Guttridge Medical Centre (Dr Shahid Surgery)

Quality Report

Guttridge Medical Centre
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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	Requires improvement
Are services safe?	Requires improvement
Are services effective?	Requires improvement
Are services caring?	Good
Are services responsive to people's needs?	Requires improvement
Are services well-led?	Requires improvement

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Guttridge Medical Centre (Dr Shahid Surgery) on 13 June 2017. Overall the practice is rated as requires improvement.

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. However, there was insufficient evidence of discussion of incidents and no evidence to show that learning from events had been shared. Staff did not follow the practice policy and there was no review of actions taken as a result of events nor an annual review. The management overview of events was incomplete.
- The practice lacked defined and embedded systems to minimise risks to patient safety in the areas of management of patient safety alerts, the use of prescriptions and those relating to recruitment checks. Non-clinical staff had not been risk-assessed for their role or received a DBS check, including those acting as chaperones. There were occasional daily gaps in the recording of the temperature of the fridge used to store vaccines.
- Staff told us that they were aware of current evidence based guidance although evidence to support this was lacking. There was no evidence of shared learning and clinical meetings were not documented. Clinical audits did not demonstrate quality improvement.
- Staff could not always evidence that they had the skills and knowledge to deliver effective care and treatment. There was a lack of training records for the principal GP and there was no practice information available for locums in the form of an induction pack. Non-clinical staff were removing some electronic items of post and filing normal test results without the GP having had sight of them and without a practice protocol. There was no formal system in place to ensure that patients received and attended appointments for urgent "two-week-wait" referrals.

Summary of findings

- Results from the national GP patient survey showed patients were treated with compassion, dignity and respect and were involved in their care and decisions about their treatment. However, we were shown no examples of personalised patient care plans developed by the practice. A total of 20 patients had been identified as carers (0.4% of the practice list).
- Information about services and how to complain was available. Improvements were made to the quality of care as a result of complaints and concerns. However, there was little evidence that learning from complaints was shared with staff and other stakeholders and no annual review of complaints was undertaken.
- Patients we spoke with said they found it easy to make an urgent appointment on the same day with a GP although comment cards and the national patient survey said that there was a long wait for routine appointments.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- The practice had policies and procedures to govern activity although these policies were not easily available to staff and some needed review as they were out of date.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients although this feedback was not acted on in relation to the availability of appointments.
- The provider was aware of the requirements of the duty of candour. Examples we reviewed showed the practice complied with these requirements.

The areas where the provider must make improvement are:

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

The areas where the provider should make improvement are:

- Take steps to better identify patients on the practice list who are also carers.

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?

Requires improvement

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

- From the sample of documented examples we reviewed, we found the system for reporting and recording significant events was insufficient. There was no evidence that lessons were shared when action was taken to improve safety in the practice and no review of any actions taken to mitigate risks. We did however see that when things went wrong patients were informed as soon as practicable, received reasonable support, truthful information, and a verbal or written apology. They were told about any actions to improve processes to prevent the same thing happening again.
- The practice lacked defined and embedded systems, processes and practices to minimise risks to patient safety. Patient safety alerts were received by clinical staff but there was no record of actions taken as a result of these alerts or of shared learning. Also, although non-clinical staff were trained to act as chaperones, they had not been risk assessed for the role or received a DBS check. The practice told us that the nurse had received a DBS check but they were unable to evidence this. They told us that the certificate had been mislaid. They sent us evidence following the inspection that a further DBS check had been requested urgently. Prescriptions coming into the practice were held securely and a log was kept of their receipt, however, there was no record of those prescriptions used or taken out of the practice. There were occasional daily gaps in records of refrigerator temperatures for stored vaccines. Recruitment checks for staff employed at the practice were insufficient for one staff member employed in 2015 and for locum GPs.
- Staff demonstrated that they understood their responsibilities and all had received training on safeguarding children and vulnerable adults relevant to their role, although the policy for safeguarding children was out of date.
- The practice had adequate arrangements to respond to emergencies and major incidents although the practice business continuity plan was incomplete and the principal GP was unaware of any details of the plan.
- Environmental risk assessments had been completed for the premises before the practice occupied the building in October 2016 and all clinical and portable electrical equipment had been checked to be safe.

Summary of findings

Are services effective?

Requires improvement

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

- Data from the Quality and Outcomes Framework showed patient outcomes were similar to the national average.
- Staff told us that they were aware of current evidence based guidance although evidence to support this was lacking. There was no evidence of shared learning and clinical meetings were not documented.
- Clinical audits did not demonstrate quality improvement. We were given only two clinical audits which were cost-based and conducted by an external agency.
- Staff could not always evidence that they had the skills and knowledge to deliver effective care and treatment. There was a lack of training records for the principal GP in topics such as safeguarding adults, the mental capacity act, deprivation of liberty safeguards, end of life care and basic life support. We were sent evidence following the inspection to show that training in these areas had been completed online during the following two days. There was no practice information available for locums in the form of an induction pack.
- There was evidence of appraisals and personal development plans for all staff.
- Staff worked with other health care professionals to understand and meet the range and complexity of patients' needs. There were regular meetings with other health and social care professionals although the GP was unable to show us any specific patient care plans. We also saw that some practice communications received from other services and patient normal test results were being filed by non-clinical staff without sight of the GP. There was no practice protocol or audit in place for this. Although patient urgent referrals were made in a timely way, there was no formal system in place to ensure that patients received timely appointments and attended them.
- End of life care was coordinated with other services involved.

Are services caring?

Good

The practice is rated as good for providing caring services.

- Data from the national GP patient survey showed patients rated the practice similarly to others for most aspects of care.
- Survey information we reviewed showed that patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Staff turnover at the practice was very low and this enabled good working relationships with patients.

Summary of findings

- The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 20 patients as carers (0.4% of the practice list). The practice was trying to identify carers more effectively by having forms clearly available on the reception desk for patients to identify themselves as carers.
- Information for patients about the services available was accessible.
- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.

Are services responsive to people's needs?

Requires improvement

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

- The practice understood its population profile and had used this understanding to meet the needs of its population. The practice offered extended hours on a Wednesday evening until 7.30pm for working patients who could not attend during normal opening hours.
- The practice took account of the needs and preferences of patients with life-limiting conditions, including patients with a condition other than cancer and patients living with dementia. A member of the local dementia awareness team attended the practice weekly to provide information for patients.
- Patients we spoke with said they found it easy to make an appointment with the GP although results of the GP national survey and comments left on seven of our comment cards said that booking routine appointments was difficult. We saw that the next available routine appointment with the GP was just over two weeks away. Urgent appointments were available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- Information about how to complain was available and evidence from three examples reviewed showed the practice responded quickly to issues raised. However, there was little evidence that learning from complaints was shared with staff and other stakeholders and no annual review of complaints.

Are services well-led?

Requires improvement

The practice is rated as requires improvement for being well-led.

- The practice had a vision and strategy to deliver high quality care and promote good outcomes for patients. Staff were clear about the vision and their responsibilities in relation to it.

Summary of findings

- There was a clear leadership structure and staff felt supported by management. The practice had policies and procedures to govern activity although these policies were not easily available to staff, some needed review and some were not being followed.
- An overarching governance framework to support the delivery of the strategy and good quality care was lacking. There were few arrangements to monitor and improve quality and identify risk. There was little evidence of quality improvement, including clinical audit. Non-clinical staff were filing patient normal test results and items of electronic post without sight of the GP and with no protocols or audit process in place. There was no information about the practice available to new locum GPs and staff recruitment checks were insufficient for a new staff member and for locum GPs. There were no risk assessments for staff working or checks with the disclosure and barring service, including for non-clinical staff working as chaperones in the practice.
- Staff had received inductions, annual performance reviews and attended staff meetings and training opportunities. However, meeting minutes lacked sufficient detail to evidence or share learning from patient complaints or significant events. There were no minutes of clinical meetings or evidence that clinical learning was shared. Meeting minutes were not easily available to staff. There was no practice overview of complaints or significant events to identify trends and no review of any actions taken. Staff training records were incomplete apart from any training conducted online; there was no management overview of training conducted in-house or externally.
- The provider was aware of the requirements of the duty of candour. In three examples we reviewed we saw evidence the practice complied with these requirements.
- The partners encouraged a culture of openness and honesty. The practice had systems for being aware of notifiable safety incidents and sharing the information with staff although there was no system in place to ensure that appropriate action was taken. Information about patient safety alerts was not kept for locum staff.
- The practice proactively sought feedback from staff and patients although this feedback was not acted on in relation to the availability of appointments. The practice engaged with the patient participation group.

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

Requires improvement

The practice is rated as requires improvement for the care of older people. The issues identified as being requiring improvement overall affected all patients including this population group.

- We were unable to see any evidence of formal personalised care planning for vulnerable elderly patients. There was no routine follow-up of patients discharged from hospital after an unplanned admission.

However:

- Staff were able to recognise the signs of abuse in older patients and knew how to escalate any concerns.
- Longer appointments at the practice were available for those patients with complex needs.
- The practice identified at an early stage older patients who may need palliative care as they were approaching the end of life. It involved older patients in making decisions about their care, including their end of life care.
- The practice held multidisciplinary meetings on a monthly basis where patients with complex needs were discussed to ensure they were being cared for appropriately.
- Where older patients had complex needs, the practice shared summary care records with local care services including the out of hours service.
- The practice invited vulnerable older patients to a Christmas party every year at the practice where they provided food, a visit from Father Christmas and entertainment.

People with long term conditions

Requires improvement

The practice is rated as requires improvement for the care of people with long-term conditions. The issues identified as being requiring improvement overall affected all patients including this population group. However:

- The practice nurse carried out long-term disease management and patients at risk of hospital admission were identified as a priority.
- Performance for diabetes related indicators was similar to or lower than the local and national averages.

Summary of findings

- There was a system to recall patients for a structured annual review to check their health and medicines needs were being met. For those patients with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.
- A phlebotomist visited the practice twice a week to take patient bloods.
- There were several other services available in the building including podiatry, a community eye care service, a hearing aid clinic and a physiotherapy service.

Families, children and young people

Requires improvement

The practice is rated as requires improvement for the care of families, children and young people. The issues identified as being requiring improvement overall affected all patients including this population group.

- Childhood immunisations were carried out in line with the national childhood vaccination programme. Uptake rates for the vaccines given were lower when compared to local averages.
- The practice's uptake for the cervical screening programme was 62%, which was considerably lower than the local average of 81% and the national average of 82%.

However:

- There were systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances.
- We saw on the day of inspection, that children and young people were treated in an age-appropriate way and were recognised as individuals.
- Appointments were available outside of school hours and the premises were suitable for children and babies.
- The practice worked with midwives, health visitors and school nurses to support this population group. For example, in the provision of ante-natal, post-natal and child health surveillance clinics.
- The practice had emergency processes for acutely ill children and young people and for acute pregnancy complications.

Summary of findings

Working age people (including those recently retired and students)

Requires improvement

The practice is rated as requires improvement for the care of working age people (including those recently retired and students). The issues identified as being requiring improvement overall affected all patients including this population group. However:

- The needs of these populations had been identified and the practice had adjusted the services it offered to ensure these were accessible, for example, a late night clinic on a Wednesday for working patients.
- The practice had recently adopted a system to offer online services and telephone appointments with clinicians were available.
- The practice offered a full range of health promotion and screening that reflects the needs for this age group.

People whose circumstances may make them vulnerable

Requires improvement

The practice is rated as requires improvement for the care of people whose circumstances may make them vulnerable. The issues identified as being requiring improvement overall affected all patients including this population group. However:

- The practice held a register of patients living in vulnerable circumstances including those with a learning disability.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice offered longer appointments for patients with a learning disability.
- The practice regularly worked with other health care professionals in the case management of vulnerable patients.
- The practice had information available for vulnerable patients about how to access various support groups and voluntary organisations.
- Staff interviewed knew how to recognise signs of abuse in children, young people and adults whose circumstances may make them vulnerable. They 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.
- One member of the practice PPG had an allotment “club” which could be attended by vulnerable, lonely patients. Patients could go to the allotment to garden together. This was advertised to patients in the waiting area.

Summary of findings

People experiencing poor mental health (including people with dementia)

Requires improvement 

The practice is rated as requires improvement for the care of people experiencing poor mental health (including people with dementia). The issues identified as being requiring improvement overall affected all patients including this population group. However:

- The practice carried out advance care planning for patients living with dementia.
- 100% of patients diagnosed with dementia had their care reviewed in a face-to-face review compared to the local average of 86% and national average of 84%.
- The practice specifically considered the physical health needs of patients with poor mental health and dementia and all patients were invited for an annual health review.
- The practice had a system for monitoring repeat prescribing for patients receiving medicines for mental health needs.
- 100% of people experiencing poor mental health had a comprehensive, agreed care plan documented in the record compared to the local and national average of 89%.
- The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those living with dementia.
- Patients at risk of dementia were identified and offered an assessment. A member of the local dementia awareness team visited the practice each week to provide information for patients in the waiting area.
- The practice had information available for patients experiencing poor mental health about how they could access various support groups and voluntary organisations.
- The practice had a system to follow up patients who had attended accident and emergency where they may have been experiencing poor mental health.

Summary of findings

What people who use the service say

The national GP patient survey results were published on 7 July 2016. The results showed the practice was performing in line with or below local and national averages. A total of 358 survey forms were distributed and 88 were returned (25%). This represented 3.6% of the practice's patient list.

- 82% of patients described the overall experience of this GP practice as good compared with the clinical commissioning group (CCG) average of 87% and the national average of 85%.
- 56% of patients described their experience of making an appointment as good compared with the CCG average of 74% and the national average of 73%.
- 59% 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 80% and the national average of 78%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 41 comment cards; a total of 27 of these were positive about the service experienced and a further four were mixed. Another five cards contained only negative comments, four cards had been signed but were blank and one card was illegible. Patients wrote that staff were helpful, supportive and professional. The negative comments were generally related to the availability of appointments.

We spoke with four patients during the inspection. All four patients said they were satisfied with the care they received and thought staff were approachable, committed and caring. Patients said that they never felt rushed and that staff always took time to listen to them.

Areas for improvement

Action the service MUST take to improve

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

Action the service SHOULD take to improve

- Take steps to better identify patients on the practice list who are also carers.

Guttridge Medical Centre (Dr Shahid Surgery)

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector and included a GP specialist adviser.

Background to Guttridge Medical Centre (Dr Shahid Surgery)

Guttridge Medical Centre (Dr Shahid Surgery) is situated on the Deepdale Road in Preston at PR1 6LL serving a mainly urban population. The building is a newly-converted church that has been occupied by the practice since September 2016. The practice shares the building with two other single-handed GP practices, a physiotherapy service and a pharmacy. The practice provides ramped access for patients to the building with disabled facilities available and fully automated entrance doors. Part of the reception desk is lowered to aid patient access.

The practice has parking for disabled patients and there is parking available on nearby streets for all other patients, and the surgery is close to public transport.

The practice is part of the Greater Preston Clinical Commissioning Group (CCG) and services are provided under a General Medical Services Contract (GMS) with NHS England. There is one male GP principal who provides nine surgery sessions each week. A practice nurse, a practice manager and seven additional administrative and reception staff assist them. One of the administrative staff is also the practice healthcare assistant providing a blood pressure clinic for patients and one also acts as the practice medicines co-ordinator. One staff member is the practice information technology lead.

The practice doors open from Monday to Friday from 8.30am to 6pm, except for Wednesday, and telephone access to the practice starts at 8am and finishes at 6.30pm. Doors are open late on a Wednesday until 7.30pm. Appointments are offered from 10.10am to 12 noon and from 4.10pm to 5pm on Monday, Tuesday and Friday, from 10.10am to 12 noon and from 4.10pm to 5.30pm and 6.30pm to 7pm on Wednesday, and from 10.20am to 12.20pm on Thursday. There is a rota for the three GP practices in the Medical Centre to cover any patient emergency appointments, including home visits, on a Thursday afternoon. When the practice is closed, patients are able to access out of hours services offered locally by the provider GotoDoc by telephoning 111.

The practice provides services to approximately 2,460 patients. There are lower numbers of patients aged over 65 years of age (14%) than the national average (17%) and the same number of patients aged under 18 years of age (21%). The practice also has considerably more male patients than female.

Information published by Public Health England (PHE) rates the level of deprivation within the practice population group as three on a scale of one to ten. Level one represents the highest levels of deprivation and level ten the lowest. The ethnicity estimate given by PHE gives an estimate of 2.7% mixed and 32.8% Asian. Male life expectancy is given as 77 years of age and female as 80 years.

Detailed findings

Why we carried out this inspection

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

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 13 June 2017. During our visit we:

- Spoke with a range of staff including the principal GP, the practice nurse, the practice manager and four members of the practice administration team including the staff member who also acted as the practice healthcare assistant, the staff member who was also the practice medicines co-ordinator and the practice information technology lead.
- Spoke with four patients who used the service who were also members of the practice patient participation group.
- Observed how patients were being cared for in the reception area and talked with carers and family members.
- Reviewed a sample of the personal care or treatment records of patients.
- Reviewed comment cards where patients and members of the public shared their views and experiences of the service.
- Looked at information the practice used to deliver care and treatment plans.

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 living with dementia).

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

Requires improvement

Are services safe?

Our findings

Safe track record and learning

The practice system for reporting and recording significant events was incomplete.

- Staff told us they would inform the practice manager of any incidents and there was a recording form available in reception. There was a comprehensive policy for reporting and managing significant events which supported the recording of notifiable incidents under the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment). However, this policy was not being followed. There was insufficient evidence of discussion of incidents and no evidence to show that learning from events had been shared. Minutes of meetings where significant events were discussed, contained an entry "Significant Event" with no identification of the event discussed or details of discussion. The summary of incidents in the last year contained details of only two significant events and we were given evidence of at least five such incidents. The GP also told us of an incident for which there was apparently no record. Staff we spoke to were unaware of some of the incidents and records of significant events were only stored in a file in the practice manager's office. Actions taken as a result of incidents were not reviewed and the practice did not carry out an annual review of significant events.
- The records of significant events that we were shown had arisen from patient complaints. From an example that we reviewed we found that when the patient had complained about their care and treatment, they received reasonable support, truthful information and were told about any actions to improve processes to prevent the same thing happening again.
- The practice had policies and procedures in place to deal with patient safety alerts although there were two conflicting policies for dealing with drug alerts and the practice was not following either of these policies. Patient safety alerts were being received by the GP and the nurse but there was no record of any action taken or discussion of these. Clinical meetings were not minuted and there was no record of shared learning. Patient safety alerts were not kept for information for locum staff as detailed in the policies.

Overview of safety systems and processes

The practice systems, processes and practices to minimise risks to patient safety were lacking in some areas.

- Arrangements for safeguarding reflected relevant legislation and local requirements. Policies were accessible to all staff in a folder in the reception office, although we saw that the policy for safeguarding children was out of date. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare and contact numbers for reporting concerns were displayed on the staff noticeboard in the reception office. There was a lead member of staff for safeguarding and the practice had a leaflet for patients called "Keeping children and young people safe". The practice had also conducted an audit of safeguarding services for the local clinical commissioning group (CCG) at the practice to ensure that they were compliant with the requirements for safeguarding. We were told that the GP attended safeguarding meetings when possible or provided reports where necessary for other agencies.
- Staff interviewed demonstrated they understood their responsibilities regarding safeguarding and had received training on safeguarding children and vulnerable adults relevant to their role. The principal GP, the practice nurse and the healthcare assistant were trained to child protection or child safeguarding level three.
- Notices in the waiting room and in treatment rooms advised patients that chaperones were available if required. All staff who acted as chaperones were trained for the role, however only clinical staff had received a Disclosure and Barring Service (DBS) check or been risk assessed. (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). On the day of inspection, we asked for a copy of the practice chaperone policy. We were given a policy that was insufficient and did not describe the practice procedure for staff acting as chaperones but was a policy for patients to be able to request a chaperone. Following our inspection, we were sent a policy that correctly described chaperoning procedures.

The practice maintained appropriate standards of cleanliness and hygiene.

- We observed the premises to be clean and tidy. There were cleaning schedules and monitoring systems in place.
- The practice nurse was the infection prevention and control (IPC) clinical lead who liaised with the local infection prevention teams to keep up to date with best practice. There was an IPC protocol and staff had received up to date training. Annual IPC audits were undertaken and we saw evidence that action was taken to address any improvements identified as a result.

The arrangements for managing medicines, including emergency medicines and vaccines, in the practice largely minimised risks to patient safety (including obtaining, prescribing, recording, handling, storing, security and disposal).

- There were processes for handling repeat prescriptions which included the review of high risk medicines. Repeat prescriptions were signed before being dispensed to patients and there was a reliable process to ensure this occurred. The local CCG pharmacy team carried out regular medicines audits, with the support of the practice medicines co-ordinator to ensure prescribing was in line with best practice guidelines for safe prescribing. The practice medicines co-ordinator attended regular meetings with the CCG pharmacy team. Refrigerated medicines were stored and monitored regularly although there were occasional gaps of one day in the recording of fridge temperatures. Blank prescription forms and pads were securely stored and all prescriptions entering the practice were logged. However, systems to monitor their use were lacking; there was no system to log prescriptions used or taken out of the practice. Patient Group Directions had been adopted by the practice to allow the nurse to administer medicines in line with legislation.

We reviewed two personnel files and three GP online locum files. Staff at the practice had generally been employed in the practice for over 10 years, some for over 20. We found that records did not evidence that appropriate recruitment checks prior to employment had been undertaken for one staff member employed 10 years ago. However, we also found that these checks were also missing for one staff member employed in 2015. There was no proof of identification and evidence of satisfactory conduct in previous employments in the form of references, nor was there any confidential health check made by the practice to assure that suitable provision was made for working conditions. The practice showed us a receipt for an application that had been made for a DBS check on the 5 June 2017. The practice healthcare assistant had received a DBS check, but there were no DBS checks or risk assessments in place for non-clinical staff. The practice nurse had been with the practice for 17 years. We were told that there was a DBS check in place but there was no evidence for this and we were told that the certificate had been mislaid. We were sent evidence following the inspection that a further DBS check had been requested urgently. Locum GP files also lacked the necessary documentation to ensure their suitability for working at the practice.

Monitoring risks to patients

There were procedures for assessing, monitoring and managing risks to patient and staff safety.

- There was a health and safety policy available and staff were trained in health and safety issues.
- The practice had an up to date fire risk assessment and carried out regular fire drills. There were designated fire marshals within the practice. There was a fire evacuation plan which identified how staff could support patients with mobility problems to vacate the premises.
- All electrical and clinical equipment was checked and calibrated to ensure it was safe to use and was in good working order.
- The practice had a variety of other risk assessments to monitor safety of the premises such as control of substances hazardous to health and infection control and legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings). A full risk assessment of the premises had been made prior to the practice occupying the building in September 2016. We were told that these risk assessments would be repeated after one year to ensure that the premises were still suitable for use. There were no risk assessments in place for specific staff working arrangements.
- There were arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system to ensure enough staff were on duty to meet the needs of patients.

Requires improvement

Are services safe?

Arrangements to deal with emergencies and major incidents

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

- There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency and also panic buttons under desks.
- All clinical staff and most non-clinical staff received annual basic life support training and there were emergency medicines available in the treatment room. Training records in basic life support were lacking for one staff member and showed that training had last been completed in 2009, even though we were assured that further courses had been attended. We were sent evidence following the inspection to show that online training had been completed for this staff member on the day following our inspection.
- The practice had a defibrillator available on the premises and oxygen with adult and children's masks. A first aid kit and accident book were available.
- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and stored securely.
- The practice had a business continuity plan for major incidents such as power failure or building damage. However, the plan did not include emergency contact numbers for staff and the GP was unaware of the details of the plan.

Requires improvement

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Clinicians were aware of relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines.

- The practice had systems to keep all clinical staff up to date. Staff had access to guidelines from NICE and told us that they used this information to deliver care and treatment that met patients' needs. However, the principal GP was unable to evidence this and there was no evidence that clinical updates were discussed, implemented and monitored to ensure that changes were embedded in practice.

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 (2015/16) were 89% of the total number of points available compared with the clinical commissioning group (CCG) average of 93% and national average of 94%. We saw unverified data for 2016/17 that was very similar to these results. Exception reporting was 11.6% which was slightly higher than the local CCG level of 9.6% and national average of 9.8%. (Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects).

This practice was not an outlier for any QOF (or other national) clinical targets. Data from 2015/16 showed:

- Performance for diabetes related indicators was similar to or lower than the CCG and national averages. For example, blood measurements for diabetic patients (IFCC-HbA1c of 64 mmol/mol or less in the preceding 12 months) showed that 67% of patients had well controlled blood sugar levels compared with the CCG and national average of 78%. However, the percentage of patients with blood pressure readings within recommended levels (150/90 mmHG or less) was 91%, the same as the CCG and national average.
- Performance for mental health related indicators was higher than the local and national averages. For example, 100% of people experiencing poor mental health had a comprehensive, agreed care plan documented in the record compared to the CCG and national average of 89%. Exception reporting for this indicator was lower than local and national averages. Also, 100% of patients diagnosed with dementia had their care reviewed in a face-to-face review compared to the CCG average of 86% and national average of 84%, and the practice had not exception reported any patients for this indicator.

Evidence of quality improvement including clinical audit was lacking:

- We asked for evidence of clinical audit and were given two audits that had been conducted in the last year. They had both been carried out by an external agency and were aimed at reducing prescribing costs for the practice and had not produced any system changes. We were not given any evidence of audit activity conducted by clinicians in the practice. The principal GP carried out minor surgery at the practice and the effectiveness of this work had not been audited.
- We saw that the practice nurse reviewed figures for any inadequate cytology samples, however, there was no other evidence of any clinical quality improvement work to identify areas of clinical improvement.

Effective staffing

Evidence reviewed showed that staff had the skills and knowledge to deliver effective care and treatment.

- The practice had an induction programme for all newly appointed staff. This covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality. However, the induction pack for new locum GPs was a suggested template for information inclusion and did not contain any practice information at all.
- The practice was not always able to demonstrate how they ensured role-specific training and updating for relevant staff. For example, for the principal GP. There was no evidence that the GP had trained in safeguarding

Requires improvement

Are services effective?

(for example, treatment is effective)

adults, the mental capacity act, deprivation of liberty safeguards, end of life care and basic life support. We were sent evidence following the inspection to show that training in these areas had been completed online during the following two days. Staff had trained in dementia awareness and in handling patient complaints. One member of the practice administration team had trained as a healthcare assistant and provided a blood pressure measuring clinic for patients each week.

- Staff administering vaccines and taking samples for the cervical screening programme had received specific training which had included an assessment of competence. Staff who administered vaccines could demonstrate how they stayed up to date with changes to the immunisation programmes, for example by access to on line resources and discussion at practice nurse forums.
- The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. Staff had access to appropriate training to meet their learning needs and to cover the scope of their work. This included ongoing support, one-to-one meetings, coaching and mentoring, clinical supervision and facilitation and support for the revalidating GP and nurse. The practice was also providing supervision once a week for a nurse practitioner in training. All staff had received an appraisal within the last 12 months.
- Staff received training that included: safeguarding, fire safety awareness, health and safety and information governance. Staff had access to and made use of e-learning training modules and in-house and external training.

Coordinating patient care and information sharing

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

- This included medical records and investigation and test results. However, we were given no evidence of patient care planning other than patient resuscitation orders. There was no routine follow-up of patients discharged from hospital after an unplanned admission. We also saw that some practice electronic communications received from other services and patient normal test results were being filed by non-clinical staff without sight of the GP. There was no practice protocol or audit in place for this.
- We saw that the practice shared relevant information with other services in a timely way when referring patients to other services. A member of the practice administration staff assisted the GP directly with these referrals every day. However, although the GP told us that he always knew to check referrals made for patients to the two week wait service, there was no system in place to ensure that this happened.

Staff worked together and with other health and social care professionals to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. This included when patients moved between services, including when they were referred, or after they were discharged from hospital. Information was shared between services, with patients' consent, using a shared care record. Meetings took place with other health care professionals on a monthly basis when vulnerable patients and those with complex needs were routinely reviewed.

The practice ensured that end of life care was delivered in a coordinated way which took into account the needs of different patients, including those who may be vulnerable because of their circumstances. They shared information about these patients with the local out-of-hours service.

Consent to care and treatment

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

- Staff told us that they understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005 although the principal GP told us that he had had no formal training in the Mental Capacity Act or Deprivation of Liberty safeguards. We were sent evidence that this training had been completed online following our inspection.
- When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance.

Requires improvement

Are services effective?

(for example, treatment is effective)

- Where a patient's mental capacity to consent to care or treatment was unclear the GP or practice nurse assessed the patient's capacity and, recorded the outcome of the assessment.

Supporting patients to live healthier lives

The practice identified patients who may be in need of extra support and signposted them to relevant services. 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 and patients with mental health needs.
- Smoking cessation advice was available from a local support group.

The practice's uptake for the cervical screening programme was 62%, which was considerably lower than the CCG average of 81% and the national average of 82%. We were told that due to difficulties in engaging patients to attend for cervical screening, the practice had participated in a local cancer screening initiative project during late 2015, early 2016. A member of the local black and minority ethnic (BME) network attended the practice and contacted patients who had failed to attend for cervical screening. Although we were told that this had improved uptake in screening, the practice had no figures for this.

There was a policy to offer telephone or written reminders for patients who did not attend for their cervical screening test. The practice ensured that a female sample taker was available. There were failsafe systems to ensure results were received for all samples sent for the cervical screening programme and the practice followed up women who were referred as a result of abnormal results.

The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer and there were posters displayed in the patient waiting area.

Childhood immunisations were carried out in line with the national childhood vaccination programme. Uptake rates for the vaccines given were lower when compared to CCG averages. For example, from child health surveillance figures for the previous 12 months, childhood immunisation rates for the vaccinations given to under two year olds ranged from 7% to 91% compared to the CCG averages of 89% to 94%. Figures for five year olds ranged from 77% to 91% compared to the CCG averages of 82% to 95%. Patients had access to appropriate health assessments and checks. These included health checks for new patients and NHS health checks for patients aged 40–74. Appropriate follow-ups for the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.

Good

Are services caring?

Our findings

Kindness, dignity, respect and compassion

During our inspection we observed that members of staff were courteous and very helpful to patients and treated them with dignity and respect.

- Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- Consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- Reception staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.

We received 41 patient Care Quality Commission comment cards. A total of 27 of these were positive about the service experienced and a further four were mixed. Another five cards contained only negative comments, four cards were blank and one card was illegible. Patients said they felt the practice offered a very good, professional service and staff were helpful, caring and treated them with dignity and respect. The negative comments were generally related to the availability of appointments.

We spoke with four patients who were also members of the patient participation group (PPG). They told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. Comments highlighted that staff responded compassionately when they needed help and that the surgery environment was first class. Staff told us that because the practice was small and staff turnover was very low, staff had an excellent knowledge of the patients and had good relationships with them.

Results from the national GP patient survey showed patients felt they were treated with compassion, dignity and respect. The practice was similar to local and national figures for its satisfaction scores on consultations with GPs and nurses. For example:

- 82% of patients said the GP was good at listening to them compared with the clinical commissioning group (CCG) and the national average of 89%.
- 88% of patients said the GP gave them enough time compared to the CCG and the national average of 87%.
- 93% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 96% and the national average of 95%
- 88% of patients said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 86% and the national average of 85%.
- 89% of patients said the nurse was good at listening to them compared with the CCG and the national average of 91%.
- 91% of patients said the nurse gave them enough time compared with the CCG and the national average of 92%.
- 97% of patients said they had confidence and trust in the last nurse they saw compared with the CCG and the national average of 97%.
- 89% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the CCG and national average of 91%.
- 81% of patients said they found the receptionists at the practice helpful compared with the CCG average of 86% and the national average of 87%.

Care planning and involvement in decisions about care and treatment

Patients told us they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them. Patients said that they were never rushed during consultations and that, although this sometimes meant longer waiting times in surgery, they felt that it was worth it. Patient feedback from the comment cards we received was also positive and aligned with these views.

Children and young people were treated in an age-appropriate way and recognised as individuals.

Results from the national GP patient survey showed patients responded fairly positively to questions about their involvement in planning and making decisions about their care and treatment. Results were generally in line with local and national averages. For example:

- 84% of patients said the last GP they saw was good at explaining tests and treatments compared with the CCG and the national average of 86%.

Good

Are services caring?

- 77% of patients said the last GP they saw was good at involving them in decisions about their care compared to the CCG and national average of 82%.
- 87% of patients said the last nurse they saw was good at explaining tests and treatments compared with the CCG average of 91% and the national average of 90%.
- 83% of patients said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average of 86% and the national average of 85%.

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

- Staff told us that interpretation services were available for patients who did not have English as a first language. The practice generally used multi-lingual staff to support patients and they were able to use a mobile 'phone app for any language that was not covered this way. However, we were told that this was rarely needed.
- Information leaflets were available in easy read format.
- The Choose and Book service was used with patients as appropriate. (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.)

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. At the time of our inspection, the practice was in the process of developing a website for patients to provide information online.

Support for isolated or house-bound patients included signposting to relevant support and volunteer services. One member of the practice PPG had an allotment "club" which was able to be attended by vulnerable, lonely patients. Patients could go to the allotment to garden together. This was advertised to patients in the waiting area. The practice also invited vulnerable older patients to a Christmas party every year at the practice where they provided food, a visit from Father Christmas and entertainment.

A member of the local dementia awareness organisation attended the practice weekly to speak to patients in the waiting area and raise patient awareness. There had also been a dementia awareness presentation to the PPG and to staff at a training event. There was a permanent table of literature on this subject in the waiting area.

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 20 patients as carers (0.4% of the practice list). This figure was low and the practice was trying to identify carers more effectively by having forms clearly available on the reception desk for patients to identify themselves as carers. They had also invited a member of the local carers support service to speak to the PPG at their last meeting. Written information was available to direct carers to the various avenues of support available to them and all were invited for 'flu vaccinations.

Staff told us that if families had experienced bereavement, the practice offered support to the family where appropriate. This was usually in the form of a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service.

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice understood its population profile and had used this understanding to meet the needs of its population:

- The practice offered extended hours on a Wednesday evening until 7.30pm for working patients who could not attend during normal opening hours.
- There were longer appointments available for patients with a learning disability.
- The practice had just started to use the online service for patients that offered access to booking appointments and ordering prescriptions online.
- Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice.
- The practice took account of the needs and preferences of patients with life-limiting progressive conditions. There were early and ongoing conversations with these patients about their end of life care as part of their wider treatment and care planning.
- Same day appointments were available for children and those patients with medical problems that require same day consultation.
- Patients were able to receive travel vaccines available on the NHS as well as those only available privately.
- There were accessible facilities, which included a hearing loop, and interpretation services available.
- A phlebotomist visited the practice twice a week to take patient bloods.
- A midwife provided antenatal clinics twice every week and clinics for baby vaccinations and immunisations were held every other week.
- There were several other services available in the building including podiatry, a community eye care service, a hearing aid clinic and a physiotherapy service. There was a pharmacy available in the same building.
- All practice patient services were on the ground floor. There was a ramp both outside and inside the building to aid access and the reception counter was lowered in one area. The building also had a lift to aid patients attending services on the upper floor.
- Other reasonable adjustments were made and action was taken to remove barriers when patients find it hard to use or access services.

Access to the service

The practice doors opened from Monday to Friday from 8.30am to 6pm, except on a Wednesday when the doors closed at 7.30pm. Telephone access to the practice started at 8am and finished at 6.30pm. Appointments were offered from 10.10am to 12 noon and from 4.10pm to 5pm on Monday, Tuesday and Friday, from 10.10am to 12 noon and from 4.10pm to 5.30pm and 6.30pm to 7pm on Wednesday and from 10.20am to 12.20pm on Thursday. There was a rota for the three GP practices in the Medical Centre to cover any patient emergency appointments, including home visits, on a Thursday afternoon. In addition to pre-bookable appointments that could be booked up to four weeks in advance, urgent appointments and telephone appointments were also available for patients that needed them.

Results from the national GP patient survey showed that patient's satisfaction with how they could access care and treatment was generally significantly lower than local and national averages.

- 58% of patients were satisfied with the practice's opening hours compared with the clinical commissioning group (CCG) average of 77% and the national average of 76%.
- 66% of patients said they could get through easily to the practice by phone compared to the CCG average of 74% and the national average of 73%.
- 73% of patients said that the last time they wanted to speak to a GP or nurse they were able to get an appointment compared with the CCG average of 84% and the national average of 85%.
- 93% of patients said their last appointment was convenient compared with the CCG average of 93% and the national average of 92%.
- 56% of patients described their experience of making an appointment as good compared with the CCG average of 74% and the national average of 73%.
- 40% of patients said they don't normally have to wait too long to be seen compared with the CCG average of 63% and the national average of 58%.

Patients told us on the day of the inspection that they were able to get urgent appointments when they needed them although they sometimes struggled to book a routine appointment. Of the 41 patient comment cards that we received, seven highlighted difficulties in getting

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

appointments with the GP. We saw that although the GP would see any patient as an emergency on the same day if clinically necessary, the next routine appointment with the GP was on the 28 June 2017, just over two weeks away.

We asked whether the practice was aware of the results of the GP patient survey and were told that they were although they had not immediately addressed them because they had anticipated moving to the new health centre and hoped that the situation would then improve. They had conducted their own patient satisfaction survey of 100 patients, starting from April 2017. Figures from this survey indicated:

- 58% of patients were satisfied with the practice's opening hours.
- 55% of patients said they were satisfied with getting through to the practice by phone.

The practice had a system to assess:

- whether a home visit was clinically necessary; and
- the urgency of the need for medical attention.

The GP would usually telephone the patient before visiting. 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, alternative emergency care arrangements were made. Clinical and non-clinical staff were aware of their responsibilities when managing requests for home visits.

Listening and learning from concerns and complaints

The practice had a system for handling complaints and concerns.

- Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England.
- The practice manager was the designated responsible person who handled all complaints in the practice. The practice recorded both verbal and written complaints.
- We saw that information was available to help patients understand the complaints system. There was a notice displayed in the waiting area and staff had a form and policy available for patients so that complaints could be recorded in writing if necessary. There was also some brief information on the practice leaflet.

We looked at three complaints received in the last 12 months and found they had been dealt with openness and honesty. Lessons were learned from the complaints and we were told that these lessons were shared with staff at practice meetings although records to evidence this were lacking. We were told that the practice did not review complaints regularly to identify any trends. Two of the complaints had also been reported as significant events.

Are services well-led?

Requires improvement

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

Our findings

Vision and strategy

The practice had a vision to deliver high quality care and promote good outcomes for patients.

- The practice had a mission statement which was "The doctor, practice nurse and all the staff endeavour to provide a full family based integrated service to our patients. We are a committed and dedicated team giving a proactive and flexible approach to provide our patients with a high standard of service". Some of the staff we spoke to were not aware of this statement but we found that they knew and understood the values.
- The practice did not have a business plan or a formal succession plan. They told us that they were in discussion with other single-handed GP practices locally regarding the possibility of merging the practices together in some form.

Governance arrangements

The practice governance framework did not fully support the delivery of its mission statement and good quality care.

- There was a clear staffing structure and staff were aware of their own roles and responsibilities. There was a low staff turnover and we saw examples of good professional competency. However, some non-clinical staff were filing patient normal test results and items of electronic post without the GP having had sight of them and with no protocols or audit process in place.
- The practice had employed locum GPs earlier in the year to cover the principal GP unexpected absence however, there was no locum induction pack available to give them information about the practice and how services were provided. Patient safety alerts and changes to clinical guidelines were not kept for locum use.
- Practice specific policies were implemented and were available to all staff. However, these were only available in printed form. They were kept in a large folder in the reception office and some policies also as copies in individual staff files. We saw that some of the policies in staff files had not been updated. On the day of inspection, it was sometimes very difficult to locate a particular policy or procedure and one was sent to us on the day following the inspection. Sometimes, amendments to policies had been made by hand and some policies were out of date, for example the safeguarding children policy which was dated 2009. The practice business continuity plan was incomplete and the GP was unaware of the contents of the plan. Staff were not always following practice procedure, for example in the management of patient safety alerts and significant events.
- Staff training records were incomplete apart from any training conducted online; there was no management overview of training conducted in-house or externally.
- Practice meetings were held monthly which provided an opportunity for staff to learn about the performance of the practice. However, minutes of these meetings were lacking in detail and were only available in a file in the practice manager's office. Significant events were tabled for discussion but there was no record of the actual event being discussed. We found that some staff were unaware of the learning outcomes of some significant events. There was little evidence of shared learning from complaints. There was no practice overview of complaints or significant events to identify trends and no review of any actions taken.
- There was no evidence of a programme of continuous clinical and internal audit to monitor quality and to make improvements. The only two audits that we were given were cost-based and conducted by an external agency.
- Arrangements for identifying, recording and managing risks, issues and implementing mitigating actions were incomplete. There were insufficient checks made for the recruitment of new staff and locum GPs. There were no risk assessments for staff working or checks with the disclosure and barring service, including for non-clinical staff working as chaperones in the practice.

Leadership and culture

Staff told us they prioritised safe, high quality and compassionate care. They told us the lead GP was approachable and always took the time to listen to all members of staff. We found that the practice team was long-standing and worked well together.

The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).This included support training for all staff on communicating with patients about

Are services well-led?

Requires improvement

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

notifiable safety incidents. The GP encouraged a culture of openness and honesty. From the sample of three documented examples we reviewed we found that the practice had systems to ensure that when things went wrong with care and treatment:

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

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

- The practice held a range of multi-disciplinary meetings including meetings with district nurses and social workers to monitor vulnerable patients. GPs, where required, met with health visitors to monitor vulnerable families and safeguarding concerns.
- Staff told us the practice held regular team meetings. The practice told us that they also held clinical meetings but these meetings were not minuted. We were told that clinical staff were updated with changes to recommended guidance and guidelines but there was no evidence for this and the GP was unaware of a recent update received in the practice.
- Staff told us there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and felt confident and supported in doing so. The practice funded a practice social event once a year.
- Staff said they felt respected, valued and supported, particularly by the GP in the practice. All staff were involved in discussions about how to run and develop the practice, and the GP encouraged all members of staff to identify opportunities to improve the service delivered by the practice.

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

The practice encouraged and valued feedback from patients and staff. It proactively sought feedback from:

- patients through the patient participation group (PPG) and through surveys and complaints received. The practice had had a PPG for over ten years. The PPG met regularly, discussed health topics such as dementia awareness and support for carers, and submitted proposals for improvements to the practice management team. The practice was also trying to extend the face-to-face group by forming a virtual PPG.
- the NHS Friends and Family test, complaints and compliments received
- staff through meetings, appraisals and discussion. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged to improve how the practice was run.

Although staff told us that they were aware of feedback from patients, they had not acted on it in relation to the availability of appointments.

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 Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **The practice must comply with Regulation 12(1).** **Care and treatment must be provided in a safe way for service users to ensure compliance with the requirements of the fundamental standards as set out in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.** **How the regulation was not being met:** **The registered persons had not done all that was reasonably practicable to mitigate risks to the health and safety of service users receiving care and treatment. In particular:** • The temperatures for refrigerators used to store vaccines were not recorded every day. **This was in breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **The practice must comply with Regulation 17(1).**

This section is primarily information for the provider

Requirement notices

Systems or processes must be established and operated effectively to ensure compliance with the requirements of the fundamental standards as set out in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

How the regulation was not being met:

There was a lack of systems or processes that enabled the registered person to assess, monitor and improve the quality and safety of the services being provided. In particular:

- There was little evidence that significant events, patient complaints, patient safety alerts and clinical guideline changes were used to change systems or share learning.
- There was a lack of formal review of actions taken as a result of significant events.
- There was a lack of clinical audit or practice quality improvement work.

There was a lack of systems or processes that enabled the registered person to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk. In particular:

- Policies and procedures were not well managed.
- There were no risk assessments in place for staff working and non-clinical staff were acting as chaperones without any risk assessments or DBS checks.
- The system for monitoring the use of prescriptions was incomplete.
- Recruitment checks for new staff and locum GPs were incomplete. There was no locum pack of practice-specific information.
- Staff training records were incomplete.

This section is primarily information for the provider

Requirement notices

- Non-clinical staff were filing some items of post and normal patient test results without sight of the GP and without a protocol in place.
- There was no system to ensure that patients referred urgently to secondary care received and attended appointments.
- Patient feedback was not always acted on; patients had difficulty in booking routine appointments with the GP.

The registered person had systems or processes in place that operated ineffectively in that they failed to enable the registered person to assess, monitor and improve the quality and safety of the services being provided. In particular:

- The process for monitoring fridge temperatures was not being followed.
- Staff were not following the practice policy for managing patient safety alerts and for dealing with significant events.

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

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed The practice must comply with Regulation 19(1&2). Persons employed for the purposes of carrying on a regulated activity must be fit and proper persons to ensure compliance with the requirements of the fundamental standards as set out in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Requirement notices

How the regulation was not being met:

The registered person's recruitment procedures did not ensure that only persons of good character were employed. In particular:

- There was no evidence of a previous DBS check for the practice nurse. There was no proof of identification nor evidence of satisfactory conduct in previous employments in the form of references for a new member of staff.

The registered person's recruitment procedures did not establish whether staff were able, by reasons of their health and after reasonable adjustments, to properly perform tasks intrinsic to the work for which they would be employed. In particular:

- There was no confidential health check made by the practice to assure that suitable provision was made for working conditions for a new member of staff.

This was in breach of regulation 19(1&2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.