The Gadhvi Practice

Quality Report

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

Ratings

Overall rating for this service	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 The Gadhvi Practice on 24 October 2016. Overall the practice is rated as inadequate.

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

- Systems for managing patients laboratory test results did not assure patients safety.
- There was no recording structure or significant events management protocol in place. However, significant events lessons were shared and actions taken to improve safety
- Arrangements for safeguarding were satisfactory but there were gaps in safety systems and processes such as premises and equipment cleaning and maintenance, medicines management and chaperoning.
- Not all risks to patients were assessed and well managed including: staff recruitment checks, control of substances hazardous to health (COSHH) and fire safety.
- The practice did not have adequate arrangements in place to respond to a medical emergency, the first aid kit contents were incomplete or expired, and the defibrillator was shared with another practice, had a low battery and there was no system to ensure it remained fit for use.
- Fail safe systems for patients cervical screening and checking emergency medicines had lapsed and items in the practice had expired or were no longer in sterile packaging, including needles and syringes.
- Data generally showed patient outcomes were comparable to the national average but some exception reporting rates were higher than average and several GP Patient survey scores for patient access and practice nursing were below average. No effective action had been taken to improve.

Summary of findings

- The practice had a number of policies and procedures to govern activity but some were undated, incomplete or not implemented. For example, as indicated on pages 14,15, and 16 of this report.
- The practice had no clear leadership and management structure but staff felt supported and knew the values of the practice were to be caring and put patients first.
- The provider was aware of and complied with the requirements of the duty of candour.

The areas where the provider must make improvements are:

- Establish effective systems for managing risks to patient's safety including premises and equipment safety, medicines, patient's laboratory test results including failsafes for cervical screening, and in the event of a medical emergency.
- Establish effective systems and processes to assess, monitor and improve quality with reference to national GP patient's survey results and including reviewing procedures.
- Ensure patients consent is appropriately sought and recorded.
- Ensure staff are appropriately inducted and trained.
- Implement all necessary employment checks for all staff.

In addition the provider should:

- Review the business continuity plan.
- Improve arrangements for deaf or hard of hearing patients, identification of and supporting carers, and health for checks for patients with a learning disability.
- Seek to further understand or improve its higher exception reporting rates.
- Consider reviewing arrangements for staff DBS checks and Mental Capacity Act training for clinicians.

I am placing this service in special measures. Where a service is rated as inadequate for one of the five key questions or one of the six population groups or overall and after re-inspection has failed to make sufficient improvement, and is still rated as inadequate for any key question or population group, we place it into special measures.

Services placed in special measures will be inspected again within six months. If, after re-inspection, the service has failed to make sufficient improvement, and is still rated as 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 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.

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 and improvements must be made.

- There was no recording structure or significant events management protocol or process in place. However, significant events lessons were shared and actions taken to improve safety.
- When things went wrong patients received reasonable support, truthful information, and a written apology. They were told about any actions to improve processes to prevent the same thing happening again.
- There were gaps in systems, processes and practices to keep patients safe such as chaperoning, out of date needles and syringes, and premises and equipment maintenance and hygiene.
- Not all risks to patients were assessed and well managed including, staff recruitment checks, and fire safety.
- Arrangements for in the event of a medical emergency were inadequate such as a shared defibrillator with a low battery and first aid kit with contents missing or expired such as eye wash that expired in 2012.
- There was no list or organisational structure at the practice to indicate key health and safety responsibilities including for first aid, accident reporting and risk assessment.
- Systems for managing patients laboratory test results did not assure patients safety.

Are services effective?

Requires improvement

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

- Failsafe systems for cervical screening had lapsed.
- Data showed some exception reporting rates were higher than average.
- Clinical audits demonstrated quality improvement.
- Staff generally had the skills, knowledge and experience to deliver effective care and treatment but there was no induction carried out for locum clinicians most GPs had no training on the Mental Capacity Act 2005.
- Staff had not consistently sought and recorded patients consent.

Summary of findings

- There was evidence of appraisals and personal development plans for all staff.
- Staff worked with other health care professionals to understand and meet the range and complexity of patients' needs.

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 as comparable for most aspects of care but some scores for practice nursing care were below average and the practice had not taken effective action to address this.
- The practice had identified 31 patients as carers (1% of the practice list).
- The practice did not have appropriate arrangements for patients telephoning weekdays between 1.00pm and 1.30pm when its shutters were closed and did not show appropriate care or diligence to make improvements in this regard.
- 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.
- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.
- The practice kept a register of patients who had died and used it to reflect on how they could improve care for patients at the end of life and patients who had died unexpectedly.

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. For example, it had identified it had a relatively high population of patients with diabetes, one of the GPs was trained to initiate insulin for patients with diabetes where appropriate and the practice held weekly diabetes care clinics.
- Information about how to complain was available and easy to understand and evidence showed the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.

Summary of findings

- The practice had a website and offered online appointment booking and prescription requests through the online national patient access system.
- The practice did not provide an extended hours service for working patients who could not attend during normal opening hours.
- Data from the national GP patient survey showed patients rated the practice lower than others for telephone access and satisfaction with the practice's opening hours and the practice had not addressed the low results effectively.
- One of the GP partners provided education sessions on safe fasting during Ramadan at a local community centre.

Are services well-led?

Inadequate

The practice is rated as inadequate for being well-led and improvements must be made.

- The practice did not have a mission statement, forward vision or strategy.
- Staff at all levels told us the values of the practice were to be caring and put patients first.
- There was no clear leadership structure or overarching governance framework to support the delivery of care and day to day operations, but staff felt supported by management.
- The provider was aware of and complied with the requirements of the duty of candour. The partners encouraged a culture of openness and honesty.
- The practice had no systems in place for significant events or notifiable safety incidents to improve safety.
- The practice had not consistently taken effective action on feedback from patients, for example its lower GP patient survey scores.
- The patient participation group was active and had made suggestions for improvement that were implemented.
- There were gaps in systems to identify and manage risks within the practice, including health and safety.

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 provider was rated as inadequate for safety and well-led, and requires improvement for responsive, caring and effective. The issues identified as inadequate and requiring improvement overall affected all patients including this population group.

- 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.
- The percentage of patients with atrial fibrillation with a CHADS2 score receiving anticoagulation or antiplatelet therapy was 100% compared to 98% nationally. (CHADS2 is a clinical prediction rule for estimating the risk of stroke in patients with non-rheumatic atrial fibrillation, a common heart condition).

People with long term conditions

Inadequate

The provider was rated as inadequate for safety and well-led, and requires improvement for responsive, caring and effective. The issues identified as inadequate and requiring improvement overall affected all patients including this population group.

- Patients with chronic diseases at risk of hospital admission were identified as a priority.
- The practice held weekly diabetes care clinics and one of the GPs was trained to initiate insulin for patients with diabetes.
- Performance for diabetes related indicators was above national averages. For example, the percentage of patients on the diabetes register with a record of a foot examination and risk classification within the preceding 12 months was 99% compared with the national average of 88%. Over all exception reporting for diabetes indicators was 12% compared 9% within the CCG and 11% nationally.
- The percentage of patients with hypertension having regular blood pressure tests was 86%, which is similar to national average of 84%. Overall exception reporting for hypertension was 8% (compared to 4% within the CCG and nationally).
- Longer appointments and home visits were available when needed.

Summary of findings

- For those patients with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.
- These patients had a named GP and a structured annual review to check their health and medicines needs were being met.
- One of the GP partners provided education sessions on safe fasting during Ramadan at a local community centre.

Families, children and young people

Inadequate

The provider was rated as inadequate for safety and well-led, and requires improvement for responsive, caring and effective. The issues identified as inadequate and requiring improvement overall affected all patients including this population group.

- 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.
- 74% of patients diagnosed with asthma, on the register had an asthma review in the last 12 months compared to 75% nationally.
- Childhood immunisation rates were comparable to national averages and ranged from 83% to 90% (ranged from 88% to 95% nationally) for under two year olds; and from 78% to 90% (ranged from 81% to 95% nationally) for five year olds.
- 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's uptake for the cervical screening programme was 81%, which was comparable to the CCG average of 79% and the national average of 82%, but failsafes for cervical screening had lapsed.
- 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 provider was rated as inadequate for safety and well-led, and requires improvement for responsive, caring and effective. The issues identified as inadequate and requiring improvement overall affected all patients including this population group.

Summary of findings

- The practice did not offer extended hours for working age patients having difficulty attending for an appointment in working hours.
- The practice had online appointment booking and prescription requests but had not effectively addressed lower GP patient survey scores for telephone access and patients satisfaction with its opening hours.
- The practice offered NHS health checks for patients aged 40–74. Appropriate follow-ups for the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.

People whose circumstances may make them vulnerable

Inadequate

The provider was rated as inadequate for safety and well-led, and requires improvement for responsive, caring and effective. The issues identified as inadequate and requiring improvement overall affected all patients including this population group.

- 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 and had identified seven on its register, only three of these patients (43%) had received an annual health check.
- The practice regularly 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.
- Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

People experiencing poor mental health (including people with dementia)

Inadequate

The provider was rated as inadequate for safety and well-led, and requires improvement for responsive, caring and effective. The issues identified as inadequate and requiring improvement overall affected all patients including this population group.

- 77% of patients diagnosed with dementia had their care reviewed in a face to face meeting in the last 12 months, which was comparable to national average of 84%. However, exception reporting for dementia was 14% (compared to 4% within the CCG and 8% nationally).

Summary of findings

- The practice had identified 58 patients on its register with a mental health condition, 88% of these patients had their alcohol consumption recorded. However, exception reporting for depression was 40% (compared to 29% within the CCG and 25% nationally).
- The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those with dementia and had carried out advance care planning for patients with dementia.
- The practice had 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.
- There were gaps in staff Mental Capacity Act training and arrangements for informed consent.

Summary of findings

What people who use the service say

The national GP patient survey results were published in July 2016. The results showed the practice was performing in line with or below national averages. Three hundred and sixty eighty forms were distributed and 95 were returned. This represented 1% of the practice's patient list.

- 45% found it easy to get through to this surgery by phone which compared to the national average of the national average of 73%.
- 66% were able to get an appointment to see or speak to someone the last time they tried compared to the national average of 76%.
- 73% described the overall experience of their GP surgery as fairly good or very good compared to the national average of 85%.
- 61% said they would recommend their GP surgery to someone who has just moved to the local area compared to the national average of 80%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 29 comment cards and 26 of them were entirely positive about the standard of care received. Three had mixed feedback and there were no overlapping themes of concern. Patients said staff were professional, polite and friendly.

We spoke with seven patients during the inspection. All seven patients said they were satisfied with the care they received and thought staff were approachable, committed and caring.

The practice friends and family test results patient's satisfaction score showed 60% said they would recommend the surgery.

Areas for improvement

Action the service MUST take to improve

- Establish effective systems for managing risks to patient's safety including premises and equipment safety, medicines, patient's laboratory test results including failsafes for cervical screening, and in the event of a medical emergency.
- Establish effective systems and processes to assess, monitor and improve quality with reference to national GP patient's survey results and including reviewing procedures.
- Ensure patients consent is appropriately sought and recorded.
- Ensure staff are appropriately inducted, trained.
- Implement all necessary employment checks for all staff.

Action the service SHOULD take to improve

- Review the business continuity plan.
- Improve arrangements for deaf or hard of hearing patients, identifying and supporting carers, and health for checks for patients with a learning disability.
- Seek to further understand or improve its higher exception reporting rates.
- Consider reviewing arrangements for staff DBS checks and Mental Capacity Act training for clinicians.

The Gadhvi Practice

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a lead CQC inspector and included a GP specialist adviser and an expert by experience.

Background to The Gadhvi Practice

The Gadhvi Practice is situated within the NHS City and Hackney Clinical Commissioning Group (CCG). The practice provides services under a General Medical Services (GMS) contract to approximately 4,800 patients. It is located on the ground floor within the purpose built Fountayne Road Health Centre. Two further GP practices and community services are also located within the building. The Gadhvi Practice shares its waiting area with the Elm GP practice and community services.

The practice provides a full range of enhanced services including minor surgery, child health clinics, and child and travel vaccines including Yellow Fever. It is registered with the Care Quality Commission to carry on the regulated activities of maternity and midwifery services, family planning services, treatment of disease, disorder or injury, and diagnostic and screening procedures.

The staff team at the practice includes three GP partners, (two male working a total of 14 sessions, and one female working seven sessions per week), a male long term locum GP working two sessions per week or more if required, a female practice nurse working 20 hours per week plus five extra hours per month (however, the nurse had been away intermittently for several months and the practice had recently recruited a locum nurse to cover seven hours one day per week), a female health care assistant working 22 hours per week, a practice manager working 24 hours per week, a deputy practice manager working 28 hours per week, and a team of reception and administrative staff working a mixture of part time hours. The practice teaches medical students.

The practices opening hours are between 9:00am to 6.30pm every weekday except Thursday when it is open 9.00am to 1.00pm. GP appointments are available 9.30am to 11.00am, with telephone consultations from 11.00am to 12.30pm, and then GP appointments resume 3.30pm to 5.30pm every weekday except Thursday when the last appointment is at 11.00am. Appointments include home visits, online pre-bookable appointments, and urgent appointments for patients who need them. The practice closes its internal shutters between 1.00pm and 1.30pm and informs us telephone calls are answered during this time; however, we found this is not the case. The practice does not provide an extended hours service. Patients telephoning when the practice is closed were transferred automatically to the local out-of-hours service provider until 8.00am. Staff told us that between the hours of 8.00am and 9.00am the out-of-hours service provider contacts the practice duty doctor with details of patients that need care.

The information published by Public Health England rates the level of deprivation within the practice population group as three on a scale of one to ten. Level one represents the highest levels of deprivation and level ten the lowest. The practice area has a lower percentage of people over 65 years of age (10% compared to 17% nationally). The average male and female life expectancy for the practice is 79 years for males (compared to 78 years within the Clinical Commissioning Group and 79 years nationally), and 84 years for females (compared to 82 years

within the Clinical Commissioning Group and 83 years nationally). The practice told us patients on its list were mainly from the following groups: Jewish, Caribbean, African, Asian, Polish, Turkish, White British and Indian.

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. The practice had not been inspected previously.

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 24 October 2016.

During our visit we:

- Spoke with a range of staff (GP partners, practice manager and deputy practice manager, health care assistant, and reception and administrative staff) and spoke with patients who used the service. The practice nurse was absent and unavailable for us to speak to.
- Observed how patients were being cared for and 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.

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 no recording structure or significant events management protocol or process in place. However, significant events lessons were shared and actions taken to improve safety.

- Staff told us they would inform the practice manager of any incidents. There was a recording book available but it was a plain diary format and contained no recording structure; for example, to prompt follow up action to prevent recurrence, or to support the recording of notifiable incidents under the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment). There was no other system for recording or managing significant events.
- However, the practice carried out an analysis of the significant events. We saw evidence that when things went wrong with care and treatment, patients were informed of the incident, received reasonable support, truthful information, a written apology and were told about any actions to improve processes to prevent the same thing happening again.

We reviewed safety records, patient safety alerts and minutes of meetings where these were discussed. Patient's safety alerts were appropriately disseminated and followed up and lessons were shared to improve safety in the practice. For example, after a patient with a specific symptom had attended the practice and there was a risk of infection transfer to other patients. Practice staff met to discuss the event to raise staff awareness and agreed to ensure patients with this particular symptom were asked further relevant questions before being invited in for an appointment. The practice provided symptoms training for its staff and put up a poster in its reception area to raise patient's awareness.

Overview of safety systems and processes

There were gaps in systems, processes and practices to keep patients safe:

- Records showed there were multiple laboratory test results that had not been checked or actioned since and many were abnormal. We raised concerns about this with GPs and the need to implement an effective system without delay. GPs told us the results had not been checked due to one of the partners being away and began checking the results immediately. After inspection the practice sent us a new protocol but there was no clear scheme of delegation to cover the absent GP or method to verify or assure patients results are checked. There was no indication of a date or plan for review/ evaluation of the new arrangement. We discussed this with the London team from NHS England who will be following this up with the provider. The practice subsequently sent us evidence they had taken necessary action in response to applicable test results and not compromised patient care. The practice also highlighted problems with systems for GP practices receiving patients laboratory tests in the local area such as receiving duplicated of patients laboratory test results, and demonstrating the practice had made efforts to address this. However, the practices' systems for managing patients laboratory test results were not sufficiently formalised with clear lines of accountability and so they did not assure patients safety.
- Arrangements were 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 clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. There was a lead member of staff for safeguarding. The GPs attended safeguarding meetings when possible and always provided reports where necessary for other agencies. Staff demonstrated they understood their responsibilities 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 3, nurses to level 2 and non-clinical staff to level 1 or 2.
- A notice in the waiting room advised patients that chaperones were available if required. Staff who acted as chaperones were trained for the role and had 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). The practice had a chaperone policy that was reviewed in March 2016 and stated clinicians would record in the patient notes when a chaperone is present, but it did not indicate the need to record when a chaperone is offered. The

provider told us chaperones were offered but were unable to confirm this on records, for example to accompany an intimate examination. Staff told us they had offered patient's a chaperone but had not recorded it.

- The practice generally maintained appropriate standards of premises cleanliness and hygiene. It was mostly clean and tidy but carpets in clinical rooms were visibly worn and stained and there was a ceiling tile in the minor surgery room that was also visibly stained and potentially materially damaged following water leakage from the floor above. Staff told us they approached the landlord to make repairs and improvements but no action had been taken. The practice applied for a grant in August 2015 to replace its carpets and improve its telephone system but the application had been declined. There was no evidence of cleaning of clinical equipment such as the ear irrigator, staff told us it was cleaned after use but not documented.
- There were out of date syringes within the practice storage cupboard that expired in 2008 and needles that expired in 2014. We asked staff about systems to ensure items in the cupboard remained in date and they told us there was a designated staff member responsible for this task but no log of checks was kept. There was no list or organisational structure at the practice to indicate this responsibility or any other staff delegated responsibilities. However, we checked needles and syringes that were ready for use in clinical rooms across the practice and all were in date.
- The practice nurse was the infection control clinical lead but had been away intermittently for several months. A locum nurse had been recruited to cover the practices nurses' role and the practice manager maintained annual infection control audits in the absence of the regular practice nurse. We saw evidence that action was taken to address any improvements identified as a result of the infection control audit. There was a protocol in place and staff had received up to date training.
- Most arrangements for managing medicines, including emergency medicines and vaccines, in the practice kept patients safe (including obtaining, prescribing, recording, handling, storing, security and disposal). Processes were in place for handling repeat prescriptions which included the review of high risk medicines. The practice carried out regular medicines audits, with the support of the local CCG pharmacy teams, to ensure prescribing was in line with best practice guidelines for safe prescribing. Blank prescription forms and pads were securely stored and there were systems in place to monitor their use. Health Care Assistants were trained to administer vaccines and medicines against a patient specific prescription or direction (PSD) from a prescriber. A PSD is a written instruction, signed by a doctor, dentist, or non-medical prescriber for medicines to be supplied and/or administered to a named patient after the prescriber has assessed the patient on an individual basis. However, all Patient Group Directions (PGDs) adopted by the practice to allow nurses to administer medicines in line with legislation had expired, the most recent in March 2016. (PGDs are written instructions for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment. Staff told us they were waiting for updated PGDs to be issued).
- We reviewed three personnel files and found appropriate recruitment checks had not always been undertaken prior to employment, including Disclosure and Barring Service (DBS) checks for clinical and non –clinical staff. For example, there was no evidence of an identification check for a member of non-clinical staff or any recruitment checks for a locum GP or locum practice nurse except an itemised list from the nurses referring agency. However, this information had not been verified and there was no recruitment protocol for locum clinicians. There was no system for repeat DBS checks for existing staff including clinicians. For example, a health care assistants' DBS check dated back to 2007 and a GP partners' to 2009. Timescales for repeating DBS checks and the associated risk had not been assessed. GPs were revalidated and clinicians were registered with the appropriate professional body.

Monitoring risks to patients

Risks to patients were generally not assessed or well managed.

- There were no clear lines of responsibility for health and safety. For example, the policy stated overall responsibility was held by the practice partners and a member of management team had day to day responsibility. However, we asked the nominated

manager about health and safety and they told us the practice nurse was responsible for health and safety. The policy template contained prompts to add the names of persons responsible in areas such as first aid, accident reporting and risk assessment but no staff roles or names were indicated.

- There was no premises environmental risk assessment available and the health and safety poster had not been completed to identify local health and safety representatives.
- The practice had a fire risk assessment but staff were unable to establish the date it was carried out. None of the management staff team had any awareness of risks identified or whether or not they had been managed. The fire alarm system had been checked earlier in the month and immediately after inspection the practice sent us a copy of a risk assessment undertaken by the landlord in July 2015. However, some fire risk management actions identified had no dates for completion, and others indicated actions were carried out in 2013 which was in contradiction to the same risks being identified again in July 2015. Management staff did not know about actions that indicated "premises staff" were responsible and could not provide further information during or after inspection. There was a designated and appropriately trained fire marshal but no fire drills had been carried out for at least two years.
- Electrical equipment was not checked to ensure it was safe to use. Some items such as printers were checked in February 2015 and other items checks dated back to 2013 and 2009. Staff immediately arranged for electrical safety testing to be carried out and showed us evidence it was due to take place on 3 November 2016. We followed this up after inspection and the practice subsequently sent us evidence electrical safety testing had been carried out.
- There was no inventory of clinical equipment to cross check it was all working properly, but we checked a sample of items such as a blood pressure monitor and weighing scales and they had been calibrated and were fit for use.
- The practice had a control of substances hazardous to health (COSHH) risk assessment but there were no chemicals safety data sheets available and management staff did not know where the main cleaning cupboard was and could not locate cleaning equipment such as mops. Staff told us a contract cleaner came to do the cleaning and we saw appropriate premises schedules were in place and had been completed.
- A Legionella risk assessment had been undertaken and relevant safety measures were in place such as water sample monitoring (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. There was a rota system in place for all the different staffing groups to ensure enough staff were on duty.

Arrangements to deal with emergencies and major incidents

The practice did not have 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 and staff received annual basic life support training.
- Emergency medicines were secure and easily accessible to staff in a treatment room and all staff knew of their location. The emergency use medicines we checked were in date and stored securely. However, the practice had no emergency use Glucagon or Glucagel (for use in the event of a patient with diabetes very low blood sugar level), GTN spray (for use in the event of chest pain and potential heart attack), or Diazepam (for use in some circumstances in the event of a patients epileptic seizure). There was a system in place to check emergency medicines monthly but it had lapsed, the last record had been made in the month of March with no year recorded. Staff told us the permanent practice nurse was delegated to check emergency use medicines, checks lapsed in their absence, and that a GP had checked them instead. However, there was no evidence of a scheme of delegation or of checks undertaken since "March". The practice obtained some of the missing emergency medicines on the day of inspection and immediately after inspection sent us evidence it had obtained the remainder.
- There was no accident book and the contents of the first aid kit were incomplete or out of date; for example there were no large sterile gauze dressings or eye dressings

and the eye wash solution expired in 2012. Staff told us the first aid kit was shared with another practice within the building and there were no arrangements to check it remained fit for purpose.

- The practice had a defibrillator available on the premises that was also shared with another practice, the defibrillator gave a "low battery" warning and there was no shared agreement or other system to check it remained fit for use. Immediately after inspection the practice sent us evidence it had obtained new defibrillator batteries and had commenced a shared agreement checking system to ensure the defibrillator remained fit for use, but it did not include a plan to review or evaluate the new system for effectiveness. The practice had its own emergency use oxygen available but not all masks were sealed and there were no paediatric masks or checks to ensure oxygen remained fit for use. After inspection the practice sent us evidence it had immediately obtained paediatric masks and commenced a checklist for the oxygen.
- The practice had a comprehensive business continuity plan in place for major incidents such as power failure or building damage. The plan included emergency contact numbers for senior staff but there were no contact numbers recorded for most of the staff team to ensure effective communication in the event of an emergency.

Requires improvement

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice 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.

- The practice had systems in place to keep all clinical staff up to date. Staff had access to guidelines from NICE and used this information to deliver care and treatment that met patients' needs.
- The practice monitored that these guidelines were followed through audits.

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 were 94% of the total number of points available (compared to 96% with the CCG and 95% nationally), with 11% exception reporting (compared to 8% within the CCG and 9% nationally).

We checked exception reporting rates in more detail to establish the reasons for the practices slightly higher rate. Exception reporting for atrial fibrillation was 28% (compared to 20% within the CCG and 11% nationally), coronary heart disease was 17% (compared to 9% within the CCG and 8% nationally), heart failure was 13% (compared to 7% within the CCG and 9% nationally), peripheral arterial disease was 16% (compared to 6% within the CCG and nationally), stroke and transient ischaemic attack was 21% (compared to 11% within the CCG and 10% nationally).

Data from 1 April 2014 to 31 March 2015 showed the practice was an outlier for QOF clinical target:

- The percentage of patients with diabetes, on the register, who had an influenza immunisation between 1 April 2014 and 31 March 2015 was 81%, which was below 93% within the CCG and 94% nationally. Staff told us there had been a service redesign in the local area that had resulted in other providers administering influenza immunisations to its patients, and many on its list declined the vaccine for religious reasons and that they had taken steps to raise awareness monitor the results. The most recent data held at the practice showed the percentage of patients with diabetes, on the register, who had an influenza immunisation between 1 April 2015 and 31 March 2016 had increased by 6% on the previous year to 87%. The target was 95%.

Data showed the practice was an outlier for an NHS Business Services Authority (NHSBSA) prescribing target relative to the CCG average between 1 July 2014 and 30 June 2015:

- Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit was 0.48 compared to 0.2 which indicated possible over prescribing of hypnotic medicines. However, the practice showed us evidence it was participating in a Quality, Innovation, Productivity and Prevention (QIPP) initiative with a local pharmacy team to improve in this area. (QIPP is a national, regional and local level programme designed to support clinical teams and NHS organisations to improve the quality of care they deliver while making efficiency savings that can be reinvested into the NHS).

There was no further evidence of the practice attempting to understand or improve its exception reporting rates.

The practice was not an outlier for any other QOF (or other national) clinical targets. Data from 2014 - 2015 showed:

- Performance for diabetes related indicators was above national averages. For example, the percentage of patients on the diabetes register with a record of a foot examination and risk classification within the preceding 12 months was 99% compared with the national average of 88%. Over all exception reporting for diabetes indicators was 12% compared 9% within the CCG and 11% nationally.
- The percentage of patients with hypertension having regular blood pressure tests was 86%, which is similar to national average of 84%. Overall exception reporting for hypertension was 8% (compared to 4% both within the CCG and nationally)
- Performance for mental health related indicators was similar to the national average. For example, the percentage of patients diagnosed with a mental health condition who had a comprehensive, agreed care plan documented in the record in the preceding 12 months

was 77% compared with a national average of 88%. Exception reporting for dementia was 14% (compared to 4% within the CCG and 8% nationally), and exception reporting for depression was 40% (compared to 29% within the CCG and 25% nationally).

There was evidence of quality improvement including clinical audit.

- There had been 10 clinical audits undertaken in the last two years, two of these were completed audits where the improvements made were implemented and monitored. For example, the practice undertook an audit to reduce overprescribing of medicines used to control blood sugar level for people with diabetes in line with NICE best practice guidelines. In the first audit cycle the practice analysed 30 patients prescribed multiple medicines for diabetes management, this was 100% of patients in the first cycle. It identified criteria for reviewing patients with diabetes medicines and implemented 5 elements of specific GP guidance to improve and reduce prescribing for this group of patients. In the second cycle prescribing for 17 patients prescribed multiple medicines for diabetes management was checked and seven of the 10 patients had medicines reduced. This represented a 41% reduction of overprescribing of medicines for patients with diabetes in line with best practice guidelines.
- The practice participated in peer review and local audits and benchmarking. Findings were used by the practice to reduce over use and inappropriate use of antibiotics in order to reduce the spread of antimicrobial resistance.

Effective staffing

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

- The practice had an induction programme for all newly appointed staff. This covered such topics as fire safety, health and safety and confidentiality but did not cover safeguarding or infection prevention and control. We checked the most recently recruited non-clinical staff file and found they had subsequently undertaken both safeguarding and infection control training. However, there was no induction protocol for locum clinicians such as GPs or practice nurses or evidence this had been carried out.
- The practice could demonstrate how they ensured role-specific training and updating for relevant staff. For example, for those reviewing patients with long-term conditions.
- 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 and discussion at practice meetings.
- The learning needs of staff were identified through a system of appraisals and practice meetings. Staff had access to appropriate training to meet their learning needs and to cover the scope of their work. This included ongoing support, one-to-one meetings, clinical supervision and facilitation and support for revalidating GPs. 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 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. However, not all arrangements ensured effective patient follow up:

- Systems for managing patients laboratory test results did not assure patients safety.
- Patient's care plans were in place and appropriately reviewed. For example for people with long term conditions such as diabetes and for people with a mental health condition such as dementia.
- 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

Requires improvement

Are services effective?

(for example, treatment is effective)

referred, or after they were discharged from hospital. Meetings took place with other health care professionals on a monthly basis when care plans were routinely reviewed and updated for patients with complex needs.

Consent to care and treatment

Staff did not seek or record patients' consent to care and treatment in line with legislation and guidance.

- Staff had knowledge of relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005. However, one of the GP partners had no training in this area. We asked for evidence of GPs training and after the inspection the practice sent us evidence this had occurred for one GP but there was no further evidence of relevant training for other GPs or locum practice nursing staff. The health care assistant understood consent and decision-making at a level appropriate to the role and consent had been obtained and recorded for patients receiving a vaccine.
- A GP partner told us patients verbal consent was obtained for procedures such as intimate examinations but this was not recorded in the consultation notes. Staff showed us a blank template for recording patient's written consent for minor surgery. However, there were no completed example forms demonstrating informed consent had been requested, or of verbal consent being recorded. The process for seeking consent was not monitored. After inspection the practice sent us examples of handwritten completed consent forms for minor surgery dating from February 2016 to August 2016, and evidence these forms corresponded to appointments.
- When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance.

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.

The practice's uptake for the cervical screening programme was 81%, which was comparable to the CCG average of 79% and the national average of 82%. Exception reporting was 7% which was the same as within the CCG and comparable to the national average of 6%.

Failsafe systems to ensure results were received for all samples sent for the cervical screening programme and the practice followed up women who were referred as a result of abnormal results had lapsed. No records had been made since 3 May 2016. Staff told us this was due to absence of the regular practice nurse and that patients were signposted to a centre within a local hospital service in their absence, until a new locum nurse started on13 September 2016. Immediately after inspection the practice sent us handwritten records indicating failsafe checks were being made from 13 September 2016 but this did not cover for the period between 4 May and 12 September 2016. We invited the practice to send us further evidence demonstrating failsafes for patients cervical screening between the dates 4 May 2016 to 12 September 2016. However, the information we received did not demonstrate sufficient oversight or operational effectiveness and there was no system in place to ensure appropriate arrangements for cervical screening. For example, it remained unclear how the practice established who had not received a smear and who may need one.

The practice demonstrated how they encouraged uptake of the screening programme by ensuring a female sample taker was available and encouraged its patients to attend national screening programmes for bowel and breast cancer screening.

Childhood immunisation rates were comparable to national averages and ranged from 83% to 90% (ranged from 88% to 95% nationally) for under two year olds; and from 78% to 90% (ranged from 81% to 95% nationally) for five year olds.

Patients had access to appropriate health assessments and checks. These included health checks for new patients and NHS health checks for patients aged 40–74. Appropriate follow-ups 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.

Twenty six of the 29 patient Care Quality Commission comment cards we received were entirely positive about the service experienced. Three had mixed feedback and there were no overlapping themes of concern. Patients said they felt the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect.

We spoke with one member of the patient participation group (PPG). 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 they needed help and provided support when required.

Results from the national GP patient survey published July 2016 generally showed patients felt they were treated with compassion, dignity and respect. However, some results for practice nursing were below average. For example:

- 84% said the GP was good at listening to them compared to the national average of 89%.
- 85% said the GP gave them enough time compared to the national average of 87%.
- 92% said they had confidence and trust in the last GP they saw compared to the national average of 95%.
- 81% said the last GP they spoke to was good at treating them with care and concern compared to the national average of 85%.
- 72% said the last nurse they spoke to was good at treating them with care and concern compared to the national average of 91%.
- 77% said the last nurse they saw or spoke to was good at listening to them compared to the national average of 91%.
- 85% said the last nurse they saw or spoke to was good at giving them enough time compared to the national average of 92%.
- 79% said the last nurse they saw or spoke to was good at explaining tests and treatments compared to the national average of 90%.
- 95% said they had confidence and trust in the last nurse they saw or spoke to compared to the national average of 97%.
- 77% said they found the receptionists at the practice helpful compared to the national average of 87%.

We asked a GP partner and management staff about the lower survey scores for practice nurses that are also reflected in the responsive section of this report. A GP partner was not aware of any action being taken and management staff told us nurses scores had been lower for a number of years. Actions the management team told us were taken demonstrated no efforts to better understand reasons for the lower results or action to address them effectively.

The practice told us telephone calls continued to be answered between 1.00pm and 1.30pm when it closed its internal shutters. However, we found there was a recorded message that only stated "The Gadhvi Surgery is now closed please call back after 1.30". The message was short and abrupt in tone and we had to call back several times to discern what was being said in the recording. We fed this information back to the practice and they denied the message was recorded and told us it was a member of staff. However, this was not the case as the message was identical with the same voice and content and immediately cut off after playing on each of the three occasions we called and there was no indication of any out of hour's arrangement or what to do in an urgent or emergency situation.

Care planning and involvement in decisions about care and treatment

Patients told us they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed

decision about the choice of treatment available to them. Patient feedback from the comment cards we received was also positive and aligned with these views. We also saw that care plans were personalised.

Results from the national GP patient survey showed patients generally responded positively to questions about their involvement in planning and making decisions about their care and treatment. Results were comparable to local and national averages, with the exception of practice nursing scores. For example:

- 82% said the last GP they saw was good at explaining tests and treatments compared to the national average of 86%.
- 75% said the last GP they saw was good at involving them in decisions about their care compared to the national average of 82%.
- 63% said the last nurse they saw was good at involving them in decisions about their care compared to the national average of 85%.

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

- Staff told us that interpreter 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.
- Information leaflets were available in easy read format.

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.

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 31 patients as carers (1% of the practice list). 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 or sent them a sympathy card. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service. The practice kept a register of patients who had died and used it to reflect on how they could improve care for patients at the end of life and patients who had died unexpectedly.

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, it had identified it had a relatively high population of patients with diabetes, one of the GPs was trained to initiate insulin for patients with diabetes where appropriate and the practice held weekly diabetes care clinics.

- The practice did not provide an extended hours service for working patients who could not attend during normal opening hours.
- The practice offered longer appointments for patients with a learning disability and had identified seven on its register, but only three of these patients (43%) had received an annual health check.
- Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice.
- Same day appointments were available for children and those patients with medical problems that required same day consultation.
- The practice had a website and offered online appointment booking and prescription requests through the online national patient access system.
- Patients were able to receive travel vaccines available on the NHS as well as those only available privately such as Yellow Fever.
- There were disabled facilities and interpreter services available. On the day of inspection the practice manager told us they had a hearing loop; however, we could not locate it and reception staff told us they did not have one. Interpreter services included British Sign Language (BSL) interpreters if required.
- One of the GP partners provided education sessions on safe fasting during Ramadan at a local community centre.

Access to the service

The practices opening hours were between 9:00am to 6.30pm every weekday except Thursday when it is open 9.00am to 1.00pm. GP appointments were available 9.30am to 11.00am, with telephone consultations from 11.00am to 12.00pm, and then GP appointments resumed 3.30pm to 5.30pm every weekday except Thursday when the last appointment was at 11.00am. Appointments included home visits and urgent appointments for patients who need them. The practice closed its internal shutters between 1.00pm and 1.30pm and told us telephone calls continued to be answered during this time; however, we found this was not the case. The practice did not provide an extended hours service. Patients telephoning when the practice was closed were transferred automatically to the local out-of-hours service provider until 8.00am. Staff told us that between the hours of 8.00am and 9.00am the out-of-hours service provider contacted the practice duty doctor with details of patients that needed care.

Results from the national GP patient survey showed that patient's satisfaction with how they could access care and treatment were below national averages:

- 61% of patients were satisfied with the practice's opening hours compared to the national average of 79%.
- 45% of patients said they could get through easily to the practice by phone compared to the national average of 73%.

The practice noted its low GP patient survey results in relation to telephone access and had contacted the landlord and service contract holder to make improvements, staff told us this had not been possible. The practice applied for a grant in August 2015 to improve its telephone system which was declined. The practice showed us evidence it had booked an independent contractor for 8 November 2016 to get a telephone access improvement plan and quote, and it had increased reception staffing capacity to answer more calls. A GP partner told us there were no plans to provide an extended hours service. There was no evidence of any further consideration or action to address patient's dissatisfaction with opening hours or telephone access.

The seven patients we spoke to on the day of the inspection told us 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.

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

- Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England.
- The practice manager was the designated lead who handled all complaints in the practice and one of the GP partners had overall responsibility.
- We saw that information was available to help patients understand the complaints system such as a complaints poster.

We looked at four complaints received in the last 12 months, two in detail and found these were dealt with satisfactorily in a timely way and with openness when dealing with the complaint. Lessons were learnt from individual concerns and complaints and also from analysis of trends; action was taken to as a result to improve the quality of care. For example, the practice contacted a patient who had complained about a member of reception staff. The practice apologised to the patient and the complaint was investigated. Meetings were held with the relevant staff and wider team and training was implemented to ensure staff awareness of practice policy. Outcomes were monitored by relevant staff.

Are services well-led?

Inadequate

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

Our findings

The delivery of high-quality care was not assured by leadership or governance arrangements.

Vision and strategy

- The practice did not have a mission statement, forward vision or strategy.
- Staff at all levels told us the values of the practice were to be caring and put patients first, but this was not evident when we raised concerns about care for patients when the practice shutters were closed.

Governance arrangements

The practice had no overarching governance framework to support the effective delivery of care and day to day operations.

- Staff were mostly aware of their own roles and responsibilities but there was a lack of clarity, structure or cover arrangements for safety critical areas. For example to ensure prompt attention to patient's laboratory test results, and arrangements for ensuring equipment, including clinical equipment remained safe and fit for use.
- Practice specific policies were available but had gaps or were not implemented such as health and safety, recruitment, and chaperoning.
- An understanding of the performance of the practice was maintained. However, the practice failed to implement actions to improve areas of concern.
- A programme of continuous clinical audit was used to monitor quality and to make improvements. However, there was no evidence of the practice attempting to further understand or improve its exception reporting rates.
- Premises issues such as dirty carpets in clinical rooms had not been dealt with.

Leadership and culture

On the day of inspection the partners in the practice told us they prioritised safe, high quality and compassionate care. However, arrangements for identifying, recording and managing risks or issues and implementing mitigating actions were not effective in fundamental areas such as failsafe systems for patient's cervical screening, fire safety, first aid, and in the event of a medical emergency.

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 partners encouraged a culture of openness and honesty and 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 no clear leadership structure in place but staff felt supported by management and told us the partners were approachable and always took the time to listen.

- Staff told us the practice held regular team meetings and we saw evidence this was the case.
- Staff told us there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and felt confident and supported in doing so. We noted regular team social events were held.
- Staff said they felt respected, valued and supported, particularly by the partners in the practice. Staff were involved in discussions about how to run and develop the practice, and the partners encouraged them to identify opportunities to improve the service delivered. For example, the practice improved its repeat prescriptions process as a result of feedback from staff.

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

The practice encouraged feedback from patients and staff but had not taken effective action to improve lower GP patient survey results relating to patient access and practice nursing care.

- The practice had recognised its low GP patient survey results and contacted the landlord contract holder to make improvements which had not been possible. It had also increased reception staffing capacity to answer more calls and made an appointment for 11 November 2016 for an independent telephone services contractor to attend and provide an improvement plan and quote. However, these actions did not demonstrate sufficient progress or impact to improve patient's outcomes.
- The practice had gathered feedback from patients through the patient participation group (PPG) and

Are services well-led?

Inadequate

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

through surveys and complaints received. The PPG met regularly and submitted proposals for improvements to the practice management team. The practice changed its website to make it more user friendly and installed a TV patient's information screen in the reception area in response feedback form the PPG.

- The practice had gathered feedback from staff through social events, staff meetings, appraisals and generally through day to day discussion. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management and felt involved and engaged to improve how the practice was run.

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 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance There was no process for significant events identification or management. There was no system to ensure items such as needles and syringes or the first aid kit remained fit for use. Operational arrangements for recording chaperoning were ineffective. Organisational structures were absent or unclear, including no clear lines of responsibility for health and safety and governance arrangements were incomplete. There was no inventory of clinical equipment or electrical equipment to cross check it was all working properly or system to ensure electrical safety testing was carried out. The system in place to check emergency medicines and equipment was ineffective. Fire safety and COSHH arrangements were insufficient or unknown to staff. Failsafe systems for patient's cervical cytology results had lapsed. The provider did not act on feedback from relevant persons effectively for the purposes of continually evaluating and improving such services. This was in breach of regulation 17 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Diagnostic and screening procedures	Regulation 18 HSCA (RA) Regulations 2014 Staffing

This section is primarily information for the provider

Requirement notices

Family planning services Maternity and midwifery services Treatment of disease, disorder or injury	There were gaps in staff induction and training. This was in breach of regulation 18 (2) 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 19 HSCA (RA) Regulations 2014 Fit and proper persons employed The provider had failed to make available all the information required in respect of persons employed or appointed for the purposes of a regulated activity, as set out in Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was in breach of Regulation 19 (3)(a) 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 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider did not do all that was reasonably practicable to assess and mitigate risks to the health and safety of service users. Systems for managing patients laboratory test results did not assure patients safety. Premises and equipment was not adequately cleaned or maintained. The contents of first aid kit were incomplete or had expired. Patient Group Directions (PGDs) were not in place to allow nurses to administer medicines in line with legislation.

This section is primarily information for the provider

Requirement notices

This was in breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.