Dr Steven Nimmo

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?	Good
Are services responsive to people's needs?	Requires improvement
Are services well-led?	Inadequate

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Dr Steven Nimmo (Barton Surgery) on Wednesday 29 April 2015.

Overall the practice is rated as inadequate.

Specifically, we found the practice to be good for providing caring services, requires improvement for effective and responsive services and inadequate in providing safe and well led services. Whilst patients were received a caring service the shortfalls in some aspects of safety, and the lack of communication, leadership, and quality monitoring have meant that the ratings for the population groups are also inadequate.

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Although the practice carried out investigations when things went wrong, the process followed was not systematic and did not always follow the practice policy. The lessons learnt were not always documented or communicated to all staff and so safety was not improved.
- Clinical risks to patients were assessed and well managed.
- Patients were at risk of harm because systems and processes were not in place to keep them safe. For example appropriate recruitment checks on staff had not been undertaken prior to their employment.
- Infection control procedures did not protect patients from risk. There had not been an infection control audit performed at the practice in the last five years
- Data showed patient outcomes were average for the locality. Although some clinical audits had been carried out, evidence did not always show that audits were driving improvement in performance to improve patient outcomes.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.

Summary of findings

- Staff worked with multidisciplinary teams although this was on an informal basis as and when the GP needed to discuss individual patients with health care professionals.
- Information about services and how to complain was available and easy to understand.
- Urgent appointments were usually available on the day they were requested. However patients said that they sometimes had to wait a long time for non-urgent appointments.
- The practice had a number of policies and procedures to govern activity, but these were over five years old and had not been reviewed since.
- The practice did not hold systematic governance meetings. Issues were discussed when an issue happened.
- The practice did not proactively seek feedback from staff or patients.

There were areas of practice where the provider needs to make improvements.

Action the provider MUST take to improve:

- There must be proper and safe management of medicines including: consistent monitoring and recording fridge temperatures on a daily basis; keeping medicines policies under review, ensuring all patient group directives are signed by the staff using them, and ensuring staff are aware of and follow the system to record when blank prescription printer forms are taken from the secure storage to GP consulting rooms to show the whereabouts of these forms.
- Assess the risk and prevent, detect and control the spread of infections, including those that are health care associated by ensuring comprehensive infection control guidance and policies are available for staff, and by auditing infection control to assess the risks and to demonstrate they are mitigating any such risks where reasonably practicable.
- Ensure that systems are in place to ensure the equipment used by the service provider for providing care or treatment to a patient is safe for such use and is used in a safe way:

- A system must be in place to ensure all clinical equipment is checked and portable appliance testing carried out (PAT) where appropriate.

-Introduce records to confirm the emergency equipment is checked regularly.

- Emergency equipment must also be checked regularly to ensure it is ready for use in an emergency.

- Establish and operate recruitment procedures to ensure that all required information regarding pre-employment checks is recorded and kept.
- Establish systems or processes to assess, monitor and improve the quality and safety of the services provided.
- Perform an annual or more frequent patient survey to ascertain experience of patients.
- Ensure that significant events and complaints are effectively managed and recorded. Identify any trends and risks to patients and demonstrate learning and action taken. Review all policies and procedures annually or more frequently to enable staff to have up to date and current guidance to follow.

Action the provider SHOULD take to improve:

- Ensure patients are aware of the chaperone service.
- Consider having regular scheduled meetings with staff at the practice and the multidisciplinary team to discuss vulnerable patients and end of life care patients.
- Ensure all staff have an awareness of their roles in relation to the Mental Capacity Act (MCA).
- Consider ways of improving communication amongst staff.

I am placing the service into 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 vary the provider's

Summary of findings

registration to remove this location or cancel the provider's registration. Special measures will give people who use the service the reassurance that the care they get should improve.

Professor Steve Field (CBE FRCP FFPH FRCGP)
Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Inadequate

The practice is rated as inadequate for providing safe services and improvements must be made.

Staff were clear about reporting incidents, near misses and concerns. However, although the practice carried out investigations when things went wrong, the process followed was not systematic and did not always follow the practice policy. Management staff were able to describe the lessons learnt but these were not always documented or communicated to all staff.

Clinical risks to patients who used services were assessed.

There were not proper and safe management of medicines at the practice. The consistent monitoring and recording fridge temperatures had not been consistently performed on a daily basis. Medicines policies had not been kept under review on an annual basis and not all patient group directives had been signed by the staff using them. Staff were not using or aware of a system to record when blank prescription printer forms were taken from the secure storage to GP consulting rooms.

The practice had effective procedures for managing emergencies, however, checks of emergency equipment was not always recorded.

Are services effective?

Requires improvement

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

Data showed patient outcomes for health promotion and screening were average for the locality. The practice were consistently performing adequately with childhood and seasonal flu vaccines, cervical screening and smoking cessation.

Staff referred to guidance from National Institute for Health and Care Excellence (NICE) and used this guidance routinely. Patient's needs were assessed and care was effectively and efficiently planned and delivered in line with current legislation. This included the management of patients with long term conditions and promoting good health.

Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. Staff worked with multidisciplinary teams although this was on an informal basis.

Are services caring?

Good

The practice is rated as good for providing caring services.

Summary of findings

Data showed that patients rated the practice for several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information to help patients understand the services available was easy to understand. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Feedback from patients about the reception staff was consistently good. Patients said the process for obtaining repeat prescriptions was effective.

Patients were complimentary about the clinical care they received and said that staff listened well.

Are services responsive to people's needs?

Requires improvement

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

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.

Patients said they found it easy to make an emergency appointment with a GP and said that there was continuity of care. However, patients also said there was a delay getting through on the telephone at times and also when trying to make a routine appointment with a GP of their choice.

The practice facilities were not always suitable for the needs of patients and were not always well equipped to treat patients and meet their health needs. The practice had not acted upon risk assessments regarding the environment.

Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. However, the process for monitoring complaints was not always systematic. The practice learnt from complaints and from feedback with staff and other stakeholders.

Are services well-led?

Inadequate

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

The practice did not have a vision and a strategy but the GP said the practice aimed to be 'small and family friendly'. However, staff we spoke with were not clear about this or their responsibilities in relation to this.

The practice had a small number of staff working. The GP was not present at the practice for two days of the week. The salaried GP was present on these days. The practice manager role was part time but

she worked in a different role at the practice and was present each day. Staff said there was difficulty in holding regular staff meetings as staff working days did not overlap. Staff were not aware of the lines of responsibility for medicines management, management of emergency equipment or infection control at the practice. The systems and processes to address some risks within the practice were not implemented well enough to ensure patients were kept safe. For example, recruitment records for staff did not demonstrate that pre-employment checks had been performed. Infection prevention processes were not being followed and the management of equipment required improvements.

Staff told us the practice held governance meetings as and when any event occurred. Any staff issues could be discussed if listed as agenda items prior to the meeting but staff said they could raise any issues as they arose.

Systems were not in place to record and monitor that checks of emergency equipment had taken place.

The practice had a number of policies and procedures to govern activity, but many of had not been reviewed for a number of years. The practice had a suggestion box but had not proactively sought formal feedback from staff or patients. The practice had just set up a patient participation group (PPG). Not all staff had received regular performance reviews and did not have clear learning objectives.

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 for well-led and requires improvement for effective and responsive. The concerns which led to these ratings apply to everyone using the practice, including this population group.

Patients aged 75 and over had an allocated GP but also the choice of seeing the other GP if they preferred.

Pneumococcal vaccination and shingles vaccinations were provided at the practice for older people.

The practice maintained a register of 'at risk' patients and made sure each person had a care plan which is reviewed regularly.

The practice was signed up to the avoiding unnecessary admissions to hospital enhanced service and worked with other health care professionals to provide joint working. Unplanned admissions to hospital were reviewed monthly to identify any gaps in care and treatment or areas for service improvement. The practice worked with the community nurses to follow up hospital discharge to ensure all needs were met. The practice had access to a rapid response service and single point of access for referral to specialist services.

The practice provided care to four local care homes for older people and worked with them to ensure new patients had appropriate health and medication reviews and treatment escalation plans in place.

There is level access to the practice and all consultation rooms are on the ground floor. The practice offered home visits to patients who had difficulty with mobility or medical issues.

People with long term conditions

Inadequate

The provider was rated as inadequate for safety and for well-led and requires improvement for effective and responsive. The concerns which led to these ratings apply to everyone using the practice, including this population group.

The practice maintained a register of all patients with long term conditions and had computer prompts via the computer system to remind staff to book additional screening as required.

The practice had a lead GP and nurse for each clinical area and developed clinical protocols to ensure best practice was followed.

Summary of findings

Patients with long term conditions were invited to attend the practice for an annual check. Patients were offered flu, shingles, and pneumococcal vaccinations. Receptionists had been trained to identify these patients and carers opportunistically and arrange appointments to meet all their needs in one visit.

The practice offered nurse led clinics for diabetes, cardiovascular disease, asthma and Chronic Obstructive Pulmonary Disease. These clinics were overseen by a GP.

The practice referred housebound patients to the community nursing team for follow up of their long term condition as appropriate.

There were systems in place to identify patients who were carers. These carers were offered health checks.

The GPs met or spoke with the community and Macmillan nurses to review palliative care patients as appropriate.

GPs contacted patients following bereavement of their relatives to offer support and ensure emotional needs were met.

Families, children and young people

Inadequate

The provider was rated as inadequate for safety and for well-led and requires improvement for effective and responsive. The concerns which led to these ratings apply to everyone using the practice, including this population group.

Appropriate systems were in place to help safeguard children or young people who may be vulnerable or at risk of abuse. Safeguarding was a standing item on the agenda for any clinical meetings. At risk families, children and young people were flagged on the computer system and families were encouraged to register with the same GP.

Receptionists had been given authority to automatically book children in for a face-to-face appointment with a GP without the need for triage as appropriate.

The Health Visitors had full access to the medical records and direct access to the GPs for urgent matters when they visited the practice. The midwife held weekly clinics at the practice and had access to the patients' computerised notes and could speak with a GP should the need arise.

The practice offered childhood immunisations and contacted patients and liaised with the health visitor regarding non-attenders as appropriate.

Summary of findings

Patients had access to contraception services and sexual health screening including chlamydia testing and cervical screening. Coils and implants were done by the local Family Planning Clinic. There were designated gynaecological appointments available as appropriate.

The waiting room had a dedicated children's play area.

Working age people (including those recently retired and students)

Inadequate

The provider was rated as inadequate for safety and for well-led and requires improvement for effective and responsive. The concerns which led to these ratings apply to everyone using the practice, including this population group.

Routine appointments were bookable up to 6 weeks in advance and appointments were available before 9am and after 5pm by appointment, although patients said it was sometimes difficult to book these appointments. The practice offered telephone consultations to any telephone number provided by the patient within the UK.

Patients could book appointments and request repeat prescriptions through the website. Prescription requests could be transferred electronically to a pharmacy of the patient's choice. Adequate supplies of medication were provided for holiday and business trips.

People whose circumstances may make them vulnerable

Inadequate

The provider was rated as inadequate for safety and for well-led and requires improvement for effective and responsive. The concerns which led to these ratings apply to everyone using the practice, including this population group.

All patients were registered with a named GP to encourage continuity of care. If appropriate the computer system flagged concerns regarding vulnerable patients. The practice maintained a register of its top 2% of 'at risk' patients. These patients had care plans in place and were reviewed as appropriate.

The practice worked with the district nurses and health visitors. These health care professionals had access to the patient medical records. The practice had access to a rapid response service for vulnerable patients to prevent hospital admission.

Patients with learning disabilities were offered a health check every year during which their long term care plans are discussed with the patient and their carer if appropriate.

Summary of findings

Systems were in place for the practice to alert the out of hours service of vulnerable patients with a 'special message' (a way of electronically passing relevant information to emergency and out of hours staff).

People experiencing poor mental health (including people with dementia)

Inadequate

The provider was rated as inadequate for safety and for well-led and requires improvement for effective and responsive. The concerns which led to these ratings apply to everyone using the practice, including this population group.

The practice maintained a register for patients with mental health and dementia. Annual mental health reviews were offered to patients with long term mental illness.

Patients with chronic diseases were screened and asked about underlying depression.

Patients were encouraged to book double appointments if appropriate to give time for effective conversation.

The practice had access to a local Crisis Team and Depression and Anxiety Service and liaised with healthcare professionals as appropriate. The GPs refer patients to an online cognitive behavioural therapy service (or mindfulness meditation). Cognitive behavioural therapy (CBT) is a talking therapy that can be used to treat anxiety and depression, but can be useful for other mental and physical health problems.

Summary of findings

What people who use the service say

We spoke with 13 patients during our inspection.

The practice had provided patients with information about the Care Quality Commission prior to the inspection. Our comment box was displayed and comment cards had been made available for patients to share their experience with us. We collected two comment cards. There were no negative comments. Positive comments from our discussions with patients indicated that patients appreciated the caring staff, excellent care and appointment system. Patients made reference to the good care they received, the dignity and respect they were shown and praised the staff who listened and provided thorough treatment and care.

These findings were reflected when we looked at the practice's 187 friends and family test results from December 2014 to March 2015.

Of the 187 friends and family test results a monthly average of 77% patients said they were extremely likely, or likely to, recommend the practice. There were many positive comments to support these findings. The remaining 23% of respondents stated they were neither likely nor unlikely to recommend their practice.

Patients said they could either book routine appointments six weeks in advance or could make an appointment on the day. Three patients said waiting to get through on the phone was time consuming. Another three patients said booking an appointment with their choice of a GP was sometimes difficult because the GPs worked part time hours. All 13 patients we spoke with said they could get a same day appointment and that children were seen on the same day.

Patients knew how to contact services out of hours and said information at the practice was good. Patients knew how to make a complaint. None of the patients we spoke with had done so but all agreed that they felt any problems would be managed well. Patients said they felt listened to and felt confident the practice would listen and act on complaints.

Patients commented on the building always being clean and well maintained but that the practice could do with a 'spruce up'. Patients told us staff respected their privacy, dignity and used gloves and aprons where needed and washed their hands before treatment was provided.

Patients said they found it easy to get repeat prescriptions processed. Patients said this was done by depositing the request in the box at reception, by telephone, auto-renewal on-line. The usual time delay was one to two days.

Areas for improvement

Action the service MUST take to improve

- There must be proper and safe management of medicines including: consistent monitoring and recording fridge temperatures on a daily basis; keeping medicines policies under review, ensuring all patient group directives are signed by the staff using them and ensuring staff are aware of and follow the system to record when blank prescription printer forms are taken from the secure storage to GP consulting rooms to show the whereabouts of these forms.
- Assess the risk and prevent, detect and control the spread of infections, including those that are health care associated by ensuring comprehensive infection control guidance and policies are available for staff, and by auditing infection control to assess the risks and to demonstrate they are mitigating any such risks where reasonably practicable.
- Ensure that systems are in place to ensure the equipment used by the service provider for providing care or treatment to a patient is safe for such use and is used in a safe way:

- All clinical equipment must be calibrated and portable appliance testing carried out (PAT) where appropriate.

-Introduce records to confirm the emergency equipment is checked regularly.

Summary of findings

- Emergency equipment must also be checked regularly to ensure it is ready for use in an emergency.

- Establish and operate recruitment procedures to ensure that all required information regarding pre-employment checks is recorded and kept.
- Establish systems or processes to assess, monitor and improve the quality and safety of the services provided.
- Perform an annual or more frequent patient survey to ascertain experience of patients.
- Ensure that significant events and complaints are effectively managed and recorded. Identify any trends and risks to patients and demonstrate learning and action taken. Review all policies and procedures annually or more frequently to enable staff to have up to date and current guidance to follow.

Action the service SHOULD take to improve

- Ensure patients are aware of the chaperone service and introduce a chaperone policy.
- Consider having regular scheduled meetings with staff at the practice and the multidisciplinary team to discuss vulnerable patients and end of life care patients.
- Ensure all staff have an awareness of their roles in relation to the Mental Capacity Act (MCA).
- Consider ways of improving communication amongst staff.
- Ensure staff have access to up to date policies to conduct their roles safely and effectively.

Dr Steven Nimmo

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC lead inspector. The team also included a GP specialist advisor, a practice nurse specialist advisor and an expert by experience. Experts by Experience are people who have experience of using care services.

Background to Dr Steven Nimmo

Dr Steven Nimmo (Barton Surgery) was inspected on Wednesday 29 April 2015. This was a comprehensive inspection.

Barton Surgery in the town of Plymstock, Plymouth. The practice provides a primary medical service to approximately 3,100 patients of a diverse age group.

This is a single handed practice. (A practice with one GP who held managerial and financial responsibility for running the business.) The GP was supported by a salaried GP. There are one male and one female GP. Both GPs cover 14 sessions. A further GP is being recruited to work an additional 3 sessions. The GPs are supported by a practice manager. There are four practice nurses who collectively work the equivalent of 1.09 full time hours. The nursing team are supported by one health care assistant. The clinical team are supported by additional reception, secretarial and administration staff.

Patients using the practice also had access to community staff including community matron, district nurses, community psychiatric nurses, health visitors, physiotherapists, speech therapists, counsellors, podiatrists and midwives.

The practice is open from Monday to Friday, between the hours of 8.00am and 6.30pm. Appointments can be booked up to six weeks in advance and take place between 8.30am and 5.30pm. Outside of these times the GPs make telephone calls and see patients that have been triaged. The practice offered extended appointments on Thursday evenings on request.

The practice had opted out of providing out-of-hours services to their own patients and referred them to another out of hours service.

Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

How we carried out this inspection

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

Detailed findings

• Is it safe?

• Is it effective?

• Is it caring?

• Is it responsive to people's needs?

• Is it well-led?

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

• Older people

• People with long-term conditions

• Families, children and young people

• The 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)

Before conducting our announced inspection of Dr Steven Nimmo (Barton Surgery), we reviewed a range of information we held about the service and asked other organisations to share what they knew about the service. Organisations included the local Healthwatch, NHS England, and the local NEW Devon Clinical Commissioning Group.

We requested information and documentation from the provider which was made available to us either before, during or 48 hours after the inspection.

We carried out our announced visit on Wednesday 29 April 2015. We spoke with 13 patients, a member of the patient participation group, one GP, three of the nursing team and four members of the management, reception and administration team. We collected 2 patient responses from our comments box which had been displayed in the waiting room. We observed how the practice was run and looked at the facilities and the information available to patients.

We looked at documentation that related to the management of the practice and anonymised patient records in order to see the processes followed by the staff.

We observed staff interactions with other staff and with patients and made observations throughout the internal and external areas of the building.

Inadequate

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. Staff explained they would report the issue and would complete a document which was then managed by the GPs and practice manager for action. This was then reviewed at the clinical governance meetings which were held when a situation arose.

Learning and improvement from safety incidents

We were told the last significant event had taken place in 2012 regarding an attempted suicide. The practice manager told us there was a system in place for reporting, recording and monitoring significant events, incidents and accidents. However, it was not always clear from documents how these were managed. For example, the policy stated the threshold for managing events but one incident we saw from 2014 should have been managed as part of the significant event process but had been managed and recorded as a complaint. This was a communication error between a care home, district nurse and the practice fell under the practice policy for significant events as a communication failure. This was then recorded and managed as a complaint relating to the district nurses and not taken any further. We asked to see safety records, incident reports and minutes of meetings where significant events were discussed. Not all significant event records clearly showed what learning and actions had taken place. However, we also saw examples where documents showed how the practice had actioned these and had learnt from them. Examples included where communication errors had been highlighted regarding repeat prescriptions. Records showed the practice had introduced a communication book for the practice and pharmacy and had organised monthly meetings to reduce any errors being made. There was no overall summary of such events to monitor trends.

Significant events were a standing item at any clinical governance meetings held or at clinical meetings. Staff said these were not held on a regular basis but minutes were sent if they missed these meetings. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings.

National patient safety alerts were disseminated by the practice manager or GPs to practice staff by email or memo.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. Staff knew how to recognise signs of abuse, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. The majority of staff said this would include discussing and reporting to their line manager. Contact details were accessible using the policies in the practice although some out of date information was stored alongside the correct information.

The GP was the lead GP in safeguarding vulnerable adults and children, although not all staff were aware of this. They had been trained and could demonstrate they had the necessary training to enable them to fulfil this role. GPs had attended level three training and nursing staff had attended level two training. This met current practice.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments; for example children subject to child protection plans or information about vulnerable patients.

There was a chaperone policy which had been reviewed in 2013. There was a poster on the waiting room wall, but patients told us they were unaware of they could request a chaperone, although three patients said if an intimate examination was being performed, the nursing staff were automatically asked to chaperone. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). Nursing staff, including health care assistants acted as chaperones when required.

Medicines management

Inadequate

Are services safe?

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were not stored securely. For example, medicines were kept in a basket in the treatment room alongside emergency medicines. The practice had just introduced a system for checking that these medicines were within their expiry dates. However, these checks did not include checks for emergency equipment. There were refrigerators in the treatment rooms for any items requiring cold-storage. We found the electrical plugs were easily accessible and not labelled to warn staff not to unplug them, thus could be at risk of being unplugged or switched off.

There was a policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. However, this policy had not been reviewed since 2010 and was not being followed by all staff consistently. Practice staff had not always consistently monitored fridge temperatures each day.

Formal processes had been introduced in the last month to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

Clinical Commissioning Group (CCG) data showed that the practice performed appropriately with regard to prescribing. Practice staff used CCG guidance and the Plymouth formulary to ensure they were prescribing within acceptable therapeutic ranges. This system was on the clinical computer system to prompt the GPs when prescribing.

The practice nurses administered vaccines using directions that had been produced in line with legal requirements and national guidance. These directives enabled nursing staff to be able to administer immunisations and vaccines without the need for individual prescriptions. We saw up-to-date copies of directions but noted that all practice nurses had not signed the directive for shingles vaccines despite continuing to administer the vaccines. One nurse had not signed five directives and one nurse had missed three directives. The GP had signed all of these directives.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were securely stored in accordance with national guidance. However, staff were not aware of or were not using the system in place to record when blank prescription printer forms are taken from the secure storage to GP consulting rooms to show the whereabouts of these forms.

Cleanliness and infection control

We observed the premises to be clean and tidy. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control. Patients said staff washed their hands prior to care and treatment being provided.

Nursing staff had received training about infection control specific to their role and received updates. However, not all staff were clear whether there was a lead for infection control or not.

There were policies relating to cleanliness and infection control at the practice but these had not been reviewed in recent years. There was a lack of policies for staff to follow to enable them to plan and implement measures to control infection. For example, there were no clinical cleaning procedures identified, no cleaning policy or cleaning schedules in place. There was no decontamination policy or handling of specimens policy.

Personal protective equipment including disposable gloves, aprons and coverings were available for staff to use. However, reusable nail brushes were sited at sinks which are not considered best practice for use in clinical areas.

There was a flowchart and policy for needle stick injury although evidence was not present to show that these documents had been reviewed to ensure were still current since they were introduced in 2010. However, staff we spoke with knew the procedure to follow in the event of an injury.

Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms.

The practice manager told us she was in the process of organising checks for legionella testing. (Legionella is a bacterium that can grow in contaminated water and can be potentially fatal). There was no policy or risk assessment for this.

Equipment

Inadequate

Are services safe?

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. Nursing staff told us that they thought all clinical equipment was tested and maintained regularly. We saw equipment maintenance records showed that the majority of portable electrical equipment was routinely tested and had last been completed in March 2014. However, we found that some clinical equipment had not been included on the routine calibration and safety checks. For example the defibrillator had not been checked since 2012 and the nebulisers had not been PAT tested. (Safety checks for portable electrical equipment).

Staffing and recruitment

The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. However, this policy had not been updated to reflect the change of regulator of nursing in 2002 (Nursing and Midwifery Council) and had also not been followed when recruiting new staff.

Recruitment records we looked at were disorganised and did not contain evidence that all recruitment checks had been undertaken prior to employment.

All files contained evidence of training certificates. Nurses were registered with the Nursing and Midwifery Council. However, there was no system in place to ensure this information was kept up to date.

All GPs had undergone a criminal record checks through the Disclosure and Barring Service (DBS). One of the nursing team had a DBS check and two of the nursing staff were using DBS checks from other employers. Two of the nursing team and all nine of the administration team had not had a DBS check performed. A risk assessment for this was requested to explain this decision but was not produced at the inspection.

Staff told us there were enough staff on duty to keep patients safe but noted that there had been additional pressure on nursing appointments because of less GP sessions being available on set days of the week.

There were approximately 3100 patients registered at the practice. There GPs worked 14 sessions between them. Staff said there was an above average elderly population. The GP told us there was not high deprivation in the area so workload was not as high as other parts of city. The GP worked at the local acute trust as an occupational health medic on Monday and Friday. The salaried GP was in practice those days. The practice manager explained they were in the process of recruiting another salaried GP to work three sessions per week.

Monitoring safety and responding to risk

The practice had written a health and safety policy in place. Health and safety information was displayed for staff to see. Staff were not clear whether there was a nominated health and safety individual.

The practice had arrangements in place to manage medical emergencies. Records showed that all staff had received training in basic life support. Emergency equipment was available and included access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). When we asked members of staff, they all knew the location of this equipment. There were no records to confirm this equipment was checked regularly.

Emergency medicines were available in a secure area of the practice. Staff were aware where medicines were stored. However, these were stored with other medicines within the practice which could delay locating emergency medicines. Emergency medicines included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. The practice had introduced records in the last month to demonstrate that emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use. However, these were stored with other medicines within the practice which could delay locating emergency medicines.

Arrangements to deal with emergencies and major incidents

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was listed and contained actions recorded to reduce and manage the risk. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to. For example, contact details of a heating company to contact if the heating system failed. The Business Continuity Plan had been reviewed in January 2015.

Inadequate

Are services safe?

The practice had carried out a fire risk assessment and fire alarms were tested weekly. An external fire safety company performed routine fire equipment and fire lighting servicing and had last visited the practice in October 2014.

Requires improvement

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. The staff we spoke with and the evidence we reviewed confirmed that each patient received support to achieve the best health outcome for them. We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate. Staff explained they used these guidelines to influence the care templates they used at the practice.

The nursing team held specialist diabetes, cardiovascular and asthma appointments and were able to access advice from the GP.

The practice used computerised tools to identify patients with complex needs who had multidisciplinary care plans documented in their case notes.

National data showed that the practice was performing in line with other practices in the CCG area for referral rates to secondary and other community care services for all conditions. The GPs used national standards for the referral of patients with suspected cancers referred and seen within two weeks. We spoke with administration staff who explained how this process was monitored.

Discrimination was avoided when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were cared for and treated based on need and the practice took account of patient's age, gender, race and culture as appropriate.

Management, monitoring and improving outcomes for people

The practice showed us two clinical audits that had been undertaken in the last two years and sent a further four audits and medication reviews. These had been completed and had been discussed by the two GPs. Three were completed audits where the practice was able to demonstrate the service they provided was appropriate. For example, audits had been completed on the management of back pain and another on the management of depression in patients with long term conditions. The audit for back pain showed that appropriate treatment was being provided in line with NICE guidance so was not planned to be repeated again. The audit for depression had highlighted poor compliance with asking patients follow up questions. As a result a re-audit had been scheduled to be repeated later in the year.

The GPs told us clinical audits were also linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). (QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). For example, we saw an audit regarding the prescribing of medicines for patients who were taking a medicine used in neuropathic pain, anxiety disorder, and partial epilepsy. Following the audit, the GPs carried out medication reviews for patients who were prescribed these medicines and altered their prescribing practice, in line with the guidelines.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor and improve outcomes for patients. For example, data from 2013-2014 showed that 42.48% of patients on the diabetic register had received a foot examination. We discussed this with the GP who explained the QOF results had prompted a change in nurse appointment scheduling. For the year ending for 2015 the scores were better and the practice had scored 93.5%. In addition scores for mental health monitoring had also increased to 100% from 82.12%. The practice met all the minimum standards for QOF in asthma and chronic obstructive pulmonary disease (lung disease). This practice was not an outlier for any QOF (or other national) clinical targets.

There was a protocol for repeat prescribing which followed national guidance. In line with this, the practice was using a computer system to prompt the nurse practitioner and GPs to ensure the medicines being prescribed according to local guidance. There were systems in place to ensure that patients receiving repeat prescriptions had been reviewed by the GP. There were also systems, checks and computer data which prompted routine health checks were being completed for long-term conditions such as diabetes, asthma and heart disease. The IT system flagged up

Requires improvement

Are services effective?

(for example, treatment is effective)

relevant medicines alerts when the GP was prescribing medicines. We saw evidence to confirm that, after receiving an alert, the GPs had reviewed the use of the medicine in question and, where they continued to prescribe it, outlined the reason why they decided this was necessary. The evidence we saw confirmed that the GPs had oversight and a good understanding of best treatment for each patient's needs.

Blank prescription pads and printer forms were held securely on arrival in the practice, before use. Records were held of forms received. However, systems were not in place to record when the blank printer prescription forms were taken for use, to enable an audit trail to be maintained of the whereabouts of these forms.

The practice spoke with multidisciplinary staff when needed regarding end of life care and there was a palliative care register. Staff said a regular scheduled internal meetings to discuss individual vulnerable patients would be useful.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with mandatory training such as safeguarding and infection control. All staff had received annual basic life support. The GP worked as an occupational health doctor at the local acute hospital trust twice a week. He also takes part in occupational health research, edits an occupational health journal and is an examiner for the faculty of occupational medicine. The GP we spoke with was up to date with their yearly continuing professional development requirements and all either have been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

All staff undertook annual appraisals that identified learning needs from which action plans were documented. Practice nurses were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties. For example, on administration of vaccines, cervical cytology and travel health. Those with extended roles, for example, seeing patients with long-term conditions such as asthma, diabetes and coronary heart disease were also able to demonstrate that they had appropriate training to fulfil these roles.

Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and manage those of patients with complex needs. It received blood test results, X-ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. The practice had systems in place to ensure that the passing on, reading and acting on any issues arising from communications with other care providers on the day they were received took place. All staff we spoke with understood their roles. There were no instances identified within the last year of any results or discharge summaries that were not followed up appropriately.

The practice staff spoke with members of the multi-disciplinary team as and when it was necessary. Staff explained that because of the small numbers of vulnerable patients the GPs and nursing staff spoke with health care professionals as and when was needed rather than having regular formal meetings. Staff spoken to said they thought it would be beneficial to have regular scheduled meetings to discuss vulnerable patients but recognised this may not be practical.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. Electronic systems were also in place for making referrals, managing recalls for cervical screening. The practice used the Choose and Book system. (Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital). Staff reported that this system was easy to use.

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record to coordinate, document and manage patients' care. All staff were fully trained on the system, and

Requires improvement

Are services effective?

(for example, treatment is effective)

commented positively about the system's safety and ease of use. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005 and some, but not all staff had received training for this. The staff were aware of the Children Acts 1989 and 2004 and their duties in fulfilling it. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice. For some specific scenarios where capacity to make decisions was an issue for a patient, the practice had worked with other healthcare professionals, for example with patients with learning disabilities to ensure that decisions about care and treatment choices were made in the patient's best interest.

Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. These care plans were reviewed annually with the patient at a health care review.

There were systems in place for documenting consent for specific interventions including ear irrigation, minor surgery and joint injections into the electronic patient notes. We saw examples of these.

Health promotion and prevention

The practice worked with patients to maintain or improve mental, physical health and wellbeing. For example, by offering opportunistic chlamydia screening to patients aged 18 to 25 years and offering smoking cessation advice. The practice had numerous ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice had identified the smoking status of 93% of patients over the age of 16 with a combination of conditions including Stroke, high blood pressure, asthma, mental illness and chronic pulmonary disease. The practice had actively offered nurse-led smoking cessation clinics to these patients. There was evidence these were having some success. For example, six patients had successfully quit smoking following attendance at these clinics.

The practice's performance for cervical smear uptake was good. For example, the percentage of women (aged from 25 to 64) whose notes record that a cervical screening test has been performed in the last five years was 80% which was in line with other practices nationally and in the CCG area. There were systems in place to offer reminders for patients who did not attend for cervical smears.

The practice offered a full range of immunisations for children, travel and flu vaccinations in line with current national guidance. Last year's performance for all immunisations was average for the CCG and nationally. For example, 492 patients (48.1%) who were over 65 years of age with a health related problem had received the flu immunisation. The score for this nationally was 48.8% In addition, 96.2% of babies aged 12 months had received their childhood immunisations.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This was results from the friends and family test performed between December 2014 and March 2015 and 119 results from an independent survey agency, administering the survey on behalf of NHS England in January 2015. The practice manager said there had not been a formal patient survey performed by the practice since 2013 as this had not been requested and that any feedback came from the friends and family test.

Feedback from these sources was mixed. For example the independent survey stated that 68% of respondents say the last GP they saw or spoke to was good at treating them with care and concern. This was lower than the local (CCG) average of 89%. However, 96% of respondents said the last nurse they saw or spoke to was good at treating them with care and concern. This was higher than the local (CCG) average of 93**%**. Staff explained that there had been a recent change of GPs since this survey and patients are able to choose to see which GP they prefer.

Patients completed CQC comment cards to tell us what they thought about the practice. We received two completed cards both of which were positive about the service experienced.

Staff and patients we spoke with on the day of our inspection told us that all consultations and treatments were carried out in the privacy of a consulting room. Curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard. The practice switchboard was shielded by glass partitions which helped keep patient information private and prevented patients overhearing potentially private conversations between patients and reception staff. We saw this system in operation during our inspection and noted that it enabled confidentiality to be maintained.

Staff told us that if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected, they would raise these with the practice manager.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed from 2013 showed patients feedback was similar to national figures in this area. For example, privacy at the reception desk and being treated with care and concern by nursing staff. However, other areas included patients not being treated with care and concern by the GPs. Staff explained that there had been a change of GPs since this survey. Patients also said they were able to choose to see which GP they prefer. 96% of respondents say the last nurse they saw or spoke to was good at listening to them. This was higher than the local (CCG) average of **93%.**

Patients we spoke with on the day of our inspection told us that they were satisfied with the attitude of the GPs and that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive.

We were shown a system which monitored care plans for vulnerable patients and made sure these were kept under review. For example, one GP is responsible for reviewing care plans for patients with learning disabilities. This system ensured GPs were able to discuss the care needs and patient's wishes with the patients and their carer.

Staff told us that translation services were available for patients who did not have English as a first language. We saw notices stating that this service was available.

Patient/carer support to cope emotionally with care and treatment

Patients were positive about the emotional support provided by the practice. For example, patients we spoke with on the day of our inspection and the comment cards we received showed that patients had received help to access support services to help them manage their treatment and care when it had been needed.

Notices and leaflets in the patient waiting room told patients how to access a number of support groups and organisations. There were systems in place to identify and offer health checks to patients who were carers.

Good

Are services caring?

Staff told us that if families had suffered bereavement the GP coordinated any follow up and counselling should this be required.

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patient's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered.

The NHS England Area Team and Clinical Commissioning Group (CCG) told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised. We saw records of significant events and complaints which had been shared with the local CCG.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example, local nursing homes and care homes. As a result the GPs visited the local four nursing and care homes.

All consultations were offered on the ground floor. There was level access to the building and a door which would allow a standard sized wheelchair access. Waiting rooms and consultation rooms were of a good size and enabled patients to negotiate in wheelchairs or pushchairs.

Accessible toilet facilities were available for all patients attending the practice including baby changing facilities. However, there were no grab rails or drop down bar in these toilet facilities to assist patients with mobility issues. This had been highlighted in a risk assessment in October 2014 but no action had been taken. There were examination couches in each treatment and consultation room. One of the four couches did not have a step stool or other facility to facilitate patients getting on the high couch. This was in the process of being replaced.

A health and safety audit had been performed in October 2014 and had highlighted issues relating to the lack of grab rails in some toilet areas. Staff said that any risks within the building were usually discussed within meetings.

Access to the service

The practice was open from Monday to Friday, between the hours of 8.30am and 6.00pm. Appointments could be booked up to six weeks in advance and took place between 8.30 to 10.00am. Following this the GPs make telephone calls and see patients that have been triaged. Between 12 noon and 3pm The GPs work on call and start afternoon surgery again at 3pm until 5.30pm. The practice offered extended appointments on Thursday evenings on request. Patients we spoke with were not aware of the extended opening times. Patients also said it was difficult to make an appointment with the GP at times and was hard to get through on the telephone. Patients said that emergency appointments were always available.

The practice had opted out of providing out-of-hours services to their own patients and referred them to another out of hours service.

There were two GPs. There were approximately 3100 patients registered at the practice. The GPs worked 14 sessions between them. A further GP was in the process of being recruited to work an additional three sessions following feedback from patients that it was difficult to make a routine appointment. Staff said there was an above average elderly population. The GP told us there was not high deprivation in the area so workload was not as high as other parts of city.

Three of the 13 patients we spoke with said waiting to get through on the telephone could be time-consuming and three patients said getting a routine appointment was still difficult at times. The national independent survey in January 2015 found that 86% of the 119 respondents found it easy to get through to this practice by phone. Reception staff said there had been a struggle with appointments. The practice manager explained that the additional GP being recruited would help ease this pressure. Patients were unaware of this.

Patients said that emergency appointments were always available. The GP worked at the local acute trust as an occupational health medic on Monday and Friday.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns although this was not always formalised. The practice manager was the designated responsible person who handled all complaints in the practice.

Information was available in the waiting room and on the website about how patients could make a complaint.

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

Patients we spoke with were aware of the process to follow if they wished to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice.

The practice kept complaints register for all formal written complaints but not for verbal concerns and feedback. We looked at 11 complaint records received in the last 12 months. Eight of these were formal complaints and had been handled in a satisfactory and timely way. However, some telephone conversations and feedback had not been recorded to show what action and learning had taken place. Of the 11 records we saw that two records were compliments and one was a significant event. There was no evidence to show that complaints were monitored as a way of improving the service or to detect themes or trends.

Are services well-led?

Inadequate

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

Our findings

Vision and strategy

The management structure for the practice comprised of a single handed GP who held the managerial and financial responsibility for the practice. He was supported by a salaried GP. The GP worked in an occupational health role at the local hospital on Monday and Friday and was therefore not at the practice on these days. The salaried GP worked to cover for these days.

The practice did not have a formal mission statement and the statement of purpose sent prior to the inspection did not include the aims and objectives for the practice. The GP told us that the practice was 'small and family friendly'. Staff were not aware of any formal clear vision but said they knew the patients well and focused on providing the best patient care they could.

The five members of the nursing team all worked on separate days. Some of these staff worked at other practices. The nursing team considered that they worked as well as they could as a team but communication was difficult and more regular scheduled meetings to discuss patients would be beneficial to improve communication. Staff explained they would phone their colleagues when at home so important information could be passed on.

Reception staff said they worked well as a team.

We requested but were not provided with a business or strategic plan for the future, but were told of the plans to recruit another salaried GP. The practice had not allocated, or developed internal staff with lines of responsibilities or lead roles to fulfil leadership positions within the practice. Staff told us they had had a recent team meeting following announcement of the inspection but had not have regular team meetings.

The staff said there was mutual respect shown between each other and that the GPs were approachable when concerns relating to patients were identified.

Governance arrangements

The governance arrangements did not demonstrate a clear and systematic approach to identifying and mitigating risks. Processes were disorganised and not managed consistently or recorded in a way to monitor performance, trends or show what actions and learning had taken place

For example, the recording and approach for managing complaints and significant events was not always structured or recorded in a way that could clearly identify trends or show what action had been taken or what learning had been identified. The significant event management policy was not being followed. For example, an event which fell under the practice policy for significant events as a communication failure was managed as a complaint.

There was no system to keep policies and procedure guidance documents under review. There were two sets of duplicated paper policies and procedures in the practice which staff could access. Many of these policies were out of date. For example, the emergency contraception policy had not been reviewed since 2008, the management of cervical smears policy had been last reviewed in 2008 and the chronic obstructive pulmonary disease guidelines had not been reviewed since 2009.

We saw ten clinical policies which had not been reviewed. Policies relating to cleanliness and infection control at the practice had not been reviewed in recent years. For example, we saw a waste policy, an aseptic technique policy, and MRSA policy. Two of these had not been reviewed since 2006 and 2010.

There was no monitoring that audits and checks were being performed. For example, there had not been an infection control audit performed at the practice in the last five years and it had not been highlighted that fridge temperatures or emergency equipment had not been consistently monitored.

The staff records did not demonstrate clear and systematic processes were in place for staff recruitment. The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. However, this policy had not been updated to reflect the change of regulator of nursing (Nursing and Midwifery Council) and had also not been followed when recruiting new staff.

Recruitment records were disorganised and did not show that staff had received all required pre-employment checks. For example, we looked at five staff files. Only one file contained references to assess conduct in previous employment. There were no interview records seen to show that the procedure was consistent and met equal opportunities. The manager explained she discarded these

Are services well-led?

Inadequate

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

notes after the interview. Two of the five files contained proof of identification, although we were informed after the inspection that staff smart cards were used as identification.

All files contained evidence of training certificates. Nurses were all on the Nursing and Midwifery Council but none of the staff files contained evidence that routine checks were performed to check that nursing staff were registered with the appropriate professional body. There were no systems in place to ensure these annual checks were kept under review. For example, a member of the nursing team had worked as a locum nurse and transferred to permanent staff in the last two years. No further checks had been performed. The last registration check was performed in 2002 with the previous regulator. Only one of the five files contained evidence of indemnity insurance cover, this was relevant to four of the files.

We spoke with members of the administration and nursing team who were clear about their own clinical roles and responsibilities regarding the management of long term conditions. However, staff were unsure whether there was a named lead for infection control, health and safety lead or lead for maintaining emergency equipment. The systems in place for routine safety and calibration testing of equipment did not ensure all clinical equipment was checked.

Staff did not all agree that the practice ran efficiently. Staff told us some decisions were made without full consultation and that staff meetings were not held regularly enough to discuss individual patient concerns. Staff said that if meetings were arranged issues could be discussed if listed as agenda items prior to the meeting. Staff said they would speak with either the GPs or practice manager with any individual patient concerns and found the GPs approachable when doing this.

The GP used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data from 2013-2014 for this practice showed it was generally performing in line with national standards but had been lower than national standards in the area of diabetes. The GP explained this had been identified and had improved for the current year and was being monitored more closely by the GPs. We saw that QOF data was discussed at clinical meetings. However, there were no documented action plans to monitor outcomes.

Leadership, openness and transparency

Staff explained that team meetings were not held regularly because staff did not work on the same days but added that communication happened when issues needed to be shared. Nursing staff said communication sometimes relied on staff phoning each other when they were at home as staff did not work on the same days. Staff told us that the GPs and practice manager were approachable. Reception staff told us communication was good amongst the administration team.

Seeking and acting on feedback from patients, public and staff

There was a suggestion box within the waiting room but minimal additional proactive engagement with patients took place. The service relied on what had to be done rather than proactively requesting feedback from patients to improve the service. For example, the practice had not performed a detailed patient satisfaction survey since 2013 to gain feedback from patients about the service they provided. The practice manager said feedback from the friends and family test was used and the practice had not been asked to do an additional survey.

The practice had a patient participation group (PPG) whom had met once. Staff explained they had not been successful previously due to lack of patient interest.

The practice manager explained that feedback from staff was given informally. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they did not always feel involved and engaged in the practice to improve outcomes for both staff and patients but felt this could be due to working part time hours.

The practice had a whistleblowing policy which had not been reviewed since 2009 and did not include guidance of how staff could report clinical concerns. Staff explained that they would not hesitate to report concerns to the practice manager.

Management lead through learning and improvement

The approach to service delivery and improvement was reactive and focused on short-term issues. Staff told us structured regular clinical meetings were not taking place. As a result, topics such as referrals, prescribing methods/ errors and significant event analysis were discussed as they arose.

Are services well-led?

Inadequate

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

Staff told us that the practice supported them to maintain their clinical professional development through training, peer support and appraisal although this was also provided with additional employers. Nursing staff said that regular appraisals took place which included a personal development and training plan. Staff told us that the practice was very supportive of training and that they had never been refused training related to their role.

The practice had completed reviews of some significant events and other incidents and shared with staff at meetings and any clinical governance meetings to ensure the practice improved outcomes for patients. However, records did not always show this process had taken place.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Care and treatment was not being provided in a safe way for patients and did not include- The proper and safe management of medicines: • Regular fridge temperatures had not been consistently recorded • The medicines policies was not kept under review • Staff had not signed all patient group directives • Systems were not in place to minimise risks of all vaccine fridges becoming unplugged.

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 Systems or processes were not established to assess, monitor and improve the quality and safety of the services provided (including the quality of the experience of patients in receiving those services) · Patient survey to ascertain extended experience of patients had not been performed since 2013 Ensure systems are in place and monitored to assess the risk of, and prevent, detect and control the spread of infections, including those that are health care associated Regulation 17.(2b) How the regulation was not being met: Systems or process were not being operated effectively to ensure assessment and monitoring was taking place to mitigate risks relating the health, safety and welfare of patients and others:

This section is primarily information for the provider

Requirement notices

· Systematic processes and records were not in place to monitor and manage significant events, complaints or untoward incidents.

· An infection control audit had not been performed to assess the risks and to demonstrate any mitigating risks where reasonably practicable.

· Comprehensive infection control guidance and policies were not available or kept under review for staff to follow.

· Significant events and complaints were not effectively managed or monitored to identify any trends and risks to patients

· Policies and procedures had not been reviewed to enable staff to have up to date and current guidance to follow.

· Clinical equipment had not all been calibrated and PAT tested where appropriate.

· Action from disability access audits had not been completed

Regulation 17 (2d)

How the regulation was not being met:

Systems and process were not in place to ensure secure records were kept in relation to persons employed at the practice.

· Recruitment records were not being kept to show that staff employed were registered with the staff were registered with the relevant professional body

· Proof of identity was not provided

· A full employment history, together with a satisfactory written explanation of any gaps in employment was not provided.

· Satisfactory evidence of conduct in previous employment was not always sought

· Satisfactory information about any physical or mental health conditions which are relevant to the person's capability were not recorded for all staff.