# Lister House Surgery

## Inspection report

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

## Ratings

| Overall rating for this location | Inadequate |
|---|---|
| Are services safe? | Inadequate |
| Are services effective? | Inadequate |
| Are services caring? | Requires improvement |
| Are services responsive? | Inadequate |
| Are services well-led? | Inadequate |

# Overall summary

**This practice is rated as inadequate overall.** (Previous rating April 2015 – Good)

The key questions are rated as:

Are services safe? – Inadequate

Are services effective? – Inadequate

Are services caring? – Requires Improvement

Are services responsive? – Inadequate

Are services well-led? - Inadequate

We carried out an announced comprehensive inspection at Lister House Surgery on 18 and 19 June 2018. The inspection was carried out in response to concerns raised regarding the leadership at the practice. There were also concerns shared specific to the supervision and training of staff, the management of correspondence from other care providers including test results, governance processes and access to care and treatment.

At this inspection we found:

- Significant concerns in the leadership and governance of the practice. There had been a breakdown in the professional relationship between the individual GP partners and some practice staff.
- The process for identifying significant events was not followed. We found that no significant events had been identified or reported on for two years.
- There was no system in place to manage safety alerts and Medicines and Healthcare products Regulatory Agency (MHRA) alerts received by the practice.
- Policies in place were not practice specific and many were overdue a review. This included policies for safeguarding children and vulnerable adults. There were no policies in place to cover whistleblowing or business continuity.
- Appropriate staff checks were made prior to recruitment. However, a disclosure and barring check (DBS) was missing for a member of the nursing team.
- There had been no infection prevention and control (IPC) audits completed so areas that required attention had not been identified.
- Staff morale was low and there had been recent resignations which left some of the remaining staff fulfilling more than one role.
- There was an inconsistent approach to managing test results and communications from secondary care which lead to some recommended actions not completed.
- There was not a process in place for the use of Patient Specific Directions (PSDs).
- There were no up to date risk assessments in place for the control of substances hazardous to health (COSHH), Fire Safety, Legionella, Health and Safety or Infection Prevention and Control.
- There was a lack of patient engagement. There was no patient participation group (PPG), no patient surveys had been completed and no actions taken in response to the national GP patient survey. The NHS friends and family test (FFT) was done via the practice website but there was no analysis of the results.
- Processes for providing staff with the development they needed were lacking. There had been no staff appraisals in the previous two years. New staff who had joined the practice in the previous two years had not received a formal, documented induction and there were no contracts or job descriptions available for these staff. Some staff were carrying out roles that they were not qualified or trained to do. For instance, members of the nursing team had completed medicine reviews that they were not qualified to do.
- The complaints policy was overdue a review. Not all complaints were handled in accordance with the recommended guidance.
- Feedback from patients on the CQC comments cards was generally positive.
- Feedback from a local care home that the practice was aligned to was positive. The home commented that the practice was responsive to requests for home visits.

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

- Ensure care and treatment is provided in a safe way to patients.
- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.
- Act in accordance with the Duty of Candour

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

- Ensure clinical waste is stored securely.
- Continue to identify and support carers.
- Consider how to respond to GP patient survey results.

# Overall summary

I am placing this service in special measures. Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate for any population group, key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

The service will be kept under review and if needed could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service by adopting our proposal to remove this location or cancel the provider's registration.

Special measures will give people who use the service the reassurance that the care they get should improve.

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

## Population group ratings

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

## Our inspection team

Our inspection team was led by a Care Quality Commission (CQC) lead inspector**.** The team included a CQC inspection manager, a GP specialist adviser and a practice nurse specialist adviser.

## Background to Lister House Surgery

Lister House Surgery provides a range of primary medical services to the residents of Luton. The practice has a registered manager in place. A registered manager is an individual registered with CQC to manage the regulated activities provided.

The practice provides primary medical services under a general medical services (GMS) contract from its location of 473 Dunstable Road, Luton, Bedfordshire, LU4 8DG. Online services can be accessed from the practice website www.listerhouseluton.co.uk

The practice has approximately 7100 patients. The practice population is of mixed ethnicity with an average age range. National data indicates the area is one of mid deprivation.

The practice is led by two male GP partners. They use three regular GP locums, one male and two female, to support the clinical team. The nursing team consists of a nurse practitioner, a practice nurse and a health care assistant, all female. There is a team of administrative and reception staff. At the time of the inspection there was no practice manager in post and one of the GPs who was the registered manager was absent from the practice.

Lister House Surgery is open from 8.30am to 6.30pm Monday to Friday with the telephone lines open from 8am. The practice offers extended hours opening for pre-booked appointments on Saturdays from 8am to 12pm.

When the practice is closed out-of-hours services are provided by Herts Urgent Care and can be accessed via the NHS 111 service.

Inadequate

# Are services safe?

**We rated the practice as inadequate for providing safe services.**

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

- We identified significant concerns in respect of the systems and processes in place and the levels of risk associated with patient safety.
- The process for identifying significant events was not followed.
- There was no system in place to manage safety alerts and Medicines and Healthcare products Regulatory Agency (MHRA) alerts received by the practice.
- Disclosure and barring service check (DBS) had not been completed for all staff.
- There was no register of staff vaccinations or immunisation status. There were no risk assessments in place to explain why the immunisation status was not evident for either clinical or non-clinical staff.
- We found there were no clinical meetings taking place in the practice to discuss and share learning, safety alerts, complaints and significant events.
- Patient Specific Directions (PSDs) were not used in the practice.
- Safeguarding procedures in the practice were lacking.
- The system for checking the monitoring of medicines that required review was not effective.
- Actions identified in secondary care with regards to changes to patients prescribed medicines or treatment were not always completed.

**Safety systems and processes**

The practice did not have clear systems to keep people safe and safeguarded from abuse.

- The practice did not have appropriate systems to safeguard children and vulnerable adults from abuse. All staff received up-to-date safeguarding and safety training appropriate to their role and they knew how to identify and report concerns. However, the safeguarding policies were not practice specific, they did not identify who was the lead member of staff for safeguarding and they did not contain review dates to indicate the information they contained was up to date and relevant. The local authority contact details were dated 2015. There were no reports and learning from safeguarding incidents available to staff. The nursing staff acted as chaperones and were trained for their role. However, the practice was unable to provide evidence to assure us that they had all received a DBS check. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable.)
- A review of the patient record system showed that there was no evidence of information sharing with the local health visitor with regards to children with multiple visits and non-attenders, to identify safeguarding concerns.
- There was not an effective system to manage infection prevention and control (IPC). The IPC policy was overdue a review and IPC audits had not been completed. IPC training was not included in the induction of new staff.
- The practice did not have arrangements in place to ensure that facilities and equipment were safe and in good working order.
- Arrangements for managing waste and clinical specimens kept people safe in most instances. However, the clinical waste bin used to store waste for collection was not secure.
- The practice carried out appropriate staff checks at the time of recruitment and on an ongoing basis for most staff. The practice was unable to assure us that a DBS check had been completed for a member of the nursing team.

**Risks to patients**

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

- Arrangements were in place for planning and monitoring the number and mix of staff needed to meet patients' needs, including planning for holidays, sickness, busy periods and epidemics. However, at the time of the inspection there had been several staff who had recently resigned. This meant that some of the remaining staff were fulfilling more than one job role.
- The practice was equipped to deal with medical emergencies and staff were suitably trained in emergency procedures.
- Staff understood their responsibilities to manage emergencies on the premises and to recognise those in need of urgent medical attention. Clinicians knew how to identify and manage patients with severe infections including sepsis.

**Information to deliver safe care and treatment**

Inadequate

# Are services safe?

Staff had some information they needed to deliver safe care and treatment to patients.

- The care records we saw showed that information needed to deliver safe care and treatment was available to staff. However, the approach to managing test results was not consistent. The most recent results received into the practice had been reviewed and acted upon but not all blood test results were documented in the patient computer records.
- We found that actions identified in secondary care with regards to changes to patients prescribed medicines or treatment are not always completed. We reviewed two letters and found that one patient had not had their prescribed dose of medicine increased and another had not received a recommended review.
- The practice had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.
- Clinicians made timely referrals in line with protocols.

**Appropriate and safe use of medicines**

The practice did not always have reliable systems for appropriate and safe handling of medicines.

- The systems for managing and storing medicines, including vaccines, medical gases, emergency medicines and equipment, minimised risks.
- National guidance was not always followed when staff prescribed, administered or supplied medicines to patients and gave advice on medicines. The practice did not use Patient Specific Directions (PSDs) when the health care assistant administered vaccinations or injections. A PSD is the written instruction, signed by a doctor, dentist, or non-medical prescriber for medicines to be supplied and/or administered to a named patient after the prescriber has assessed the patient on an individual basis.
- Members of the nursing team had completed medicine reviews that they were not qualified to do. The practice had not reviewed its antibiotic prescribing and had not taken action to support good antimicrobial stewardship in line with local and national guidance.
- Patients' health was monitored in relation to the use of medicines. However, blood test results for patients that required a review when taking high risk medicines were not recorded in the patient computer record.

**Track record on safety**

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

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

**Lessons learned and improvements made**

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

- The GPs and staff did not understand their duty to raise concerns and report incidents and near misses.
- We found that no significant events had been identified or reported on for two years
- There were no systems for reviewing and investigating when things went wrong. The practice did not hold any clinical or staff meetings where significant events would be discussed, reviewed and lessons learnt from the event identified to improve safety in the practice.
- The practice did not act on and learn from external safety events as well as patient and medicine safety alerts.

**Please refer to the Evidence Tables for further information.**

Inadequate

# Are services effective?

**We rated the practice as inadequate for providing effective services overall and across all population groups**

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

- The practice did not have effective systems to keep clinicians up to date with current evidence-based practice and NICE guidance.
- The practice did not hold any clinical meetings to discuss performance, clinical guidelines or share learning.
- The GP partners did not always attend multi-disciplinary team meetings.
- Some medicine reviews were completed by staff without the requisite qualifications and training.
- There was a lack of quality improvement activity.
- Staff were not supported by appraisals and performance development plans.
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**Effective needs assessment, care and treatment**

The practice did not have systems to keep clinicians up to date with current evidence-based practice. We saw that clinicians did not always assess needs and deliver care and treatment in line with current legislation, standards and guidance supported by clear clinical pathways and protocols.

- We saw that when patients could not get a same day appointment staff did not advise them what to do if their condition got worse and where to seek further help and support.
- The practice did not hold clinical meetings to discuss latest guidance and protocols. The nursing staff informed us they did not always feel supported by the GPs.
- We found the nursing staff were carrying out medicine reviews that they were not trained to complete.
- Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.
- We saw no evidence of discrimination when making care and treatment decisions.

Older people:

This population group was rated inadequate for effective because:

- The concerns identified with the effectiveness of the services affect all population groups.
- All of these patients had a named GP.
- Older patients who were frail or may be vulnerable received an assessment of their physical, mental and social needs.

People with long-term conditions:

This population group was rated inadequate for effective because:

- The concerns identified with the effectiveness of the services affect all population groups.
- Nursing staff were trained to review patients with long-term conditions. However, there was a lack of clinical meetings to promote discussion about patients with complex long-term conditions.
- The practice's performance on quality indicators for long term conditions was in line with local and national averages.

Families, children and young people:

This population group was rated inadequate for effective because:

- The concerns identified with the effectiveness of the services affect all population groups.
- Childhood immunisation uptake rates were in line with the target percentage of 90% or above in most areas. There was one area where the practice was below the target percentage of 90% that they felt was due to a data input issue.
- The practice did not routinely discuss frequent attenders and those who missed appointments with the local health visiting team to help identify safeguarding concerns.

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

This population group was rated inadequate for effective because:

- The concerns identified with the effectiveness of the services affect all population groups.
- The practice's uptake for cervical screening was 61%, which was below the 80% coverage target for the national screening programme. There were posters in

the patient waiting area to support women to take up the offer of cervical screening. We were informed that patients were opportunistically offered screening if they were visiting the practice for a different issue.
- The practice's uptake for breast and bowel cancer screening was comparable with the national average.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40-74.

People whose circumstances make them vulnerable:

This population group was rated inadequate for effective because:

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

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

This population group was rated inadequate for effective because:

- The concerns identified with the effectiveness of the services affect all population groups.
- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder by providing access to health checks, interventions for physical activity, obesity, diabetes, heart disease, cancer and access to 'stop smoking' services.
- The practice offered annual health checks to patients with a learning disability.
- The practices performance on quality indicators for mental health was in line with local and national averages.

**Monitoring care and treatment**

The practice did not have a comprehensive programme of quality improvement activity and did not routinely review the effectiveness and appropriateness of the care provided.

- There was no QOF lead in the practice and no clinical meetings in place to discuss performance and QOF achievement. The practice had a higher exception reporting rate for QOF when compared to the local CCG and nationally. The practice informed us that patients were invited to attend three times before they were subject to exception.
- The practice used information about care and treatment to make improvements.
- The practice was not actively involved in quality improvement activity. They had completed one audit in the past two years that showed an improvement in the number of patients who had their blood cholesterol level checked following a heart attack.

**Effective staffing**

Staff did not always have the skills, knowledge and experience to carry out their roles.

- Staff who had joined the practice in the preceding two years had not had a formal induction. One to one meetings, coaching and mentoring were not in place. None of the staff had received an appraisal for more than two years.
- The nursing staff met once a month for meetings and clinical supervision but reported that they were not always supported by the GPs in the practice.
- Staff had appropriate knowledge for their role, for example, to carry out reviews for people with long term conditions, older people and people requiring contraceptive reviews.
- Staff whose role included immunisation and taking samples for the cervical screening programme had received specific training and could demonstrate how they stayed up to date.
- Online training courses for self-directed learning were available for staff and up to date records of skills, qualifications and training were maintained.

**Coordinating care and treatment**

Staff did not always work together and with other health and social care professionals to deliver effective care and treatment.

- Multi-disciplinary team meetings took place within the practice for all appropriate staff, including those in

different teams and organisations, to be involved in assessing, planning and delivering care and treatment. However, feedback we received was that these were not always attended by the GP partners.
- The practice shared information with relevant professionals when discussing care delivery for people with long term conditions and when coordinating healthcare for care home residents.
- The practice ensured that end of life care was delivered in a coordinated way which took into account the needs of different patients, including those who may be vulnerable because of their circumstances.

**Helping patients to live healthier lives**

Staff were proactive in helping patients to live healthier lives.

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

**Consent to care and treatment**

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

- Clinicians understood the requirements of legislation and guidance when considering consent and decision making.
- Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.

**Please refer to the evidence tables for further information.**

Requires improvement

# Are services caring?

Detailed findings narrative goes here…

**We rated the practice as inadequate/requires improvement/good/outstanding for caring.**

The practice was rated as requires improvement for caring because:

- Responses in the national GP patient survey were below average in some areas. The practice had not completed an analysis of the results or implemented any action plans to make improvements.
- The practice had identified less than 1% of the practice population as carers and the support available to carers was limited.

**Kindness, respect and compassion**

Staff treated patients with kindness, respect and compassion.

- Feedback from patients was positive about the way staff treat people.
- Staff understood patients' personal, cultural, social and religious needs.
- The practice gave patients timely support and information.
- The practice national GP patient survey results were mixed when compared to local and national averages for questions relating to kindness, respect and compassion. For example, they were comparable to others for the GPs treating patients with care and concern but below average for the nursing staff in the same area. The practice was below average for the percentage of respondents to the GP patient survey who stated that they would definitely or probably recommend their GP surgery to someone who has just moved to the local area.

The practice had not completed any actions in relation to the areas where they were below average in the GP patient survey.

**Involvement in decisions about care and treatment**

Staff helped patients to be involved in decisions about care and treatment. However, patient feedback from the national GP patient survey indicated that this was not always effective. The practice was aware of the Accessible Information Standard (a requirement to make sure that patients and their carers can access and understand the information that they are given.)

- Staff communicated with people in a way that they could understand, for example, communication aids and easy read materials were available.
- Information leaflets were available in different languages.
- The practice identified carers but did not have an identified carers lead to co-ordinate and promote the support available to them.
- The practices GP patient survey results were below local and national averages for questions relating to involvement in decisions about care and treatment for both GPs and nursing staff.

The practice had not completed any actions in relation to the areas where they were below average in the GP patient survey.

**Privacy and dignity**

The practice respected patients' privacy and dignity.

- When patients wanted to discuss sensitive issues, or appeared distressed reception staff offered them a private room to discuss their needs.
- Staff recognised the importance of people's dignity and respect. They challenged behaviour that fell short of this.

**Please refer to the evidence tables for further information.**

Inadequate

# Are services responsive to people's needs?

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

The practice was rated as inadequate for responsive because:

- Complaints were not managed in line with recognised guidance.
- The practice had not made improvements to quality in response to complaints.

**Responding to and meeting people's needs**

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

- The practice had not completed an analysis of its patient population to ensure tailored services in response to their needs.
- The facilities and premises required attention for the services it delivered. The practice building was two converted houses with consultation and treatment rooms all on the ground floor. There was level access into the building with a small ramp. The building was in a poor state of decoration and repair. There were loose carpet tiles around the building posing a trip hazard, exposed electrical wires in the upstairs staff toilet and low lighting in the corridors patients used to access the consultation and treatment rooms. The practice had not formally assessed the risk or implemented any mitigating actions in relation to health and safety in the practice.

Older people:

This population group was rated inadequate for responsive because:

- The concerns identified with the responsiveness of the services affect all population groups.
- The practice offered home visits and urgent appointments for those with enhanced needs.
- The practice was aligned with a local care home for the elderly and carried out twice weekly visits. Feedback from the home was positive. They commented that the practice responded promptly to requests for home visits.

People with long-term conditions:

This population group was rated inadequate for responsive because:

- The concerns identified with the responsiveness of the services affect all population groups.
- Patients with a long-term condition received an annual review to check their health and medicines needs were being appropriately met.
- The practice did not routinely offer one appointment for multiple conditions to be reviewed.

Families, children and young people:

This population group was rated inadequate for responsive because:

- The concerns identified with the responsiveness of the services affect all population groups.
- Appointments were available outside of school hours.

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

This population group was rated inadequate for responsive because:

- The concerns identified with the effectiveness of the services affect all population groups.
- Extended opening hours were available on Saturday mornings which was useful for those who could not attend during normal opening hours.
- Online prescription and appointment requests were available.

People whose circumstances make them vulnerable:

This population group was rated inadequate for responsive because:

- The concerns identified with the effectiveness of the services affect all population groups.
- The practice held a register of patients living in vulnerable circumstances including homeless people those with a learning disability.
- People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode.

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

This population group was rated inadequate for responsive because:

Inadequate

# Are services responsive to people's needs?

- The concerns identified with the effectiveness of the services affect all population groups.

**Timely access to care and treatment**

Patients were able to access care and treatment from the practice within an acceptable timescale for their needs.

- Patients had timely access to initial assessment, test results, diagnosis and treatment.
- Waiting times, delays and cancellations were minimal and managed appropriately.
- Patients with the most urgent needs had their care and treatment prioritised.
- The practices GP patient survey results were in line with local and national averages for questions relating to access to care and treatment in most areas. However, they were below average for the percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment. The practice had not completed any actions in relation to the below average survey score.

**Listening and learning from concerns and complaints**

Evidence provided during our inspection demonstrated that the practice did not take complaints and concerns seriously and did not respond to them appropriately to improve the quality of care. For example:

- Information about how to make a complaint or raise concerns was available. However, information in the complaints leaflet and on the practice website regarding the complaints lead was not correct.
- The practice complaints policy had not been reviewed or updated since 2013. The complaints lead identified in the policy was as an ex staff member who had left the practice two years previously.
- The complaints policy and procedures documented recommended timeframes and actions to take in line with recognised guidance but the practice did not follow the policy for the management of all complaints.
- The practice did not complete an analysis of complaints to identify any trends. There were no meetings held to share learning or discussions with staff.
- The practice had not taken any action as a result of complaints to improve the quality of care.

**Please refer to the evidence tables for further information.**

Inadequate

# Are services well-led?

**We rated the practice as inadequate for providing a well-led service.**

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

- We found significant concerns in the leadership and governance of the practice.
- There had been a breakdown in the professional relationship between the individual GP partners and some practice staff.
- The policies used to govern activity in the practice were not practice specific and there are no review dates so we could not be assured that the information contained was accurate.
- Staff were not supported through formal induction, appraisals or professional development plans.
- Essential risk assessments had not been completed.
- There was a lack of patient engagement.

**Leadership capacity and capability**

Leaders did not have the capacity and skills to deliver high-quality, sustainable care.

- Leaders were not aware of issues and priorities relating to the quality and future of services. They did not understand the challenges and no actions had been taken to address them.
- At the time of the inspection one of the GP partners was absent from the practice and the practice manager post was vacant.
- A member of the administration team had been given the job title of deputy practice manager but had not received the training or support necessary to fulfil the role.
- Staff reported that they did not always feel supported by the leaders in the practice.

**Vision and strategy**

The practice did not have a clear vision and credible strategy to deliver high quality, sustainable care.

- There was not a clear vision and set of values. The practice was unable to provide evidence of any business plans in place to achieve priorities.
- Staff we spoke with were not aware of any vision, values and strategy. However, they did say they wanted to provide a good service for patients.
- At the time of our inspection the practice lacked effective operational management and overall, leadership was inadequate as there was a lack of oversight and implementation of effective policies and procedures.

**Culture**

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

- Staff morale was low. There had been key members of staff who had left the practice in the months preceding the inspection including a GP, the practice manager and senior administration staff. Administration staff were multi-tasking to ensure tasks were completed.
- New members of staff were not supported by a formal induction. This led to staff resigning from the practice as they did not feel supported.
- Openness, honesty and transparency were demonstrated when responding to some complaints but not all complaints were handled in accordance with recommended guidance. There was some evidence that the provider was aware of and had systems to ensure compliance with the requirements of the duty of candour. However, when the practice had been alerted of a patient with a missed diagnosis, they did not complete an investigation or contact the patient to offer an explanation or apology.
- The practice was not following a process to identify and report on significant events. There were no clinical or staff meetings held to discuss complaints, significant events, shared learning or new guidance.
- The processes for providing all staff with the development they need was lacking. None of the staff had received an appraisal for more than two years. Staff were supported to meet the requirements of professional revalidation where necessary.
- As staff were asked to fulfil roles and duties for which they were not trained for or supported in we could not see that there was an emphasis on the safety and well-being of all staff.
- Staff had received equality and diversity training.

**Governance arrangements**

There were not clear responsibilities, roles and systems of accountability to support good governance and management.

Inadequate

# Are services well-led?

- Structures, processes and systems to support good governance and management were not clearly set out, understood or effective.
- Lead roles in the practice were not clearly identified.
- There was not clear oversight of clinical performance and there was not a comprehensive programme of quality improvement activity in place.
- Policies and procedures in place were not specific to the practice and many were overdue a review. Key policies including Whistleblowing and Business Continuity were missing.

**Managing risks, issues and performance**

There was no clarity around processes for managing risks, issues and performance.

- There was not an effective, process to identify, understand, monitor and address current and future risks including risks to patient safety.
- The practice did not have processes to manage current and future performance. Practice leaders did not have oversight of safety alerts, incidents, and complaints.
- Only one clinical audit had been completed in the previous two years to show a positive impact on quality of care and outcomes for patients.
- The practice did not have plans in place for major incidents. There was no business continuity plan.

**Appropriate and accurate information**

The practice did not have appropriate and accurate information.

- Regular meetings did not take place which meant quality, performance and improvement were not regularly discussed or reviewed.
- There was no identified quality and operational information lead to ensure improvements in performance.
- There were no plans in place to address any identified weaknesses.
- The practice submitted data or notifications to external organisations as required.
- There were arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

**Engagement with patients, the public, staff and external partners**

The practice did not involve patients, the public, staff and external partners to support high-quality sustainable services.

- The practice did not have a patient participation group (PPG) to represent the views of patient in the practice.
- The NHS Friends and Family Test responses were not collated, analysed or published.
- There was a lack of staff engagement due to the absence of one-to-ones, appraisals and staff meetings.
- The practice had started working with the local clinical commissioning group (CCG) to secure stability for the future of the practice.

**Continuous improvement and innovation**

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

- There was no focus on continuous learning and improvement.
- Staff did not know about improvement methods.
- The practice did not make use of internal and external reviews of incidents and complaints. Learning were not identified or shared to make improvements.

**Please refer to the evidence tables for further information.**

This section is primarily information for the provider

# Requirement notices

## Action we have told the provider to take

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

| Regulated activity | Regulation |
|---|---|
| Diagnostic and screening procedures<br>Family planning services<br>Maternity and midwifery services<br>Surgical procedures<br>Treatment of disease, disorder or injury | Regulation 20 HSCA (RA) Regulations 2014 Duty of candour<br>**How the regulation was not being met**<br>**The provider did not follow a significant event policy to identify when things went wrong.**<br>**When the provider was alerted to an incident of a missed diagnosis, an investigation was not completed and the patient was not contacted with an offer of an apology.**<br>**This was in breach of regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.** |

This section is primarily information for the provider

# Enforcement actions

## Action we have told the provider to take

The table below shows the legal requirements that the service provider was not meeting. The provider must send CQC a report that says what action it is going to take to meet these. We took enforcement action because the quality of healthcare required significant improvement.

| Regulated activity | Regulation |
|---|---|
| Diagnostic and screening procedures<br>Family planning services<br>Maternity and midwifery services<br>Surgical procedures<br>Treatment of disease, disorder or injury | Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment<br><br>We found that the process for identifying significant events was not followed. No significant events had been identified or reported on for two years. The provider did not hold any clinical or staff meetings where significant events would be discussed, reviewed and lessons learnt from the event identified.<br><br>There was no system in place to manage safety alerts and Medicines and Healthcare products Regulatory Agency (MHRA) alerts received by the practice.<br><br>A disclosure and barring service check (DBS) had not been completed for a member of the nursing staff.<br><br>There was no register of staff vaccinations. Staff files showed evidence of the Hepatitis B status of one GP, the nurse practitioner and the practice nurse. There was evidence of the MMR and varicella status of the practice nurse but not for the remaining clinical staff. There was no routine immunisation status for the non-clinical staff. There were no risk assessments in place to explain why the immunisation status was not in place for either clinical or non-clinical staff.<br><br>There were no clinical meetings taking place in the practice to discuss and share learning, safety alerts, complaints and significant events. The nursing staff informed us they met as a team once a month but felt there was a lack of clinical support from the GPs. We were informed that held bi-weekly governance and business meetings were held but there were no minutes available to evidence this.<br><br>Patient Specific Directions (PSDs) were not used in the practice.<br><br>The system for checking the monitoring of medicines that required review was not evident. |

This section is primarily information for the provider

# Enforcement actions

A member of the nursing team had completed 249 patient medicine reviews. The nurse concerned did not have non-medical prescriber training.

We found that actions identified in secondary care with regards to changes to patients prescribed medicines or treatment are not always completed.

Regulation 12 Health and Social Care Act

## Regulated activity

Diagnostic and screening procedures

Family planning services

Maternity and midwifery services

Surgical procedures

Treatment of disease, disorder or injury

## Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

There were significant concerns in the leadership and governance of the practice. One of the GP partner was absent and there was no practice manager in post.

Complaints were not always managed in accordance with recommended guidance. The complaints policy was overdue a review and the information leaflet for patients on how to make a complaint was not current.

The policies to govern activity in the practice were not practice specific and there were no review dates so we could not be assured that the information contained was accurate. Key policies were not available, for example, for Whistleblowing and Business Continuity.

Processes for providing staff with the development they needed were lacking. There had been no staff appraisals in the previous two years. New staff who had joined the practice in the previous two years had not received a formal, documented induction and there were no contracts or job descriptions available for these staff.

There were no up to date risk assessments in place for the control of substances hazardous to health (COSHH), Fire Safety, Legionella, Health and Safety or Infection Prevention and Control.

There was a lack of patient engagement. There was no patient participation group (PPG), no patient surveys had been completed and no actions had been taken in response to the national GP patient survey. The NHS friends and family test (FFT) was done via the practice website but there was no analysis of the results.

This section is primarily information for the provider

# Enforcement actions

Regulation 17 Health and Social Care Act