Dr M J Bizon & Partners

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Dr M J Bizon & Partners (Highbridge Medical Centre) on 2 August 2016 to check if improvements have been made in response to the practice being placed in special measures, with an overall rating of inadequate. Overall the practice remains rated as inadequate.

We found the practice inadequate for providing safe, effective, responsive and well-led services. The practice requires improvement for caring services. We also found the services for the population groups inadequate to align with these ratings.

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

- 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 to ensure that appropriate staff were employed.
- Staff were not following policies; procedures; guidance and current legislation for the safe storage of blank prescription papers to prevent theft or fraud.
- Risks in regard of patients and staff were ineffectively managed in areas such as; medicines management; training and development; infection control; staffing levels, access to appointments and governance arrangements.
- There was limited evidence of an overarching view or summary of significant events and information of completion of suggested actions.
- The outcomes for patients as a result of consultation, care and treatment were hard to identify as the practice governance systems made little or no reference to audits or quality improvement and there was no evidence that the practice was comparing its performance to others; either locally or nationally .
- Patients were positive about their interactions with staff and said they were treated with compassion and dignity.

Summary of findings

- Access and appointment systems were not working well, resulting in patients not receiving timely care when they needed it.
- The practice were unable to evidence formal governance arrangements.

The areas where the provider must make improvements are:

- Ensure infection prevention and control systems take account of identified risk assessment actions;
- Ensure recruitment arrangements and ongoing monitoring of staff include all necessary employment checks.
- Ensure adequate staffing levels are in place to provide timely access to the practice through the telephone system, adequate urgent and non-urgent appointments during core practice hours and timely referrals to other services for advice and treatment;
- Ensure safe systems and processes are in place to clarify the urgency of the need of patients for medical attention so they are provided with care and treatment, by the most appropriate person, in a timely manner.
- Ensure patient complaints are listen to, acted upon and responded to, to provide effective outcomes for patients.
- Introduce quality improvement initiaitves to ensure improvements in clinical care and other processes have been achieved.
- Ensure there are management support systems and records in place for staff training and ongoing staff support including appropriate supervision and appraisal.
- Ensure governance arrangements assess and monitor risks to improve the quality of the service provision.

The areas where the provider should make improvement are:

- Review the system for the significant event process. This should include evidence of completed action plans and lessons learnt.
- Provide evidence of safety checks for equipment such as boilers, electrical wiring and non-medical equipment.
- Improve the recording of patient monitoring when individual patient care and treatment plans differ from normal or recognised practice.
- Review actions taken in response to the outcomes of any patient feedback such as the Friends and Family Test and national GP patient survey with regards to improving services for patients.
- Clarify the leadership structure and ensure there is leadership capacity to deliver all improvements.

This service was placed in special measures in February 2016 in order for the provider to take steps to improve the quality of the services it provided. We found insufficient improvements have been made such that there remains a rating of inadequate for responsive and well-led. In addition safe and effective have now been rated as inadequate. Caring remains as requires improvement.

Therefore we are taking 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 vary the conditions of their registration within six months if they do not improve. The service will be kept under review and if needed measures could be escalated to urgent enforcement action.

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

At our last inspection on 29 September 2015 we rated the safe domain as requires improvement. Following this inspection the practice is rated as inadequate for providing safe services and improvements must be made.

Patients were at risk of avoidable harm or abuse. There was limited monitoring of safety and limited evidence of learning from events or action taken to improve safety. Staff told us about recent significant events and the actions following an investigation. However, they were unable to provide us with documentary evidence to support the actions stated. Systems, processes and practices did not always keep patients safe. Substantial or frequent staff shortages increased risks to patients who used services; there were three GP vacancies; two prescription clerks were absent and two specialist nurses had left the practice. Staff did not assess, monitor or manage risks to patients who used the services. Medicines were not managed in accordance with current guidance and policies were not up to date. Checks relating to the premises and equipment were not adequately managed.

Are services effective?

Inadequate

At our last inspection on 29 September 2015 we rated the effective domain as requires improvement. Following this inspection the practice is rated as inadequate for providing effective services and improvements must be made.

There was insufficient assurance in place to demonstrate care and treatment was effectively monitored. There was very limited monitoring of patients outcomes of care and treatment,

including limited clinical audit. Staff did not always have the opportunities to develop the knowledge, skills and experience to enable them to deliver good quality care. Training records were not up to date for some staff. Recent new members of staff did not have a record detailing practice mandatory training such as infection control, fire safety and safeguarding. Staff were not supervised or managed effectively, some administrative staff had not had an appraisal since 2014.

Are services caring?

Requires improvement

At our last inspection on 29 September 2015 we rated the caring domain as requires improvement. Following this inspection the practice is rated as requires improvement for providing caring services, as there are areas where improvements should be made.

Summary of findings

The majority of patients said they were treated with compassion, dignity and respect. However, not all felt cared for, supported or listened to. Patients said that staff did not always explain things clearly or give them time to respond or help them to understand. The national GP patient survey (January 2016) showed below average satisfaction scores on consultations with GPs and nurses and patient involvement in planning and making decisions about their care and treatment.

Are services responsive to people's needs?

Inadequate

At our last inspection on 29 September 2015 we rated the responsive domain as inadequate. Following this inspection the practice is rated as inadequate for providing responsive services and improvements must be made.

Services were not planned or delivered in a way that met people's needs. At times patients were unable to access the care they need. Patients were frequently and consistently not able to access appointments and services in a timely way with 50% of patients consulted during the national GP patients survey (January 2016) stating they were unable get through easily to the practice by phone. This compared to the national average of 73%. The practice responses to patient complaints did not always provide an apology. And did not provide information on how to seek further support when patients felt the complaint had not been acceptably resolved.

Are services well-led?

Inadequate

At our last inspection on 29 September 2015 we rated the well-led domain as requires improvement. Following this inspection the practice is rated as inadequate for being well-led.

The delivery of high-quality care was not assured by the leadership, governance or culture in place at the practice. There was no contingency to ensure governance arrangements were managed effectively when key management staff were absent. There was no effective system for identifying, capturing and managing issues and risks in many areas. Significant issues that threaten the delivery of safe and effective care were not identified or adequately managed.

Summary of findings

The six population groups and what we found

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

Older people

Inadequate

The practice is rated as inadequate for the care of older people. The provider was rated as inadequate for safe, effective, responsive and well-led and requires improvement for caring. The concerns which led to these ratings apply to everyone using the practice, including this population group. During our inspection we had difficulties verifying supporting evidence was in place for the care of older people. Not all the information we requested prior to our inspection was made available.

- The practice offered home visits for those with enhanced needs.
- The practice provided patients with a foot care clinic.

People with long term conditions

Inadequate

The practice is rated as inadequate for patients with long-term conditions. The provider was rated as inadequate for safe, effective, responsive and well-led and requires improvement for caring. The concerns which led to these ratings apply to everyone using the practice, including this population group. During our inspection we had difficulties verifying supporting evidence was in place for patients with long-term conditions. Not all the information we requested prior to our inspection was made available.

- Practice nurses provided home visits to ensure housebound patients received the same quality of care as patients attending the practice for management of long-term conditions.
- Practice nurses had lead roles in chronic disease management.

Families, children and young people

Inadequate

The practice is rated as inadequate for the care of families, children and young people. The provider was rated as inadequate for safe, effective, responsive and well-led and requires improvement for caring. The concerns which led to these ratings apply to everyone using the practice, including this population group. During our inspection we had difficulties verifying supporting evidence was in place for the care of families, children and young people. Not all the information we requested prior to our inspection was made available.

- We saw good examples of joint working with health visitors when following up children living in disadvantaged circumstances or who were at risk of harm or abuse.

Summary of findings

- Some patients told us they always received on the day appointments for children. However Care Quality Commission comment cards stated patients had received inappropriate referrals to other services when they requested an urgent GP appointment.

Working age people (including those recently retired and students)

Inadequate

The practice is rated as inadequate for working age patients. The provider was rated as inadequate for safe, effective, responsive and well-led and requires improvement for caring. The concerns which led to these ratings apply to everyone using the practice, including this population group. During our inspection we had difficulties verifying supporting evidence was in place for working age patients. Not all the information we requested prior to our inspection was made available.

- Although the practice offered extended opening hours for appointments patients reported difficulties accessing the practice and appointments. Extended opening was dependent on weekly availability of GPs.
- Online access was available for ordering repeat prescriptions.

People whose circumstances may make them vulnerable

Inadequate

The practice is rated as inadequate for patients whose circumstances may make them vulnerable. The provider was rated as inadequate for safe, effective, responsive and well-led and requires improvement for caring. The concerns which led to these ratings apply to everyone using the practice, including this population group. During our inspection we had difficulties verifying supporting evidence was in place patients whose circumstances may make them vulnerable. Not all the information we requested prior to our inspection was made available.

- 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.
- The practice carer's champion had ceased employment and had not been replaced. There was not a designated person to identify and prioritise the needs of carers and offer them appropriate advice and support.

Summary of findings

People experiencing poor mental health (including people with dementia)

Inadequate 

The practice is rated as inadequate for patients experiencing poor mental health. The provider was rated as inadequate for safe, effective, responsive and well-led and requires improvement for caring. The concerns which led to these ratings apply to everyone using the practice, including this population group. During our inspection we had difficulties verifying supporting evidence was in place patients experiencing poor mental health. Not all the information we requested prior to our inspection was made available.

- The practice worked with a social enterprise to provide specialist services for patients affected by substance misuse within the practice in the case management of patients experiencing poor mental health.
- We saw physical health checks for patients experiencing poor mental health had improved since our previous inspection.

Summary of findings

What people who use the service say

The national GP patient survey results were published in January 2016 and showed the practice was performing below local and national averages. Of the 257 survey forms distributed 122 were returned, representing approximately 1% of the practice's patient list. Results from the survey showed:

- 50% of patients found it easy to get through to this practice by phone compared to the local clinical commissioning group (CCG) average of 78% and national average of 78%.
- 69% of patients were able to get an appointment to see or speak to someone the last time they tried compared to the CCG average of 81% and national average of 78%.
- 58% of patients described the overall experience of this GP practice as good compared to the CCG average of 89% and national average of 85%.
- 51% of patients said they would recommend this GP practice to someone who has just moved to the local area compared to the CCG average of 84% and national average of 79%.

The NHS Friends and Family Test from December 2015 to May 2016, where patients were asked if they would recommend the practice, showed on average 68% of respondents would recommend the practice to their family and friends. The national average is 79%.

As part of our inspection we asked for Care Quality Commission (CQC) comment cards to be completed by patients prior to our inspection. We received 18 comment cards of which 12 were positive about the standard of care received. Most patients stated GPs and practice nurses were helpful, kind and listened to them. Six patients stated they had experienced difficulties getting an appointment.

We spoke with 12 patients during the inspection. Most patients said they were satisfied with the care they received and thought GPs and practice nurses were committed and caring, treating them with dignity and respect. Patients also told us they had difficulty accessing the practice as the phone lines would be engaged which meant patients had multiple attempts at phoning. Three patients told us it was easier to drive to the practice and book an appointment face to face rather than wait to get through to the practice by phone. Patients told us they had difficulty getting appointments and had experienced waiting up to three weeks for blood tests or GP appointments. Some patients told us that after a wait for a blood test they then had a long wait for a review of the outcomes of the tests with a GP. Patients with children told us they could get an urgent on the day appointment for children. Some patients told us they experienced difficulties with repeat prescriptions with these not being ready for collection within practice timescales. One patient told us their long term condition checks were not being completed.

We reviewed the 13 complaints patients had made to the CQC since our previous inspection in September 2015. We saw themes around patients experiencing difficulties accessing the practice and getting routine and urgent appointments. Patients also told us referral letters from secondary care services were not actioned quickly, with one patient waiting over a week for a change to medicines. Patients told us they had lengthy waiting times when the practice were making referrals to secondary care services. For example, three patients told us they had waited over three weeks for the practice to complete the referral. Two patients told us their long term condition checks were not being completed.

Dr M J Bizon & Partners

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC lead inspector**.** The team included a GP specialist adviser, a second CQC inspector and a nurse specialist adviser.

Background to Dr M J Bizon & Partners

Dr M J Bizon & Partners (Highbridge Medical Centre) is located in Highbridge, situated seven miles north of Bridgwater, on the edge of the Somerset Levels in the Sedgemoor district of the county of Somerset. The practice provides primary medical services to approximately 13,100 patients living in Highbridge and the surrounding area. This includes six care homes, three homes for patients with a learning disability and emergency housing for young people and up to 19 families.

The practice was previously inspected by the CQC on 29 September 2015 and as a result was placed into special measures. During that inspection we found the practice inadequate for providing responsive and well-led services. The practice required improvement for safe, effective and caring services. We told the provider to take action against areas of concern.

Data from Public Health England show that the practice had a higher than average population of patients over 65, 25%, in comparison with the clinical commissioning group (CCG) average of 23% and a national average of 17%. The population of Highbridge as a whole is older than the national average. The practice is situated in an area with less deprivation with a deprivation score of 22% compared to the CCG average of 18% and the national average of 22%.

The practice is located in a purpose built surgery built in 1993. The practice has a spacious waiting area with the ground floor and the consulting rooms accessible to patients. The first floor provides administrative rooms. Within the building is an independent pharmacy.

The practice team includes four GP partners (three male and one female) and one salaried GP (female). A locum GP provides two sessions per week. Currently the practice provides 36 GP sessions per week. A specialist diabetes practice nurse is employed and a locum respiratory nurse provides one session per week. A primary care practitioner (paramedic) has recently started and is undertaking induction with the aim of providing 10 sessions per week providing care and treatment within the practice and in patients' homes. In addition there are three practice nurses; one health care assistant; a practice manager; reception and administrative staff. One GP partner was on a sabbatical during our previous inspection and they have now left the practice. A key concern for the practice is the difficulty recruiting GPs with three whole time equivalent GP vacancies. In addition an experienced nurse practitioner and a health care assistant had recently left the practice with three more clinical staff due to leave. At the time of our inspection the practice manager was on long term leave. A temporary practice manager was in place on the day of our inspection.

The locality health visitors and midwives service is based within the practice. An osteopath and a physiotherapist provided private appointments within the practice premises.

Detailed findings

The practice is a training practice for student nurses and GP trainees. At the time of our inspection one GP trainee was being supported by the practice.

The practice has a Primary Medical Services contract (PMS) with NHS England to deliver general medical services. The practice provides enhanced services which included extended hours for appointments; facilitating timely diagnosis and support for patients diagnosed with dementia and minor surgery.

The practice is open from 8.30am to 6.30pm with lunchtime opening recently being introduced. Extended hours surgeries are available from 7.30am to 8am and 6.30pm to 7.30pm however the practice does not offer these on set days and are based on GP availability. Since our previous inspection alternate Saturday morning appointments are no longer available. In addition the practice closes at 12.30pm one Tuesday per month for training. During this time patient care is provided by another practice under a reciprocal agreement.

In addition the practice provides cover to Burnham-on-Sea Community Hospital. This is a 22-bedded unit with clinical care managed by Highbridge Medical Centre and another local GP practice during normal working hours on a two week on, two week off rota.

The practice has opted out of providing Out Of Hours services to their own patients. Patients can access a local provider which provides an NHS111 and an Out Of Hours GP 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. The inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 2 August 2016. During our visit we:

- We spoke with a range of staff (three GPs, a GP trainee, three practice nurses, the primary care practitioner, five administrative and three reception staff and the temporary practice manager).
- We spoke with patients who used the service.
- We spoke with staff from partnership organisations.
- 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 specific patient care and treatment records with patient's consent.
- 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).

Detailed findings

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

At our last inspection on 29 September 2015 we rated the safe domain as requires improvement. Concerns included safety incidents, reviews and investigations not being thorough enough and lessons learned were not communicated widely enough to support improvement; systems and processes to address risks were not implemented well enough to ensure patients were kept safe including medicines management and safe storage of prescriptions. During this inspection we found improvements had not been made and patients were at risk of avoidable harm. There was limited monitoring of safety. There was limited evidence of learning from events or action taken to improve safety. Substantial or frequent staff shortages increased risks to patients who used services. Staff did not effectively assess, monitor or manage risks to patients who used the services.

Safe track record and learning

On our inspection of 2 August 2016 we found there was not an effective system in place for reporting and recording significant events.

- Staff told us they would inform the practice manager of any incidents and there was a recording form available on the practice's computer system.
- Prior to and during our inspection we asked the practice to provide a summary of any significant events from the last twelve months, actions taken and how learning was implemented. These were not provided, prior to or during the inspection. After the inspection we received the significant event actions log without the detail of the initial event so we were unable to ascertain whether the appropriate steps were taken.
- We found the systems in support of significant events were muddled and lacked coordination. We looked at records of several significant events during our inspection and saw a level of reflection and process change on the examples provided. However, an overarching view or summary and information on completion of suggested actions was not evidenced other than in the body of the text. We looked at minutes of the practice management meetings from February until June 2016 and did not find evidence of significant event discussions. We asked for and were not provided with access to minutes of other meetings where significant events may have been discussed however supporting evidence was not made available.
- Staff told us verbally about recent significant events and the actions following an investigation. For example, a baby had been prescribed an adult medicine. We were told the family received an apology. We were not provided with documentary evidence to support this. Staff were unable to tell us if any actions or lessons had followed the investigation.

Safety records, patient safety alerts and minutes of meetings where these were discussed were requested but were not made available to us during our inspection.

Overview of safety systems and processes

The practice had systems, processes and practices in place to keep patients safe and safeguarded from abuse however these were not robust:

- Arrangements to safeguard children and vulnerable adults from abuse reflected relevant legislation and local requirements. The practice policies were accessible and 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 always provided reports where necessary for other agencies. Staff demonstrated they understood their responsibilities. However the training matrix did not list recent training for new practice staff or relevant training that had taken place previously. Not all staff, including GPs and practice nurses, had received safeguarding adults training relevant to their role. Some GPs were trained to child protection level 3.
- A notice in the waiting room advised patients that chaperones were available if required. All 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).
- We observed the premises to be clean and tidy. The practice had an infection control clinical lead and an infection control protocol was in place. Annual infection control audits were undertaken. We saw areas had been identified where action should be taken. From the

information provided to us we did not see evidence the practice had a recorded action plan to address any required improvements identified as a result of the audit. There was a potential infection control risk as we saw the baby changing area did not contain access to disinfectant wipes for patients to clean the area and a bin for nappy waste. We saw, in the cleaner's area, cleaning equipment such as mops stored incorrectly.

- We saw the practice recruitment policy was not followed. For example, personnel files contained CVs instead of application forms. Practice policy stated CVs could be submitted as additional evidence along with an application form.
- We reviewed five personnel files. We found gaps in recruitment checks, which were required to be undertaken prior to employment. For example, we saw gaps in employment history were not verified; there was no evidence of new staff's right to work in the UK, appropriate checks on registration with professional bodies and appropriate identification checks. We also saw health professionals had commenced work prior to the return of a DBS (Disclosure and Barring Service) check with no evidence of risk assessments in place to mitigate potential risks.

Medicines management

We looked at the arrangements for managing medicines, including emergency medicines and vaccines, in the practice (including obtaining, prescribing, recording, handling, storing, security and disposal).

Staff were not following policies, procedures, guidance and current legislation for the safe storage of blank prescription papers. We found blank prescription pads including prescription pads used for controlled medicines in an unlocked drawer with no evidence of a log system or regular stock checks on blank prescription pads to prevent misuse or loss. Blank prescription paper for printing prescriptions was not safely stored in a locked cupboard which increased the risk and likelihood of them being stolen or tampered with.

We checked medicines stored in the treatment rooms, fridges and those used for responding to a medical emergency. We found the medicines were kept in locked cupboards in locked rooms. We found an individually prescribed patient's medicines stored in the fridge. Staff were unable to tell us if the patient continued to use the medicines or who managed the stock of intravenous medicines indicating stock control was weak.

Medicines stored in medicine refrigerators were stored securely and were only accessible to authorised staff. Records showed refrigerator temperature checks were carried out which ensured medicines were stored at the appropriate temperature.

The nurses used Patient Group Directions (PGDs) to administer vaccines and other medicines that had been produced in line with legal requirements and national guidance. We saw two sets of PGDs that had not been updated since May 2016. One of these was the 'core' PGD. This meant practice nurses were supplying and / or administering a medicine directly to a patient with an identified clinical condition using an out of date 'core' directives. All other medicine specific PGDS (except adrenaline) were in date and signed. The health care assistant administered vaccines and other medicines using Patient Specific Directions (PSDs) that had been produced by the prescriber. We saw evidence that nurses and the health care assistant had received appropriate training and been assessed as competent to administer the medicines referred to either under a PGD or in accordance with a PSD from the prescriber.

The emergency drug policy was not up to date. There was no deputised responsible person allocated to undertake this role. The practice did not have access to the correct containers for the correct segregation of healthcare waste onsite. For example, after administration, contraceptive medicine containers were not disposed of in line with clinical waste guidance. Consequently the practice could not provide assurances that waste was stored, transported and ultimately disposed of in the correct manner to comply with clinical waste regulations.

Medicines audits were carried out with the support of the local clinical commissioning group pharmacy teams to ensure the practice was prescribing in line with best practice guidelines for safe prescribing.

Monitoring risks to patients

There was limited evidence available to us during the inspection about how well risks to patients were assessed and managed; we identified several areas of concern.

Inadequate

Are services safe?

- We were told there were procedures in place for monitoring and managing risks to patient and staff safety. Safety checks for equipment such as boilers, electrical wiring and non-medical equipment were not made available until after the inspection. There was a risk of unauthorised use of and potential access to confidential information as a GP told us they left their smart card in their unlocked computer in an unlocked room. (Smart cards allow staff access to summary care records and secondary services).
- During our inspection in September 2015 the practice were unable to provide evidence that they had carried out emergency lighting maintenance or checks. At this inspection we asked for evidence to verify our concerns had been rectified. The practice were unable to provide evidence.
- Clinical equipment was checked to ensure it was working properly. However, we saw a nebuliser (medical equipment used for the management of respiratory disease) had not been calibrated since 2014. Staff told us the equipment should not be used and should have been condemned. Staff were not aware of a formalised process to arrange for equipment disposal which could result in the equipment being inadvertently used.
- The practice had a variety of other risk assessments in place to monitor safety of the premises such as control of substances hazardous to health.
- 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 however due to staff vacancies and absences staff from other work areas were required to multi-task. The practice were unable to provide reassurance that enough staff were on duty to keep patients safe. We listened to patients comments about their experiences around appointment availability and reviewed the appointment system, it was evident there were not enough GPs or other staff to provide adequate care and treatment to meet patient demand and needs. The practice was aware of and currently working with other organisations to address staffing concerns.

Arrangements to deal with emergencies and major incidents

The practice had 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.
- Staff received annual basic life support training and there were emergency medicines available in the treatment room. A first aid kit and accident book were available.
- The practice had a defibrillator available on the premises and oxygen with adult and children's masks. Appropriate signage was not in place for the storage of oxygen. This meant that staff and visitors were unaware of the need to follow established safety procedures and of the potential risk posed of fire or explosion. Oxygen was stored in a room other than that documented within the practice oxygen policy and could place staff and patients at risk if a fire occurred.
- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and stored securely. The emergency drug policy was not up to date. The deputy responsible person allocated to undertake this role had ceased employment and measures had not been put in place to identify a member of staff to take over the role.
- The practice had a business continuity plan in place for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff. However an update to the plan regarding service contact details had not been added to the document.

Inadequate

Are services effective?

(for example, treatment is effective)

Our findings

At our last inspection on 29 September 2015 we rated the effective domain as requires improvement. Concerns included a lack of measurable action plans and weak evidence audits were driving improvements in performance to improve patient outcomes. During this inspection we found improvements had not been made and there was insufficient assurance in place to demonstrate care and treatment was effectively monitored. There was very limited monitoring of patients outcomes of care and treatment through clinical audit. Staff did not always have the opportunities to develop the knowledge, skills and experience to enable them to deliver good quality care. Staff were not supervised or managed effectively through appraisals.

Effective needs assessment

The practice told us they 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 disseminate information and aid all clinical staff to keep up to date. Staff had access to guidelines from NICE and told us they used this information to deliver care and treatment that met patients' needs.
- However the practice was unable to demonstrate that these guidelines were always followed through practice risk assessments, audits and random sample checks of patient records. We saw that the nurses had a good understanding of guidelines relating to their roles and ensured updated guidance specific to the care they delivered, changed patient management.

The practice had a system in place to assess the urgency of the need for medical attention. Reception staff were provided with a triage tool document listing medical concerns. A list of symptoms were provided along with recommended interventions such as an urgent or routine GP telephone call or appointment; patient attendance at accident and emergency; patient visit to a pharmacy.

We looked at this triage assessment tool in greater detail and saw some symptoms resulted in reception staff providing advice on self-treatment for patients. Patients telephoning with a rash were directed to a pharmacy. We saw no evidence reception staff had adequate knowledge or training to ascertain if the rash was a symptom of a serious disease. Reception staff had not received training in identifying pathways for patient care based on taking symptoms over the phone. They did not maintain a record of the advice they gave to patients and audit processes were not in place to monitor whether advice given was appropriate and safe and if individual staff improvement needed acting on. We saw that lengthening the initial call to the practice had an impact on other patients waiting to speak to a receptionist.

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 (2014/15) were 98.6% of the total number of points available, with 9.9% exception reporting. We looked at practice data for exception reporting for the QOF year 2015/16 and saw exception reporting was in line with national averages. This practice was not an outlier for any QOF (or other national) clinical targets.

Data from 2014/15 showed:

- Performance for diabetes related indicators was 100% which was 20.9% above than the Clinical Commissioning Group (CCG) average and 10.8% above national average. The data showed a high exception rate between 17.4% and 23.2% for some areas. For example, patients who had a blood glucose recording that is above average; the percentage of patients who have had a flu vaccination and the percentage of patients referred to a structured education programme. Evidence shows that monitoring patients with diabetes can reduce the risk of developing complications, such as nerve damage, eye disease, kidney disease and heart disease.
- The percentage of patients with high blood pressure having regular tests was 82.4% which was better than the CCG average of 78.1% and national average of 81.2%.
- The percentage of patients with a new diagnosis of dementia was 87.5% which was 23.3% above the CCG average and 6% above national average. At our previous inspection we reported that advance care planning had been provided for 12.5% of patients on the practice

register who were living with dementia. We looked at practice QOF data for 2015/16 and saw 88% of patients who were living with dementia had received a care plan review.

We looked at all the QOF disease and medical condition patient registers for 2015/16. For example, chronic heart disease; asthma and high blood pressure. We saw the practice had met all agreed targets with the exception of two areas of health promotion advice where the practice were just below expected targets.

Prior to our inspection and on the day of the inspection we asked the practice to supply copies of a minimum of five completed clinical audits. Following our inspection the practice sent us a copy of:

- Three completed mini audits completed in 2015/16. We saw completed audits with actions. For example, we saw actions for the management of patients with acute kidney injury included a review of patients with a GP and advice to staff around blood monitoring test requirements.
- We saw three completed audits of which one was not dated. In addition practice nurses undertook regular audits for cervical smears with high results for accurate sample taking.

During our inspection we requested a copy of an audit undertaken following a significant event. The audit looked at a group of medicines (DMARDs) commonly used in patients with rheumatoid arthritis. The practice were unable to provide the audit. In the process of the assessment of how they responded to significant events we reviewed a sample of this patient group to identify if blood tests were being done in line with guidance. We were not able to identify if all patients required monthly monitoring as individual testing regimes were not available within each patient record. Following the inspection we were sent a practice procedure for staff on blood monitoring and prescribing for this medicine.

At our previous inspection in September 2015 we looked at four audits from 2013 to 2015 which were local audits. We were not provided with evidence that measurable action plans and re-audits had taken place as recommended. During this inspection we found little evidence of quality improvement using clinical audit.

Effective staffing

The practice had some systems in place to ensure clinical staff had the skills, knowledge and experience to deliver effective care and treatment.

- 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. The diabetic specialist practice nurse had an established network of clinical supervision and updating.
- The learning needs of practice nurses were identified through a system of appraisals, meetings and reviews of practice development needs. However administrative and secretarial staff had not received an appraisal in the last twelve months with some not receiving an appraisal since 2014. We spoke with administrative managers and they confirmed appraisals had not been undertaken annually as per practice policy.
- Staff had access to mandatory training to meet their learning needs and to cover the scope of their work. However we saw the staff training record was not up to date for some staff. For example, recent new members of staff did not have a record detailing practice mandatory training such as infection control, fire safety and safeguarding. We saw some GPs had not received a fire training update despite our concerns that fire safety training had not been completed at our previous inspection. The lack of appropriate training could place patients and staff at risk in emergency situations, at times of heightened cross infection or at risk of not identifying and referring vulnerable patients to relevant authorities.
- The practice did not have evidence of checks undertaken to ensure practice nurses were appropriately registered with a professional body.
- The practice had a number of vacancies including three whole time equivalent GP positions, a health care assistant, administrative and reception staff. This meant the practice were unable to provide adequate cover for service delivery. The practice told us they experienced difficulties getting locum GP cover. One GP told us they often worked more than 12 hours a day to manage the workload.

Coordinating patient care and information sharing

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

Inadequate

Are services effective?

(for example, treatment is effective)

This included care and risk assessments, care plans and medical records. However we saw evidence that non-urgent GP referrals to other health care services outside the practice were delayed. On the day of the inspection 160 routine non-urgent referrals required action with some backlogged for 25 working days. We spoke with patients who had been waiting between three and six weeks for a routine referral to be made by the practice. The practice had not replaced a secretary who had retired and employment of a temporary secretary had ceased which led to patients not receiving services in a timely way.

Patients told us they had experienced delays with the practice taking action on letters received from other agencies about care and treatment provided. For example, one patient told us their hospital consultant had faxed a medicine change request to the practice for urgent action. The patient was told they had to wait seven days before this could be implemented, which could have impacted detrimentally on the patients' health.

We saw evidence of a back log of prescription requests. We were informed there were 105 outstanding emailed patient prescription requests on the computer system plus additional paper based requests in the prescription clerk office. We were told the practice had two members of the team absent. Patients told us their prescriptions were not always available for collection (as per practice policy timescales). We were told reception staff assisted with the prescription management whilst undertaking their normal duties. These issues could result in inconvenience for patients or delays in them receiving their medicines to support continuity of treatment.

Staff from a local pharmacy told us about concerns they had for prescription management. For example, we were told that patients' prescriptions did not always contain all the medicines patient's had requested and there were long delays between the time of the initial request and when they were received for dispensing.

Staff told us they worked together and with other health and social care professionals to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. This included when patients moved between services, including when they were referred, or after they were discharged from hospital. Meetings took place with other health care professionals on a monthly basis when care plans were routinely reviewed and updated for patients with complex needs.

Consent to care and treatment

Staff sought patients' consent to care and treatment in line with legislation and guidance.

- Staff understood the relevant consent and decision-making requirements of legislation and guidance, with most staff receiving Mental Capacity Act (2005) training in 2016.
- 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 were signposted to the relevant service.
- A dietician was available on the premises and smoking cessation advice was available from a local support group.

The practice's uptake for the cervical screening programme was 80% which was comparable to the clinical commissioning group (CCG) average of 81% and the national average of 82%. At our previous inspection we spoke with the practice as we saw 60% of patients experiencing poor mental health had received a cervical screening test in the preceding 5 years. We reviewed the current practice patient data and found the practice had reached the target of 80% of patients who had now received a cervical smear.

The practice encouraged its patients to attend national screening programmes. For example, 59% of patients had attended for bowel screening and 79% of female patients had attended breast cancer screening within the last three years. These were in line with national averages.

Childhood immunisation rates for the vaccines given were comparable to local clinical commissioning group averages. For example, childhood immunisation rates for the vaccines given to under two year olds ranged from 86% to 98% and five year olds from 92% to 98%.

During our last inspection we spoke with the practice about concerns from our previous inspection that none of the patients experiencing poor mental health had received an

Inadequate

Are services effective?

(for example, treatment is effective)

annual physical health check. During this inspection we reviewed four patients on the practice mental health register and saw evidence three patients had received a physical check.

Requires improvement

Are services caring?

Our findings

At our last inspection on 29 September 2015 we rated the caring domain as requires improvement. Concerns included patients not feeling cared for, supported and listened to. During this inspection we found improvements had not been made and there were times when patients did not feel well supported or cared for. Patients said that staff did not always explain things clearly, give them time to respond or help them to understand.

Kindness, dignity, respect and compassion

We observed members of staff were courteous and helpful to patients, treating them with dignity and respect.

- Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- We noted consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- Reception staff were aware they could offer patients a private room to discuss sensitive issues.

Twelve of the eighteen patient Care Quality Commission comment cards we received were positive about the service experienced. Most patients said they felt the practice 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.

Results from the national GP patient survey (January 2016) showed most patients felt they were treated with compassion, dignity and respect. The practice was below average for its satisfaction scores on consultations with GPs and nurses. For example:

- 74% of patients said the GP was good at listening to them compared to the clinical commissioning group (CCG) average of 92% and the national average of 89%.
- 72% of patients said the GP gave them enough time compared to the CCG average of 89% and the national average of 87%.
- 69% of patients said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 89% and national average of 85%.
- 84% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 94% and national average of 91%.
- 69% of patients said they found the receptionists at the practice helpful compared to the CCG average of 89% and the national average of 87%.

However 97% of patients said they had confidence and trust in the last GP they saw which compared to the CCG average of 97% and the national average of 95%.

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 GPs and practice nurses however some patients told us they did not always have sufficient time during consultations to make an informed decision about the choice of treatment available to them. Patient feedback from the comment cards we received was also positive and aligned with these views.

Results from the national GP patient survey (January 2016) showed patient responses to questions about their involvement in planning and making decisions about their care and treatment. Results were below average compared with local and national averages. For example:

- 70% of patients said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 90% and the national average of 86%.
- 67% of patients said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 86% and the national average of 82%.
- 76% of patients said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average of 88% and the national average of 85%.

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

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.

Requires improvement

Are services caring?

The practice's computer system alerted GPs if a patient was also a carer. At our previous inspection in September 2015 the practice had appointed a member of staff as a carer's champion. During this inspection we were informed a carer's champion was no longer available. Prior to our inspection we requested information on patients who were also carers. This included the number of patients identified as carers. This information was not provided to us during or following our inspection.

Staff told us that if families had suffered bereavement, their usual GP contacted them to offer them support.

Inadequate

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

At our last inspection on 29 September 2015 we rated the responsive domain as inadequate. Concerns included access to a named GP and continuity of care not always being available. Complaints were not thoroughly investigated; learning from complaints had not been shared with staff and had not led to improvements to the service. During this inspection we found improvements had not been made and services were not planned or delivered in a way that met people's needs. At times patients were unable to access the care they needed. Patients were frequently and consistently not able to access appointments and services in a timely way. Some patients experience unacceptable waits for some appointments and services and their concerns and complaints did not always lead to improvements in the quality of care.

Responding to and meeting people's needs

Since our previous inspection the practice had engaged with the NHS England Area Team and Somerset Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. For example, the practice had improved patient access by opening during lunchtime.

- Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice.
- There were disabled facilities, a hearing loop and translation services available.
- The practice provided patients with additional services including a foot care clinic which the practice subsidised for patients.
- The practice undertook minor surgery.
- The diabetic specialist practice nurse trained community carers on diabetic management and provided a diabetic group for patients to discuss management of their diabetes.
- The practice worked closely with a social enterprise, to provide specialist services for patients affected by substance misuse within the practice.
- The GPs met daily to discuss appointment availability and home visits.

Access to the service

The practice was open between 8.30am and 6.30pm Monday to Friday. Appointments were from 8.30am every morning. Extended hours appointments were offered between 7.30am and 8am and 6.30pm and 7.30pm however staff told us these were not provided on specific days and were dependent upon GP availability. The practice website stated that extended hour appointments were booked in advance by a GP. Since our previous inspection in September 2015 the practice no longer offered alternative Saturday appointments.

In addition to pre-bookable appointments that could be booked up to six weeks in advance, urgent appointments were also available for people that needed them. Patients with children told us they usually got an on the day appointment if needed. Other patients told us they usually had to wait three weeks for blood tests and appointments with GPs.

Patient feedback from the CQC comment cards was mixed in regard to appointments. For example, one patient said they were unable to book in their baby for its six week postnatal check and another said that their four month old baby was refused an appointment by reception and advised to attend a local chemist for infected chickenpox. This patient also said they had been directed to accident and emergency when the practice was unable to provide an appointment for their two year old until two days later.

We looked at the practice appointment system and saw the next available appointment for a practice nurse was 11 working days and for a GP 15 working days with some appointments released on most days. Most patients were required to wait 15 working days for blood tests.

Patients told us phone access to the practice was poor. Some patients described an engaged tone which would often result in a number of attempts to get through to the practice. Patients who worked described difficulties having to make a number of calls during work time. Other patients told us they preferred to drive to the practice for an appointment as it was quicker than phone system.

Staff told us there were four phone lines for reception to book appointments. During our inspection we saw up to three members of staff answering the phones. The practice had a call monitoring system in reception. We looked at this system during our inspection. At 2.45pm 167 calls had been received with an additional 32 calls terminated.

We looked at the reception staff rota and saw staff tasked with either front desk or answering phone roles. Staff could also be delegated other tasks such as managing test results

Inadequate

Are services responsive to people's needs?

(for example, to feedback?)

or undertaking administration roles. During our inspection we saw long queues at the front desk where only one member of staff provided cover. Staff designated phone duties dealt with a steady number of calls. We saw that staff had no time to complete tasks before the phone rang again. There was a potential risk of actions not being taken in a timely manner.

Patient comments about difficulties obtaining routine appointments and difficulties accessing the practice were in line with comments patients had made in complaints to the CQC and reviews on NHS choices.

Results from the national GP patient survey (January 2016) showed that patient's satisfaction with how they could access care and treatment was below local and national averages.

- 62% of patients were satisfied with the practice's opening hours compared to the clinical commissioning group average of 81% and national average of 78%.
- 50% of patients said they could get through easily to the practice by phone compared to clinical commissioning group average of 78% and the national average of 73%.

The practice had a system in place to assess whether a home visit was clinically necessary. Practice secretaries took home visit calls until 2pm daily when the reception would then process home visit requests. Staff told us at times when home visit requests were high they would not be able to carry out normal secretary roles. In cases where the urgency of need was so great that it would be inappropriate for the patient to wait for a GP home visit, patients were told to dial 999 to access emergency care.

The practice had a system in place to assess the urgency of the need for medical attention. Reception staff were provided with a triage tool listing medical concerns. A list of symptoms were provided along with recommended interventions with an aim to ensure that the patient was referred for the appropriate level of care. For example, an urgent or routine GP telephone call or appointment; patient attendance at accident and emergency or a patient visit to a pharmacy.

We looked at the triage tool and saw there was a risk to safe care and treatment as receptionists assumed they had correctly identified the condition and that the problem could be appropriately managed without clinical intervention. There was no clinical monitoring of this system to ensure the correct outcome was received by the patient or that other possible diagnosis could have been considered.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Prior to the inspection we requested a summary of complaints received in the last 12 months, action taken and how learning was implemented. A full complaints summary was provided after our inspection.

- The practice complaint policy and procedures were in line with recognised guidance and contractual obligations for GPs in England.
- There was a designated responsible person who handled all complaints in the practice. Staff were unable to advise us of the process the practice took when managing complaints.
- We saw that information such as a practice leaflet was available to help patients understand the complaints system.

We looked in depth at three of the 41 complaints received at the practice since April 2015. We did not see evidence of an investigation process. For example, there was no evidence of records of conversations with patients and/or staff. We found that practice responses to complaints did not always provide an apology or information on how to seek further support when patients felt the complaint had not been acceptably resolved such as contact details for the Complaints Ombudsman.

We looked at two of the 13 complaints patients had made to the Care Quality Commission. We saw one patient had not received a written response from the practice after a previous complaint had been made. Evidence available showed a nurse practitioner had spoken with the patient and recommended GP care. We saw there was a delay in the patient receiving the care which could have impacted on the patients' health or wellbeing.

Are services well-led?

Inadequate

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

Our findings

At our last inspection on 29 September 2015 we rated the well-led domain as inadequate. Concerns included the practice vision and a strategy not being well developed. The approach to service delivery and accessibility for patients was reactive and focused on short term issues due to long term recruitment difficulties. There was a limited approach to obtaining views of patients who used the service. During this inspection we found improvements had not been made and the delivery of high quality care was not assured by the leadership, governance or culture in place. Significant issues that threaten the delivery of safe and effective care were not identified or adequately managed.

Vision and strategy

The practice had a documented practice vision and strategy to deliver safe care and encourage patients to self-manage their own health.

- The practice had a mission statement which was displayed in the waiting area and on the practice website and staff knew and understood the values.
- We were told by staff the practice had a strategy and supporting business plans which reflected the vision and values and were regularly monitored. During our inspection we asked for copies of these documents. The vision and strategies were made available after our inspection but no business plans or related documents were provided. We were unable to review practice business strategies about meeting patient needs and had no methods of verifying what staff told us.

Governance arrangements

The practice told us they had an overarching governance framework which supported the delivery of the strategy and good quality care. However on the day of the inspection we did not have access to overarching governance documentation. This included minutes of meetings, practice policies and a programme of continuous clinical and internal audits to monitor quality and make improvements. Some of the evidence requested prior to the inspection was not received and other evidence was not received in the timescales indicated.

We were unable to verify, through supporting evidence the practice had safe systems, processes and practices in place to prevent a patient from coming to harm. There were some arrangements for identifying, recording and managing risks however, during the inspection the staff available were not confident they would be able to provide the necessary information or did not have access to systems.

There was a staffing structure and that staff were aware of their own roles and responsibilities. Administration and reception staff were in the process of learning multiple roles to meet the needs of the service. Due to staff vacancies patients were not always seen by the most appropriate person in a timely manner.

The practice were unable to evidence succession planning or a practice business plan during the inspection. We asked for these to be sent after the inspection and we did not receive them so we were unable to review practice business strategies about meeting patient needs or verify the leadership accountability of the organisation through supporting evidence.

Leadership and culture

The practice manager was unavailable prior to and during the inspection and we were made aware that not all the information and systems had been shared with other staff. For example, systems for identifying, capturing and managing risks and serious events. There was no oversight of management systems during their absence meaning we were unable to evidence systems for the delivery of safe and effective patient care. We asked the practice to provide certain information prior to our inspection and not all of the requested information was received. During the inspection staff had difficulties locating information and evidence to support compliance with the Health and Social Care Act (2008). Following the inspection we received some of the requested information.

The practice told us they prioritised safe, high quality and compassionate care. Staff told us the partners were approachable and always took the time to listen to all members of staff.

The provider was aware of 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).However we were unable to fully evidence systems to ensure

Are services well-led?

Inadequate

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

compliance. This included support training for all staff on communicating with patients about notifiable safety incidents. Staff told us the partners encouraged a culture of openness and honesty.

We saw that when things went wrong with care and treatment the practice were not always open and transparent with patients. For example, they did not always give affected people reasonable support and a written apology. The practice was not working within the framework of good practice for complaint handling and may miss opportunities to identify themes and trends which could help improve services for patients.

There was a leadership structure in place and staff felt supported by management.

- Staff told us the practice held monthly meetings with the practice manager. Since the practice commenced lunchtime opening, opportunities for staff to share information at meetings had been reduced.
- Staff told us there was an open culture within the practice and they had the opportunity to raise any issues and felt confident and supported in doing so.
- Staff said they felt respected, valued and supported. Staff told us they had been told about the CQC action plan after our previous visit. Although they were unaware of how the plan had progressed making it difficult for staff to gauge how their efforts contributed to service improvement.
- We saw no evidence of an overarching document for annual appraisals. Staff were unsure who managed the appraisals. One team manager told us they had received supervision once since September 2015. Previous to this team leaders would meet weekly thus reducing opportunities for staff to share information.

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

The practice had gathered feedback from patients through the patient participation group (PPG) and through surveys and complaints received. The practice currently had a form on their website for patients to complete questions around access to the practice. They had a 'you said, we did' document on their website responding to some of the feedback received from patients. For example, when completing the friends and family test patients expressed frustration that the check-in machine often did not work and this caused a queue at the front desk. In response the practice had purchased a new check-in system.

During our inspection we spoke to one member of the patient participation group (PPG). The PPG met regularly and told us the practice worked well with them and had started to implement some suggestions the PPG had made to improve the practice.

We found the practice did not always respond and act on patient feedback. They were unable to evidence whether they responded internally to comments and complaints made by patients through NHS Choices or the national patient survey (which showed the practice had performed lower than local and national averages). The practice did not routinely respond directly to the patient feedback left on NHS Choices.

Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. We did not see evidence the practice had gathered feedback from staff through staff meetings, surveys or other formats.

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
	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **How the regulation was not being met:** **Regulation 12(2)(b)** Significant event analysis and incidents that affect the health, safety and welfare of patients were not thoroughly investigated. There was no evidence of actions to remedy the situation and prevent reoccurrence. Information from incidents was not shared with staff to promote learning. **Regulation 12(2)(f)** Medicines were not stored appropriately and safely. Staff were not following policies, procedures, guidance and current legislation for the safe storage of blank prescription papers and Patient Group directives

Regulated activity	Regulation
	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints **How the regulation was not being met:** **Regulation 16(2)** There was no evidence that patients' complaints were listened to, acted upon and responded to, to provide effective outcomes for patients.

Regulated activity	Regulation
	Regulation 17 HSCA (RA) Regulations 2014 Good governance **How the regulation was not being met:**

This section is primarily information for the provider

Requirement notices

Regulation 17(2)(b)

Staff were not following policies, procedures, guidance and current legislation for the storage of blank

prescription papers. Infection control measures had not been risk assessed.

Regulation 17(2)(f)

Systems had not been established and operated effectively to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity. Safe systems and processes were not in place to clarify the urgency of the need of patients for medical attention so they were provided with care and treatment, by the most appropriate person, in a timely manner. The provider did not have quality improvement initiatives to ensure improvements in clinical care and other processes to improve the outcome for patients.

Regulated activity

Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing

How the regulation was not being met:

Regulation 18(1)

Sufficient numbers of suitably qualified, competent, skilled and experienced persons were not in place to provide timely access to the practice through the telephone system, adequate urgent and non-urgent appointments during core practice hours and timely referrals to other services for advice and treatment.

Regulated activity

Regulation

Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed

How the regulation was not being met:

Regulation 19(2)

This section is primarily information for the provider

Requirement notices

Recruitment practices were not effective to ensure that appropriate documentation had been obtained to evidence the persons providing the care, treatment and support to patients had the competencies, qualifications and skills to do so.