students):

- The needs of this population group had been identified but the practice had not adjusted the services it offered to ensure these were accessible, for example appointment times were not flexible and there were no extended opening hours appointments.

People whose circumstances make them vulnerable:

- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability.
- People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode

Requires improvement

Are services responsive to people's needs?

People experiencing poor mental health (including people with dementia):

- Staff interviewed had an understanding of how to support patients with mental health needs and those patients living with dementia.
- Patients who failed to attend their appointments were proactively followed up by a phone call from a member of staff.

Timely access to care and treatment

Patients were not always able to access care and treatment from the practice within an acceptable timescale for their needs.

- Patients had access to initial assessment, test results, diagnosis and treatment in the practice during normal working hours only. Outside of these hours patients would have to attend the local HUB.
- Appointment times at the practice were limited to core hours only and the practice was closed for two hours each day where patients did not have access to the premises and could not contact the practice by phone to access appointments, book appointments or pick up prescriptions.
- Waiting times and cancellations were minimal and managed appropriately.
- Patients with the most urgent needs had their care and treatment prioritised.

Data from the National GP Patient Survey showed patient satisfaction with access to appointments were below the national averages. For example:

- 57% of patients stated that the last time they wanted to see or speak with a GP or nurse they were able to get an appointment, compared to the CCG average of 67% and the national average of 76%.
- 66% of patients stated they were very satisfied or fairly satisfied with the practices opening hours, compared to the CCG average of 74% and the national average of 80%.

Listening and learning from concerns and complaints

The practice told us that they took complaints and concerns seriously and responded to them appropriately to improve the quality of care. However we found flaws in the complaints processes.

- Information about how to make a complaint or raise concerns was available and staff treated patients wishing to make a complaint compassionately.
- The complaint policy and procedures were not in line with recognised guidance as it did not include the practices responsibility to raise certain complaints with external bodies.
- The practice did not have a central system for storing complaints and did not effectively learn lessons from individual concerns and complaints and also from analysis of trends. For example, we viewed a complaint regarding a mistake made at reception which led to a letter being sent to the patient about their conduct. We saw that the patient received an apology and explanation but there was no evidence that this was discussed at a meeting where learning, outcomes and actions could be shared with all relevant staff members.

Please refer to the Evidence Tables for further information.

Inadequate

Are services well-led?

We rated the practice and all of the population groups as inadequate for providing a well-led service.

The practice was rated as inadequate for well-led because:

- *Learning from events and complaints were not always shared to ensure improvements were made.*
- *There was not a full complement of policies and procedures to govern activities.*
- *There was limited management oversight in staff training and not all staff had completed training relevant to their role.*
- *The processes to identify and mitigate risks were not effective.*

Leadership capacity and capability

Leaders did not have the capacity to deliver sustainable care.

- Leaders were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges but could not demonstrate how they were addressing them.
- Leaders were approachable but not always visible in the practice due to the number of sessions they carried out. One GP partner completed two sessions per week consisting of the average of six appointments per session and the other completed five sessions per week.
- The practice did not have effective processes to develop leadership capacity and skills. We were told the practice was planning for a change in future leadership but we were shown no documented evidence to support this.

Vision and strategy

The practice had a vision to deliver quality and sustainable care but processes in place did not always support this.

- There was a clear vision and set of values with no strategy and supporting business plans to achieve priorities.
- Staff were aware of and understood the vision, values and strategy and their role in achieving them.
- The practice did not plan its services to meet the needs of the practice population.
- The practice monitored progress against delivery of its vision.

Culture

The practice did not have a culture of high-quality sustainable care.

- Staff stated they felt respected, supported and valued. They were proud to work in the practice.
- The practice told us they focused on the needs of patients. However this was not supported by patient access to the practice and appointment times.
- Leaders and managers told us they would act on behaviour and performance inconsistent with the vision and values. However the polices to support them in doing so were very limited.
- Openness, honesty and transparency were demonstrated when responding to incidents and complaints, but learning from incidents and complaints was not always shared with all relevant staff members.
- The provider was aware of and had policy to support compliance with the requirements of the duty of candour.
- Staff we spoke with told us they were able to raise concerns. They had confidence that these would be addressed.
- Processes for providing all staff with the development they needed was not effective as not all staff members were up to date with their mandatory training and there was no centralised system for logging and managing what training had been completed. However, all staff received an appraisal in the last year.
- Staff were supported to meet the requirements of professional revalidation where necessary.
- Clinical staff told us they were considered valued members of the practice team. They were not given protected time for professional development and evaluation of their clinical work, including clinical audit.
- The practice told us that they took the safety and well-being of all staff seriously.
- The practice could not demonstrate how they actively promoted equality and diversity. Staff members had not received equality and diversity training.
- There were positive relationships between staff and teams.

Governance arrangements

Responsibilities were not always clear, roles and systems of accountability to support good governance and management was not effective.

- Structures, processes and systems to support good governance and management were not clearly set out, understood or effective.

Inadequate

Are services well-led?

- Staff were clear on their roles and accountabilities in respect of raising a safeguarding concern, but not all staff had safeguarding training and the safeguarding lead was not trained to the appropriate level.
- Infection prevention and control training was limited to handwashing techniques for non-clinical staff members and the practice was unable to demonstrate infection and prevention control training for some of their clinical staff members.
- Practice leaders had not effectively established proper policies, procedures and activities to ensure safety and assured themselves that they were operating as intended.

Managing risks, issues and performance

There was not always clarity around processes for managing risks, issues and performance.

- There was no process to identify, understand, monitor and address current and future risks including risks to patient safety.
- There was no significant events policy or reporting form.
- The practice had no processes to manage current and future performance.
- Practice leaders had oversight of national and local safety alerts, but there was no oversight of incidents and complaints.
- Clinical audit did not demonstrate an impact on quality of care and outcomes for patients. There was no clear evidence of action to change practice to improve quality.
- The practice had plans in place and had trained staff for major incidents.
- The practice could not evidence how it implemented service developments and where efficiency changes were made this was with input from clinicians to understand their impact on the quality of care.

Appropriate and accurate information

The practice did not have appropriate and accurate information.

- Quality and operational information was not systematically used to ensure and improve performance.
- Quality and sustainability was sometimes discussed in relevant meetings where all staff had sufficient access to information.
- The practice used QOF data which it monitored and managed and staff had lead roles pertaining to this.
- The practice could not evidence how it used technology systems to monitor and improve the quality of care.
- The practice told us they submitted data or notifications to external organisations as required, but they were unaware of what complaints or significant events needed to be externally reported.
- There were robust arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

Engagement with patients, the public, staff and external partners

The practice involved patients and staff to support sustainable services.

- Patient and staff views and concerns were encouraged, heard and acted on to shape services and culture. There was an active patient participation group.
- The service was transparent, collaborative and open with stakeholders about performance.

Continuous improvement and innovation

There was no evidence of systems and processes for continuous improvement and innovation.

- The practice did not make use of internal and external reviews of incidents and complaints. Learning was not always shared and used to make improvements.
- Leaders and managers did not encouraged staff to take time out to review individual and team objectives, processes and performance.
- Quality improvement work was not a priority.

Please refer to the Evidence Tables for further information.

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 the service provider was not meeting. The provider must send CQC a report that says what action it is going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met. The provider did not do all that was reasonablypracticable to assess, monitor, manage and mitigaterisks to the health and safety of service users. In particular: There was no system to share learning outcomes from significant events and complaints. There was no cytology failsafe. Resuscitation equipment did not include all the necessary components to enable them to function properly including a valve and a mask. The practice did not have an effective system to ensure that electrical equipment was safe and in good working order. This was in 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 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met. The provider did not have systems or processes to ensure that risks were assessed, monitored, improved or mitigated. The provider did not have key policies such as a significant event policy to govern activity.

This section is primarily information for the provider

Requirement notices

Staff had not completed all the required mandatory training and the provider did not have adequate arrangements to monitor training undertaken.

There was no quality improvement wok carried out.

The provider failed to ensure that the necessary pre-employment checks had been completed on staff members.

This was in breach of regulation 17 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.