Chadwell Heath Surgery

Quality Report

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

Ratings

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

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Chadwell Heath Surgery on 11 August 2016. Overall, the practice is rated as requires improvement.

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

- We saw evidence of significant events being identified but the records were incomplete and did not demonstrate actions taken to prevent the incident happening again. There was limited evidence of patients receiving a verbal or written apology.
- There were poor arrangements for identifying, recording and managing risks, issues and implementing mitigating actions. The practice was not meeting its responsibilities in ensuring the safety of its patients and this included significant event analysis, prescription management, risk assessment, fire safety and infection prevention and control.
- Staffing arrangements did not always ensure enough staff were on duty to meet patient needs.
- The practice had a number of policies and procedures to govern activity, but some of these were not effectively implemented or monitored. For example, the safeguarding policies did not highlight who the child safeguarding leads were and did not contain contact details.Staff were not familiar with key policies such as the duty of candour.
- The practice had limited information regarding chaperones on display, and four patients told us they had never been offered a chaperone. Not all staff who chaperoned had undergone a Disclosure and Barring service (DBS) check; however, the practice had carried out an assessment of risk in relation to this.
- The practice did not hold regular governance or team meetings.

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- Staff training was not well monitored and there were gaps in training for staff of all levels including in basic life support and safeguarding.
- Multidisciplinary working was taking place but was generally informal and record keeping was absent.
- Data showed patient outcomes were low when compared to the local and national average. Exception reporting for the percentage of patients (2014/15) diagnosed with dementia who had received a face to face review in the last 12 months was 17%, higher than the Clinical Commissioning Group (CCG) average of 10% and national average of 8%. Data for 2015/16 showed exception reporting for this indicator had improved to 4.5% compared to the CCG average of 8% and England average of 7%.
- Results from the national GP patient survey showed that patients' satisfaction with how they could access care and treatment was similar to local and national averages. Feedback from patients reported that telephone and appointment access were an issue despite the extended hours opening.
- Governance arrangements had systemic weaknesses and did not ensure the practice operated safely and effectively. Performance was not being monitored in all areas, although three completed clinical audits had been carried out.
- The practice had taken action to improve patient outcomes in some disease areas such as diabetes, which included reducing the age for NHS health checks from 40 to 30 years in order to improve detection of the disease.
- Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Patients rated the practice higher than others for some aspects of care.
- Information about services was available but not everybody would be able to understand or access it. For example, access to translation services was not advertised in the practice. The practice did not have a hearing loop.
- The practice had only identified 0.2% of their practice list as carers.

The areas where the provider must make improvements are:

- Ensure systems and processes are established and operated effectively to safeguard children and vulnerable adults from abuse.
- Assess, monitor and mitigate the risks to the health and safety of service users in respect of the proper and safe management of prescriptions; infection prevention and control and health and safety risk assessments.
- Ensure sufficient numbers of suitably qualified, competent, skilled and experienced persons are deployed to deliver a safe service.
- Ensure effective and sustainable governance systems and processes are implemented to assess, monitor and improve the quality and safety of the services provided including; reporting, recording, acting on and monitoring significant events, incidents and near misses and ensuring that patients affected receive reasonable support and a verbal and written apology; monitoring and responding to patient satisfaction levels in relation to access to appointments; addressing areas of poor performance relating to patient outcomes highlighted through the Quality and Outcomes Framework, discussing and acting upon safety alerts; promoting shared learning from significant events and complaints; reviewing the frequency of staff meetings to ensure all staff are aware of decisions or changes in the practice and regularly reviewing and updating procedures and guidance, ensuring staff are aware of these.
- Ensure patients are made aware that a chaperone can be requested and provided.

In addition the provider should:

- Consider improving communication options for patients who have a hearing impairment. Raise awareness amongst the patient list of the availability of translation service.
- Review how patients with caring responsibilities are identified and recorded on the clinical system to ensure information, advice and support is made available to them.
- Review advertised appointment times to ensure that patients are being given correct information.

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Where a service is rated as inadequate for one of the five key questions or one of the six population groups or overall, it will be re-inspected within six months after the report is published. If, after re-inspection, the service has failed to make sufficient improvement, and is still rated as inadequate for any key question or population group or overall, we will place the service into special measures.

Being placed into special measures represents a decision by CQC that a service has to improve within six months to avoid CQC taking steps to cancel the provider's registration.

Professor Steve Field CBE FRCP FFPH FRCGP

Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Inadequate

The practice is rated as inadequate for providing safe services.

- Patients were at risk of harm because systems and processes had weaknesses. For example, the practice had four versions of incident reporting forms. Significant events were not analysed.
- Staff understood their responsibilities to raise concerns, and to report incidents and near misses. However, when things went wrong, lessons learned were not communicated widely enough to support improvement. Patients did not always receive a verbal and written apology. The practice had a duty of candour policy but there was nothing to indicate staff followed it.
- Areas of concern were found in safeguarding. Not all staff had received the level of training required by their role. The practice had safeguarding policies in place but they did not list contact details for further guidance if staff had concerns about a patient's welfare.
- The practice had not undertaken any infection control audits although they had recently completed an infection control checklist. There was no evidence that action had been taken with regard to any of the concerns identified in the checklist.
- The practice's medicines management was ineffective. There was no process in place to monitor uncollected prescriptions. We found uncollected prescriptions dating back to April and May 2016.
- We reviewed a number of staff recruitment files. The practice told us they had applied for checks for all staff through the Disclosure and Barring Service (DBS). At the time of inspection, 11 reception and administration staff had not received this check.
- The procedures for monitoring and managing risks to patient and staff safety were not effective. The practice did not maintain up to date fire risk assessments and fire drills were not carried out regularly. Fire alarm tests were not recorded.
- Staffing arrangements did not always ensure enough staff were on duty to meet patient needs.
- Not all staff had received annual basic life support training or training in how to use the defibrillator.
- The practice had limited information regarding chaperones on display, and four patients told us they had never been offered a

Summary of findings

chaperone. Not all staff who chaperoned had undergone a Disclosure and Barring service (DBS) check; however, the practice had carried out an assessment of risk in relation to this.

Are services effective?

Requires improvement

The practice is rated as requires improvement for providing effective services, as there are areas where improvements should be made.

- Data (2014/15) showed patient outcomes were low when compared to the local and national average. The practice achieved 83% of the total number of Quality and Outcome Framework (QOF) points available. This was lower than the local average of 94% and the national average of 95%. Data for 2015/16 showed the practice again achieved 83% compared to the local average of 92% and England average of 95%.
- Exception reporting for the percentage of patients diagnosed with dementia who had received a face to face review in the last 12 months(01/04/2014 – 31/03/2015) was 17%, higher than the Clinical Commissioning Group (CCG) average of 10% and national average of 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). Data for 2015/16 showed exception reporting for this indicator had improved to 4.5% compared to the CCG average of 8% and England average of 7%.
- The practice had taken action to improve patient outcomes in some disease areas such as diabetes, which included reducing the age for NHS health checks from 40 to 30 years in order to improve detection of the disease. However, there was no evidence of what action had been taken to improve in other disease areas such as chronic obstructive pulmonary disease (COPD).
- Staff training was not well monitored and there were gaps in training for staff of all levels.
- Multidisciplinary working was taking place but was generally informal and record keeping was absent.
- There was a programme of clinical and internal audit.
- Staff assessed needs and delivered care in line with current evidence based guidance.

Are services caring?

Good

The practice is rated as good for providing caring services.

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- Data from the national GP patient survey showed ratings for the practice were comparable to others.
- Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.
- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.
- Information for patients about the services available was easy to understand and accessible. However, there were no translation or bereavement services advertised in the practice informing patients these services were available.
- The practice had only identified 0.2% of their practice list as carers and explained that this was due to the number of unofficial carers at the practice.

Are services responsive to people's needs?

Requires improvement

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

- Results from the national GP patient survey showed that patients' satisfaction with how they could access care and treatment was comparative to local and national averages.
- Feedback from patients on the day reported that telephone and appointment access were an issue despite the extended hours opening. There was evidence to show the practice had made improvements to the appointment system; however, it was too early for us to see evidence of improved patient satisfaction.
- Patients told us that some GP sessions started earlier than the scheduled time, which impacted on the ease of access to appointments.
- The practice had most facilities including lift access and was equipped to treat patients and meet their needs with the exception of a hearing loop which was not installed in the practice.
- Translation services were not advertised in the practice.
- Practice staff reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group to secure improvements to services where these were identified. For example, the appointment of two practice-based pharmacists as part of the CCG led clinical pharmacist pilot scheme.
- Home visits were triaged by a GP to assess whether a home visit was clinically necessary and the urgency of the need for medical attention.

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- Information about how to complain was available and easy to understand and evidence showed the practice responded quickly to issues raised. Learning from complaints was shared with staff.

Are services well-led?

Requires improvement

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

- The practice vision to deliver good outcomes for patients was not clear. There was no mission statement.
- Governance arrangements had systemic weaknesses and did not ensure the practice operated safely and effectively, and performance was not being monitored in all areas.
- The practice had a number of policies and procedures to govern activity, but some of these were not effectively implemented or monitored. For example, the safeguarding policies did not highlight who the child safeguarding leads were and did not contain contact details. Staff were not familiar with key policies such as the duty of candour.
- The practice did not hold regular governance or team meetings. Issues were discussed at ad hoc meetings.
- There were poor arrangements for identifying, recording and managing risks, issues and implementing mitigating actions. The governance framework in place did not ensure that the practice was meeting its responsibilities for ensuring the safety of its patients and this included significant event analysis, the lack of role appropriate training for staff such as basic life support and safeguarding and adequate fire safety precautions.
- The practice had high exception reporting rates for dementia outcomes. There was no indication they were taking steps to review this.
- Leadership arrangements were ineffective; nevertheless staff told us the partners were approachable and always took the time to listen to all members of staff.
- The practice had sought and acted on feedback from the patient participation group which was active.

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

- The practice offered proactive, personalised care to meet the needs of the older people in its population including those in the residential and nursing homes.
- The practice was responsive to the needs of older people, and offered home visits. Elderly patients were given priority appointments every day and patients unable to attend the surgery were offered telephone consultations.
- Nationally reported data showed that outcomes for patients for conditions commonly found in older people were in line with local and national averages. For example, the percentage of patients (2014/15) with atrial fibrillation who were currently treated with anticoagulation therapy was 100%, compared to the local and national averages of 98%. Data for 2015/6 showed this had dropped to 86%, compared to the local average of 81% and England average of 87%.
- The practice had responded to the needs of older people with poor mobility by installing a lift in the practice.

People with long term conditions

Requires improvement

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

- Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority.
- Outcomes for diabetic patients(2014/15) were lower than local and national averages. For example, the percentage of patients (2014/15) with diabetes on the register, who had received a foot examination in the last 12 months, was 70%, compared to the local average of 83% and national average of 88%.
- The practice had taken steps to improve diabetes care by providing an extra diabetes clinic and involving the PPG to improve diabetes awareness within the practice population.

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- The practice had lowered their age for NHS health checks from 40 to 30 in order to improve detection of diabetes and reduce the risk.
- Data for 2015/16 showed that most outcomes were now comparable to local and national averages; however, the percentage of patients in whom the last IFCC-HbA1c was 64mmol/mol or less was 62%, below the local average of 68% and national average of 78%.
- Longer appointments and home visits were available when needed.
- All these patients had a named GP; however, patient outcomes were low for some disease indicators. For example, the percentage of patients (2014/15) with chronic obstructive airways disease (COPD) who had received an assessment as per Medical Research Council guidelines was 74%, compared to the local and national averages of 90%. Data for 2015/16 showed this had dropped to 67% compared to the local and national averages of 90%.
- 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.

Families, children and young people

Requires improvement

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

- There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances.
- Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals.
- The percentage of women (2014/15) aged 25-64 who had received a cervical screening test in the preceding five years was 74%, compared to the local average of 79% and national average of 82%. Data for 2015/16 indicated the practice achieved 72% compared to the local average of 79% and England average of 81%.
- Appointments were available outside of school hours and the premises were suitable for children and babies.
- The practice offered weekly baby immunisation clinics by appointment only as well as postnatal checks and six-week baby checks. We did not see positive examples of joint working with midwives and health visitors.

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Working age people (including those recently retired and students)

Requires improvement 

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

- The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. This included the availability of telephone consultations.
- The practice had a website. Patients could book online appointments through the patient access website once they had requested and received a letter from the practice with an ID number.
- They were proactive in offering health promotion and screening that reflects the needs for this age group.

People whose circumstances may make them vulnerable

Requires improvement 

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

- The practice held a register of patients living in vulnerable circumstances including those with a learning disability.
- The practice offered longer appointments for patients with a learning disability.
- The practice informed vulnerable patients about how to access various support groups and voluntary organisations.
- Staff knew how to recognise signs of abuse in vulnerable adults and children; however, although policies were accessible to all staff, we found that both the adult and child safeguarding policies failed to list contact details for further guidance if staff had concerns about a patient's welfare, and whilst there was a child safeguarding lead, and staff knew who it was, they were not mentioned in the policy.

People experiencing poor mental health (including people with dementia)

Requires improvement 

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

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- 79% of patients diagnosed with dementia that had their care reviewed in a face to face meeting in the last 12 months, which was comparable to the national average of 84% (2014/15). Data for 2015/16 indicated this had dropped to 76% compared to the local average of 81% and national average of 84%.
- The percentage of patients (2014/15) with mental health conditions who had an agreed care plan documented in their notes was 84%, compared to the CCG average of 90%. Data from 2015/16 showed this had dropped to 76%, compared to the CCG average of 91% and national average of 89%.
- One of the lead GPs was a dementia champion, responsible for the reviews of patients with dementia.
- The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those with dementia.
- The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations.
- The practice had a system in place to follow up patients who had attended accident and emergency where they may have been experiencing poor mental health.

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What people who use the service say

The national GP patient survey results were published in July 2016. The results showed the practice was performing in line with local and national averages. Three hundred and thirty nine survey forms were distributed and 121 were returned. This represented 1% of the practice's patient list.

- 54% of patients said they could get through easily to the practice by phone compared to the CCG average of 54% and the national average of 73%.
- 65% of patients were able to get an appointment to see or speak to someone the last time they tried compared to CCG average of 65% and the national average of 76%.
- 84% of patients described the overall experience of this GP practice as good compared to the local average of 73% and the national average of 85%.
- 78% of patients said they would recommend this GP practice to someone who has just moved to the local area compared to the local average of 68% and the national average of 79%.

As part of our inspection, we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 32 comment cards which were all positive about the standard of care received. Patients said they felt the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect. Two of the comments cards highlighted issues with access to appointments.

We spoke with 10 patients during the inspection. Most of the patients said they were satisfied with the care they received and thought staff were approachable, committed and caring. Eight of the patients highlighted issues with access to appointments.

Areas for improvement

Action the service MUST take to improve

- Ensure systems and processes are established and operated effectively to safeguard children and vulnerable adults from abuse.
- Assess, monitor and mitigate the risks to the health and safety of service users in respect of the proper and safe management of prescriptions; infection prevention and control and health and safety risk assessments.
- Ensure sufficient numbers of suitably qualified, competent, skilled and experienced persons are deployed to deliver a safe service.
- Ensure effective and sustainable governance systems and processes are implemented to assess, monitor and improve the quality and safety of the services provided including; reporting, recording, acting on and monitoring significant events, incidents and near misses and ensuring that patients affected receive reasonable support and a verbal and written apology; monitoring and responding to patient satisfaction levels in relation to access to appointments; addressing areas of poor performance relating to patient outcomes highlighted through the Quality and Outcomes Framework, discussing and acting upon safety alerts; promoting shared learning from significant events and complaints; reviewing the frequency of staff meetings to ensure all staff are aware of decisions or changes in the practice and regularly reviewing and updating procedures and guidance, ensuring staff are aware of these.
- Ensure patients are made aware that a chaperone can be requested and provided.

Action the service SHOULD take to improve

- Consider improving communication options for patients who have a hearing impairment. Raise awareness amongst the patient list of the availability of translation service.
- Review how patients with caring responsibilities are identified and recorded on the clinical system to ensure information, advice and support is made available to them.

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- Review advertised appointment times to ensure that patients are being given correct information

Chadwell Heath Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

a CQC Lead Inspector**.** The team included a GP specialist adviser and a second CQC inspector.

Background to Chadwell Heath Surgery

Chadwell Heath Surgery is located in Romford, Essex and holds a Personal Medical Services (PMS) contract with NHS England. The practice's services are commissioned by Redbridge Clinical Commissioning Group (CCG). They are registered with the Care Quality Commission to provide the regulated activities of diagnostic and screening procedures, family planning, maternity and midwifery services and treatment of disease, disorder or injury.

The practice is staffed by two GP partners, one female and one male, and three part-time salaried GPs, two female and one male, who provide a combination of 33 sessions a week. The practice also employs a part-time practice nurse who provides five sessions a week and a part-time healthcare assistant. Also employed are one full-time practice manager, one part-time deputy manager, an IT manager, a secretary and nine reception and administration staff.

Two pharmacists who work two days a week have been employed by both the practice and part-funded by NHS England as part of the clinical pharmacists three year pilot scheme. The practice is also a teaching practice for medical students from a local university.

The practice is open between 9.00am and 6.30pm on Monday, Tuesday, Wednesday and Friday and between 9.00am and 1.00pm on Thursday. Telephone lines are closed between 1.00pm and 3.00pm on Monday, Tuesday, Wednesday and Friday. Extended hours are offered between 6.30pm and 8.00pm on Monday, Tuesday, Wednesday and Friday and pre-booked appointments are offered on Saturday between 10.00am and 1.00pm. Outside of these hours, the answerphone redirects patients to their out of hours provider.

The practice is part of the Healthbridge hub of 15 practices which provides patient access to appointments when the practice is closed and at weekends. The hub is open between 6.00pm and 10.00pm on Monday to Friday and between 9.00am and 5.00pm on Saturday and 9.00am and 1.00pm on Sunday.

The practice has a list size of 9,444 patients and provides a range of services including phlebotomy, ECG monitoring, counselling services, postnatal care, childhood immunisations, vaccinations such as yellow fever, chronic disease management and minor surgery including cryotherapy and family planning services.

The practice is located in an area where there is a larger than average population aged between 0-18 years of age. The two main ethnicity groups in the area (42% each) are white and Asian. The practice also provides care to 50 residents in a local residential home and 35 residents in a local nursing home.

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 11 August 2016. During our visit we:

- Spoke with a range of staff including two GPs, a practice manager, a practice nurse, a healthcare assistant and a receptionist.
- Spoke with patients who used the service and members of the patient participation group (PPG).
- Observed how patients were being cared for and talked with carers and/or family members.
- Made observations around the premises and environment.
- Reviewed an anonymised sample of the personal care or treatment records of patients.
- Reviewed comment cards where patients and members of the public shared their views and experiences of the service.

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

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

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

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

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

Inadequate

Are services safe?

Our findings

Safe track record and learning

The system in place for reporting and recording significant events was not adequate.

- Staff told us they would inform the practice manager of any incidents. Although incident recording forms were available on the intranet, we found this process was not clear, as there were four different types of incident reporting forms produced by the practice. They had a duty of candour policy in place which supported the recording of notifiable incidents; however, there was no evidence that they followed this policy. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).
- The systems in place to support patients when things went wrong with care and treatment were not always consistent. For example, we reviewed significant event records and found in one instance, relating to a staff member and a patient, the patient had been informed of the incident and both parties had received reasonable support and truthful information. In a second record, we could not find evidence that the family of a young patient had been informed of an incident or received an apology when an incorrect prescription was administered to the patient which could have resulted in potential harm. We also found that this notifiable safety incident had not been recorded under the duty of candour.

The practice had not carried out a thorough analysis of the significant events. We reviewed safety records, incident reports, patient safety alerts and minutes of meetings. There was no evidence from the practice and clinical meeting minutes provided to show that they discussed patient safety alerts or significant events; therefore, we were unable to establish how lessons learnt were shared with staff. The practice told us that practice meetings did not occur on a regular basis, so there was no evidence that lessons were shared to promote learning.

Overview of safety systems and processes

The practice systems, processes and practices in place to keep patients safe and safeguarded from abuse were not effective.

- Arrangements in place to safeguard children and vulnerable adults from abuse were not effective. These arrangements did not always reflect relevant legislation and local requirements. For example, although policies were accessible to all staff, we found that both the adult and child safeguarding policies failed to list contact details for further guidance if staff had concerns about a patient's welfare, and whilst there was a child safeguarding lead, and staff knew who it was, they were not mentioned in the policy. Despite referring to the local requirements of the multi-agency safeguarding hub (MASH) in their safeguarding clinical meeting, the practice policy did not highlight this. We saw evidence that safeguarding was discussed at their clinical meeting and the GPs always provided reports where necessary; however, there was no evidence to show that they attended external safeguarding meetings. Staff demonstrated they understood their responsibilities but had not all had received training on safeguarding children and vulnerable adults relevant to their role. One healthcare assistant had only received level 1 child safeguarding training, and not level 2 as recommended for her role, and had not received any adult safeguarding training. GPs and the practice nurse were trained to child protection level 3.
- Although we observed one notice displayed on the second floor advising patients that chaperones were available if required, there were no other notices displayed around the practice. Four female patients we spoke to on the day of inspection told us that they had never been offered chaperones. All three staff who acted as chaperones were trained for the role. Although they had not received a Disclosure and Barring Service (DBS) check, the practice had carried out a risk assessment for them. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).
- The practice maintained appropriate standards of cleanliness and hygiene. We observed the premises to be clean and tidy. The practice nurse was the infection control clinical lead. There was an infection control protocol in place and two of the clinical staff had received up to date training. The practice did not undertake comprehensive infection control audits but we were shown an infection control checklist which they had recently completed. Action had not been taken to address the concerns identified by the checklist. For

example, the checklist identified that curtains in clinical areas were not disposable or washable and identified that clinical room taps were not elbow or wrist operable, but no action had been taken to rectify these concerns. There was no evidence to show that the practice liaised with the local infection prevention and control teams to keep up to date with best practice. Following the inspection the provider told us that their checklist was incorrect, and the curtains were disposable.

- The arrangements for managing medicines (including obtaining, prescribing, recording, handling, storing, security and disposal), including emergency medicines and vaccines, in the practice were not effective. For example, there was no process in place to monitor uncollected prescriptions. We found uncollected prescriptions dating back to April and May 2016. Processes were in place for handling repeat prescriptions which included the review of high-risk medicines. The practice carried out regular medicines audits, with the support of their practice-based pharmacy team (who were part of the clinical pharmacist pilot scheme), to ensure prescribing was in line with best practice guidelines for safe prescribing. Blank prescription forms and pads were securely stored and there were systems in place to monitor their use. Patient Group Directions (PGDs) had been adopted by the practice to allow nurses to administer medicines in line with legislation. (PGDs are written instructions for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment). Health Care Assistants were trained to administer vaccines and medicines against a patient specific prescription or direction (PSD) from a prescriber. (PSDs are written instructions from a qualified and registered prescriber for a medicine including the dose, route and frequency or appliance to be supplied or administered to a named patient after the prescriber has assessed the patient on an individual basis).
- We reviewed a number of staff recruitment files. The practice told us they had applied for checks for all staff through the Disclosure and Barring Service (DBS). At the time of inspection, 11 reception and administration staff had not received this check.
- The procedures in place for monitoring and managing risks to patient and staff safety were not effective. There was a health and safety policy available but there was no poster identifying local health and safety representatives in the reception office.
- The fire safety procedures in place were not implemented well enough to keep patients safe. For example, the practice did not maintain up to date fire risk assessments and fire drills were not carried out regularly. The fire safety policy in place referred to a fire safety logbook to record fire alarm tests; however, this was not in place. The practice had a lift installed but the fire safety policy did not provide additional information on accessibility and means of escape for persons with mobility problems located upstairs. There was an evacuation chair, kept on the first floor of the practice. Staff had not received fire safety training.
- All electrical equipment was checked to ensure it was safe to use and clinical equipment was checked to ensure it was working properly. We were not assured that the risk assessments in place to monitor safety of the premises, such as control of substances hazardous to health and infection prevention and control, had been carried out. For example, the health and safety annual checklist provided by the practice showed a COSHH assessment had not been undertaken; however, this contradicted the practice's own infection control checklist carried out the day before the inspection which indicated that a COSHH assessment was available. A Legionella risk assessment had also been carried out the day before the inspection which resulted in a medium risk rating being given to the practice.
- There was a rota system in place for all the different staffing groups to ensure enough staff were on duty. Although arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs these arrangements were not always effective. For example, there was no cover provided for the healthcare assistant in her absence, therefore, clinical duties including health checks and influenza immunisations had to wait until the healthcare assistant was available. The practice stated they were unable to provide sufficient spirometry checks because of insufficient nursing resource.

Monitoring risks to patients

Risks to patients were not effectively assessed or well managed.

Arrangements to deal with emergencies and major incidents

Inadequate

Are services safe?

The practice arrangements in place to respond to emergencies and major incidents were not effective.

- There was an instant messaging system on the computers and phones in all the consultation and treatment rooms which alerted staff to any emergency.
- The practice had a defibrillator available on the premises and oxygen with adult and children's masks. However, not all clinical and non-clinical staff had received annual basic life support training and there was no evidence from staff training records that they had received automated external defibrillation (AED) training.
- There were emergency medicines available in the treatment room and 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 comprehensive business continuity plan in place for major incidents such as power failure or building damage, but not all staff were aware of this. The plan included emergency contact numbers for staff.

Requires improvement

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice assessed needs and delivered care in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines.

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

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 2014/15 published results showed the practice achieved 83% of the total number of points available. This was lower than the local average of 94% and the national average of 95%. Results for 2015/16 (which were not available at the time of the inspection), indicated the practice again achieved 83%, compared to the local average of 92% and England average of 95%.

Exception reporting for the percentage of patients diagnosed with dementia who had received a face to face review in the last 12 months(01/04/2014 – 31/03/2015) was 17%, higher than the Clinical Commissioning Group (CCG) average of 10% and national average of 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).

We were not provided with evidence of what improvements had been made to reduce their exception reporting. When we reviewed a personalised dementia care plan provided at inspection, there was no data recorded for any previous care plan reviews or medicines review for the patient. However, data for 2015/16 showed exception reporting for this indicator had improved to 4.5% compared to the CCG average of 8% and England average of 7%.

Data from 2014/2015 showed:

All the indicators for diabetes were lower than CCG and national average. For example:

- The percentage of patients with diabetes on the register, whose last average blood sugar levels were normal, was 57%, compared to the CCG average of 70% and national average of 78%.
- The percentage of patients with diabetes on the register, whose last measured cholesterol levels were within normal range was 65%, compared to the CCG average of 74% and national average of 81%.

The practice had recognised that they were not perfoming highly on diabetes measures and commented that this was because of their high population of diabetes patients within the practice. As a result they engaged the Patient Participation Group (PPG) to undertake an awareness campaign amongst the patient population and also introduced an additional diabetes clinic with the diabetes nurse specialist.

Data from 2015/2016, which were not available at the time of the inspection, showed:

- The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c was 64mmol/mol or less in the preceding 12 months was 62% compared to the CCG average of 68% and national average of 78%.
- The percentage of patients last measured cholesterol was 5mmol/lor less was 70% compared to the CCG average of 74% and national average of 80%.

Performance for mental health related indicators was comparable to the CCG and national average. For example:

- The percentage of patients with mental health conditions who had an agreed care plan documented in their notes was 84%, compared to the CCG average of 90% and national average of 88%.
- The percentage of patients with dementia whose care had been reviewed face to face in the last 12 months was 79%, compared to the CCG average of 83% and 84%.

Requires improvement

Are services effective?

(for example, treatment is effective)

Data from 2015/2016, which were not available at the time of the inspection, showed:

- The percentage of patients with mental health conditions who had an agreed care plan documented in their notes was 76%, compared to the CCG average of 91% and national average of 89%.
- The percentage of patients with dementia whose care had been reviewed face to face in the last 12 months was 76%, compared to the CCG average of 81% and 84%.

The indicators for chronic obstructive pulmonary disease (COPD) were lower than the CCG and national average. For example:

- The percentage of patients(2014/15) with COPD, who had a review undertaken using the Medical Research Council guidelines was 74%, compared to the CCG and national average of 90%. The practice was aware of this data and explained that the low figures were as a result of nursing staff shortages which had an impact on the number of patients receiving spirometry. There was no evidence provided to show what action had been taken to improve patient outcomes in this area. Data for 2015/16 showed the practice performance had dropped to 67% compared to the local and national averages of 90%.

There was evidence of quality improvement including clinical audit.

- There had been three clinical audits completed in the last two years, all of which had been through two cycles.
- The practice participated in local audits, national benchmarking, accreditation and peer review.

Effective staffing

Staff deployed did not always have the skills, knowledge and experience to deliver effective care and treatment.

- The practice had an induction programme for all newly appointed staff, but this was not always adhered to. The induction checklist highlighted formal health and safety training as part of the induction training but we found that staff had not received this training. Staff had also not received fire safety, infection control and prevention training as part of their induction.
- Staff could access role-specific training and updates when required. For example, the practice nurse and healthcare assistant attended monthly education meetings which incorporated long-term condition management training and palliative care training.
- Staff administering vaccines and taking samples for the cervical screening programme had received specific training which had included an assessment of competence. Staff who administered vaccines could demonstrate how they stayed up to date with changes to the immunisation programmes, for example by access to on line resources and discussion at practice meetings.
- The learning needs of staff were identified through a system of appraisals, 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 on-going support, one-to-one meetings, coaching and mentoring and support for revalidating GPs. All staff had received an appraisal within the last 12 months.
- Not all staff had completed mandatory training, including annual basic life support, fire safety, safeguarding and infection prevention and control.

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 care and risk assessments, care plans, medical records and investigation and test results.
- The practice shared relevant information with other services in a timely way, for example when referring patients to other services.

Staff worked together and with other health and social care professionals to understand and meet the range and complexity of patients' needs and to assess and plan on-going care and treatment. For example, they worked closely with the tissue viability nurse to meet the needs of patients requiring wound care management. Joint working also included when patients moved between services, including when they were referred, or after they were

Requires improvement

Are services effective?

(for example, treatment is effective)

discharged from hospital. Meetings took place with other health care professionals such as the district nurse and palliative care nurse; however, this was generally informal and there were no recorded minutes of meetings.

Consent to care and treatment

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

- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act (MCA) 2005.
- When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance.
- 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. For example:

- Patients receiving end of life care, carers, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation. Patients were signposted to the relevant service.

The practice's uptake for the cervical screening programme was 74%, which was lower than the CCG average of 79% and the national average of 82%. Data for 2015/16 indicated the practice achieved 72% compared to the local average of 79% and England average of 81%.There was a policy to offer telephone reminders for patients who did not attend for their cervical screening test. The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening. There were failsafe systems in place 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.

Childhood immunisation rates (2014/15) for the vaccinations given to under two year olds ranged between 69% and 88% and for five year olds it ranged between 67% and 82%. The CCG and national average figures were not available for childhood immunisation rates given to under twos and five year olds at the time of inspection.

Data for 2015/16, recorded in a different format, indicated that the practice rates for the vaccinations given were lower when compared to the national averages. There are four areas where childhood immunisations are measured; each has a target of 90%. The practice achieved the target in one out of four areas. These measures can be aggregated and scored out of 10, with the practice scoring 8.7 (compared to the national average of 9.1).

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. The practice had reduced the age for NHS health checks from 40 to 30 in order to improve the detection and reduce the risk of diabetes. 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

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

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

All of the 32 patient Care Quality Commission comment cards we received were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect. Two of the comments cards highlighted issues with access to appointments and reception staff attitude.

We spoke with one member of the patient participation group (PPG). They also told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. Comment cards highlighted that staff responded compassionately when they needed help and provided support when required.

Results from the national GP patient survey published in July 2016 showed patients felt they were treated with compassion, dignity and respect. The practice was comparable to CCG and national averages for its satisfaction scores on consultations with GPs and nurses. For example:

- 91% of patients said the GP was good at listening to them compared to the clinical commissioning group (CCG) average of 85% and the national average of 89%.
- 87% of patients said the GP gave them enough time compared to the CCG average of 82% and the national average of 87%.
- 95% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 90% and the national average of 92%.
- 89% of patients said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 81% and the national average of 85%.
- 90% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 83% and the national average of 91%.
- 78% of patients said they found the receptionists at the practice helpful compared to the CCG average of 78% 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. The majority of the patients also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them. Patient feedback from the comment cards we received was mostly positive and aligned with these views albeit two of the comments cards highlighted issues with access to appointments and reception staff attitude. We also saw that care plans were personalised.

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

- 89% of patients said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 81% and the national average of 86%.
- 85% of patients said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 76% and the national average of 82%.
- 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 77% and the national average of 85%.

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

- Staff told us that translation services were available for patients who did not have English as a first language. However, there were no notices displayed in the reception areas informing patients this service was available.

Good

Are services caring?

- Information leaflets were available in easy read format. Some information leaflets for screening services were available in different languages.
- Posters were displayed in the reception areas inviting patients to join the PPG.

Patient and carer support to cope emotionally with care and treatment

Patient information leaflets and notices were available in the patient waiting areas which told patients how to access a number of support groups and organisations.

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 20 patients as carers (0.2% of the practice list). They told us that the low figure was due to a proportion of carers who did not want to be recognised as such; hence they were not coded as carers on the practice register. Carers were offered flu immunisations and written information was available to direct carers to the various avenues of support available to them.

Staff told us that if families had suffered bereavement, their usual GP contacted them or sent them a letter or card. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs. Families were offered bereavement counselling at the practice; however, there was no information displayed in the practice to inform patients of this 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 reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. For example, they participated in the CCG led clinical pharmacist pilot scheme whereby two practice-based clinical pharmacists were employed by both NHS England and the practice for two days a week. Their role was to undertake medicines audits and review medication. They would also liaise with the pharmacy and were based at the reception desk to support the reception staff when patients had questions related to medicines.

- The practice offered extended clinics on a Monday, Tuesday, Wednesday and Friday evening until 8.00pm, as well as appointment only clinics on Saturday between 10.00am and 1.00pm for working patients who could not attend during normal opening hours.
- There were longer appointments available for patients with a learning disability, those with long-term conditions, carers and elderly patients.
- Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice.
- Telephone consultations were offered. The practice had a website. Patients could book online appointments through the patient access website once they had requested and received a letter from the practice with an ID number.
- Same day appointments were available for children and those patients with medical problems that require same day consultation.
- Patients requiring counselling had access to in-house psychological therapy and cognitive behavioural therapy.
- Patients were able to receive travel vaccinations available on the NHS as well as those only available privately.
- There were accessible facilities such as a ramp access and an accessible toilet. A lift was installed for wheelchair users and those with poor mobility to access the second floor consultation rooms.
- Baby changing facilities were available at the practice and baby immunisation clinics were offered, by appointment only, every week. The practice also offered postnatal checks and six week baby checks.
- The practice told us that most of the staff spoke a variety of languages. Although translation services were available and patients were offered longer appointments, there were no signs to advertise these services within the practice.
- A self check-in facility was available at the practice to reduce the number of patients queuing at the reception desk.
- There was no hearing loop installed in the practice for those with a hearing impairment and there were no other reasonable adjustments in place for these patients.

Access to the service

The practice was open between 9.00am and 6.30pm on Monday, Tuesday, Wednesday and Friday and between 9.00am and 1.00pm on Thursday. Telephone lines were closed between 1.00pm and 3.00pm on Monday, Tuesday, Wednesday and Friday. Extended hours were offered between 6.30pm and 8.00pm on Monday, Tuesday, Wednesday and Friday and pre-booked appointments were offered on Saturday between 10.00am and 1.00pm. In addition to pre-bookable appointments that could be booked up to two months in advance, urgent appointments were also available for people that needed them.

Results from the national GP patient survey showed that patient's satisfaction with how they could access care and treatment were comparable to local and national averages.

- 75% of patients were satisfied with the practice's opening hours compared to the CCG average of 70% and the national average of 76%.
- 54% of patients said they could get through easily to the practice by phone compared to the CCG average of 54% and the national average of 73%.
- 65% of patients were able to get an appointment to see or speak to someone the last time they tried compared to CCG average of 65% and the national average of 76%.

People told us on the day of the inspection that they were not always able to get appointments when they needed them. The PPG told us that the practice had recently upgraded their telephone system to improve access. This

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

system enabled patients to book appointments out of hours and through their mobile phones. Despite this improvement, patients continued to highlight issues with access on the day of inspection. Additionally, feedback from the practice on the day of inspection highlighted issues regarding some GP sessions being provided earlier than the scheduled time, which had an impact on patients being able to access care at suitable times. Following the inspection, the practice sent evidence to show this issue had been rectified; however, it was too early for us to see evidence that this had improved patient satisfaction.

The practice had a system in place to assess:

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

A message requesting a home visit was left on the computer system for the GP who would then telephone the patient or carer in advance to gather information to allow an informed decision to be made on prioritisation according to clinical need. 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 an effective system in place for handling complaints and concerns.

- Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England.
- There was a designated responsible person who handled all complaints in the practice.
- We saw that information was available to help patients understand the complaints system, for example, summary leaflet and a complaints poster.

We looked at six complaints received in the last 12 months and found these were satisfactorily handled and dealt with in a timely way. The practice was open when dealing with the complaints and acknowledged when they had failed the patients. Lessons were learnt from individual concerns and complaints and from analysis of trends and action was taken to as a result to improve the quality of care. For example, the practice had implemented a system whereby they would review vaccination dates the day before they were due, to ensure they were being administered at the correct time. This was after a complaint had been raised regarding the correct vaccination period.

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 vision to deliver high quality care and promote good outcomes for patients was not effective.

- The practice did not have a mission statement. The staff discussed a vision to improve services for patients, but this was not formalised.
- The practice business plan in place was not effectively monitored. For example, in relation to indentifying and mitigating risks.

Governance arrangements

Governance arrangements had systemic weaknesses and did not ensure the practice operated safely and effectively, and performance was not being monitored in all areas.

- Practice specific policies were available, but these were not implemented or monitored effectively. For example. the safeguarding policies did not highlight who the child safeguarding leads were and did not contain contact details. We also found the practice did not maintain a fire safety logbook despite this being a part of their fire safety policy.
- Practice specific policies were not familiar to all staff. For example, staff were not aware of the business continuity plan.
- There were poor arrangements for identifying, recording and managing risks, issues and implementing mitigating actions. The governance framework in place did not ensure that the practice was meeting its responsibilities for ensuring the safety of its patients and this included significant event analysis, the lack of appropriate training for staff such as basic life support and safeguarding. This also included the lack of effective risk assessments such as fire risk assessments, whereby the practice did not have procedures in place for the safe evacuation of wheelchair users upstairs in the event of a fire, albeit they did have an evacuation chair.
- There was a programme of clinical and internal audit.
- There was a clear staffing structure and staff were aware of their own roles and responsibilities.

Leadership and culture

Although on the day of inspection the partners in the practice told us they prioritised safe, high quality and compassionate care, we found leadership arrangements were not effective enough to ensure safe and high quality care. They told us that they had faced some difficulties, but hoped the recent appointment of the practice manager would lead to improvements.Staff told us the partners were approachable and always took the time to listen to all members of staff.

Although the practice told us that they encouraged a culture of openness and honesty and had a duty of candour policy in place, we were not assured that they understood or followed this policy. (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). For example, when we reviewed a significant event concerning a notifiable safety incident, there was no supporting evidence that they had followed their obligations under the duty of candour. Staff were also not aware of a duty of candour policy in place.

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

- Staff told us the practice did not hold regular team meetings. Two meetings had been held since the recent appointment of a new practice manager. Prior to that, there was no evidence that meetings were taking place.
- 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.
- Staff said they felt respected, valued and supported, particularly by the partners in the practice. All staff were involved in discussions about how to run and develop the practice, and the partners 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, the public and staff. It proactively sought patients' feedback and engaged patients in the delivery of the service.

- The practice had gathered feedback from patients through the patient participation group (PPG) and through surveys and complaints received. The PPG met

Are services well-led?

Requires improvement

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

regularly and submitted proposals for improvements to the practice management team. For example, the practice installed a self check-in system in the system after the PPG suggested this to reduce long queues at the reception desk. The PPG was also currently developing a patient survey for the practice.

- 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.

Continuous improvement

There was no evidence the practice had a continuous improvement agenda.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **How the regulation was not being met:** The provider had not ensured that: • They had assessed, monitored and mitigated the risks to the health and safety of service users in respect of the proper and safe management of prescriptions. • They had effective and sustainable governance systems and processes in place to assess, monitor and improve the quality and safety of the services provided, including appropriate safeguarding policies and procedures. 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 Family planning services Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **How the regulation was not being met:** The provider had not ensured that persons employed had received appropriate training as was necessary to enable them to carry out their duties. This was in breach of regulation 18 (2) 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 were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Why you are failing to comply with this regulation: • You had not fully assessed the risks to the health and safety of service users receiving care and treatment or taken steps to mitigate such risks; • You had not ensured that persons providing the care or treatment to service users had the qualifications, competence skills and experience to do so safely; • You had not ensured that the premises used were safe for their intended purpose and used in a safe way; • You had not assessed the risk of, and preventing, detecting and controlling the spread of infections. This was in breach of regulation 12 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.