Hove Medical Centre

Quality Report

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

Ratings

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

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Hove Medical Centre on 31 March 2016. Overall the practice is rated as inadequate.

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

- Staff understood their responsibilities to raise concerns, and to report incidents and near misses. However, the practice did not demonstrate that significant events or complaints were always thoroughly recorded, analysed and appropriately stored, or that learning was shared effectively with staff.
- Risks to patients, staff and visitors to the practice were not all assessed or well managed. This included; the practice did not ensure cleanliness was monitored, did not have fire alarms and had not conducted a fire risk assessment, no legionella or health and safety risk assessments had been completed, and no electrical safety tests had been conducted.
- Data showed patient outcomes were mixed compared to local and national patient outcomes. Evidence was hard to identify as little reference was made to audits or quality improvement.
- Patients were at risk of harm because systems and processes were not in place to keep them safe. For example, vaccines and medicines were not all stored or managed in line with national guidance.
- The majority of patients said they were treated with compassion, dignity and respect. However, not all felt they were listened to or given enough time at their appointment.
- Urgent appointments were usually available on the day they were requested. However appointment systems were not working well so patients reported that they did not receive timely care when they needed it.
- The practice had a number of policies and procedures to govern activity.

Summary of findings

- There was a leadership structure in place and most staff felt supported, but this was not always by management. All staff spoke positively about working at the practice.

The areas where the provider must make improvements are:

- Ensure that there are robust processes for reporting, recording, acting on and monitoring significant events, incidents and complaints. Ensure that lessons learnt from complaints and significant events are communicated to the appropriate staff to support improvement at all levels.
- Ensure risk assessments are completed including health and safety, legionella, electrical safety, and fire risks. This includes that an assessment of cleanliness is regularly completed, and that cleaning undertaken is recorded and monitored.
- Ensure that information security policy and process is in place to ensure that confidential patient records are accessed and stored in accordance with national guidelines.
- Ensure that all documents and processes used to govern activity are practice specific and are up to date. This includes adult safeguarding arrangements, and the use of patient specific directives when authorising clinical staff to administer vaccines and immunisations.
- Ensure all the learning and development needs of all staff are identified through a system of comprehensive induction, annual appraisals, and meetings, which are recorded and monitored. Ensure all staff are up to date with attending mandatory training courses; including adult and child safeguarding, information governance, and Deprivation of Liberty safeguards as part of the Mental Capacity Act 2005.
- Ensure the practice has robust medicines management processes and policy, to include that national guidance is followed when storing vaccines and medicines, and to ensure medical equipment is monitored and fit for use. Improve policies and procedures to ensure the security and tracking of blank prescriptions at all times. Ensure all clinical waste is correctly documented and disposed of safely in order to minimise the risks of improper disposal.
- Maintain records of all practice meetings including clinical, multidisciplinary, practice and significant events discussions to evidence the on-going care and treatment of patients and improvement of service.
- Ensure that recruitment checks, including proof of identification and references, are completed and retained as set out in the practice recruitment policy. Ensure that registration checks are completed with the appropriate professional body for clinical staff and in a timely manner.
- Ensure sufficient numbers of suitably qualified, competent, skilled and experienced staff are deployed in order to meet patients' care and treatment needs, particularly during periods of absence.
- Carry out an on-going audit programme to show that continuous improvements have been made to patient care in a range of clinical areas as a result of clinical audit.
- Ensure that all patients are treated with respect and dignity at all times, including on the telephone and at appointments. Review the availability of disposable curtains in treatment rooms and consultation rooms and ensure curtains are installed in rooms with sufficient space. Review patient privacy within the waiting area and reception desk.
- Review and improve the telephone booking system, availability of appointments and length of time allocated for appointments for patient consultations and treatment.
- Revise how the practice gathers feedback to ensure that patients and staff are involved with how the practice is run.
- Develop, document and communicate to all staff the practice governance, vision, strategy and supporting business plan. Clearly define the individual roles and responsibilities of each management staff member, including partners, within a leadership staffing structure. Revise the support mechanisms available to staff and provide arrangements for all staff to attend formal meetings and clinical supervision.

In addition the provider should:

- Continue to ensure that all staff are either risk assessed or have received a disclosure and barring (DBS) check especially for staff who act as chaperones.

I am placing this practice in special measures. Practices placed in special measures will be inspected again within

Summary of findings

six months. If insufficient improvements have been made so a rating of inadequate remains 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 practice 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.

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

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Inadequate

The practice is rated as inadequate for providing safe services.

- Staff understood their responsibilities to raise concerns, and to report incidents and near misses. However, the practice did not demonstrate that significant events were always thoroughly recorded, analysed and appropriately stored, or that learning was shared effectively with staff.
- Patients were at risk of harm because systems and processes were not in place to keep them safe. For example, vaccines and medicines were not all stored or managed in line with national guidance.
- Risks to patients, staff and visitors to the practice were not all assessed or well managed. This included; the practice did not have fire alarms and had not conducted a fire risk assessment, no legionella or health and safety risk assessment had been completed, and no electrical safety tests had been conducted.
- The practice had defined and embedded most systems, processes and practices in place to keep patients safe and safeguarded from abuse. We found that not all staff had completed training in child and adult safeguarding.

Are services effective?

Inadequate

The practice is rated as inadequate for providing effective services.

- Data showed patient outcomes were mixed compared to the locality and nationally. Although some audits had been carried out, we found a lack of evidence to support that audits were driving improvement in performance to improve patient outcomes.
- Staff assessed needs and delivered care in line with current evidence based guidance. We saw evidence that care plans were routinely reviewed and updated.
- The learning and development needs of staff were identified through a system of appraisals and meetings, but staff told us this occurred inconsistently and was not always effective.
- The practice did not demonstrate a comprehensive induction programme for all newly appointed staff, or how they ensured role-specific training and updating for relevant staff. Staff told us they had a commitment to their own continued development and learning.

Summary of findings

- The practice identified patients who may be in need of extra support. We saw examples where results were recorded, patients were referred for further investigation if necessary, and that the community mental health team were involved.
- Multidisciplinary working was taking place but record keeping was limited or absent.

Are services caring?

Inadequate

The practice is rated as inadequate for providing caring services.

- Data from the national GP patient survey showed mixed results when compared with national averages for many aspects of care. For example, 94% of patients said they had confidence and trust in the last GP they saw, compared to the Clinical Commissioning Group (CCG) average of 95% and the national average 95%. 70% of patients said the GP gave them enough time (CCG average 84%, and national average 87%).
- The majority of patients said they were treated with compassion, dignity and respect. However, not all felt they were listened to and given enough time at their appointment.
- Information for patients about the services available was easy to understand and accessible.
- The practice had a system to identify carers in order to provide support and information.

Are services responsive to people's needs?

Inadequate

The practice is rated as inadequate for providing responsive services.

- Patients could get information about how to complain in a format they could understand. However, the practice did not demonstrate that complaints were always thoroughly recorded, investigated and appropriately stored, or that learning was shared effectively with staff. The practice did not provide evidence that all complaints were dealt with satisfactorily or in a timely way.
- All patients had been allocated to a designated GP to oversee their care and treatment requirements. One GP did not have a patient list in order to provide cover in case of staff absence.
- Patient comment cards, and results from the national GP patient survey, showed mixed results for patient's satisfaction with how they could access care and treatment. For example, 55% of patients said they could get through easily to the surgery by phone (compared to the national average 73%). Out of 32 cards we received, eight (25%) commented on difficulties with appointment booking and waiting times.

Summary of findings

- Patients told us on the day that they were able to get urgent appointments when they needed them, but found it difficult to get pre-bookable appointments.
- The practice did not offer extended hours but, as part of the EPiC (Extended Primary Integrated Care) project, patients were offered pre-bookable appointments at another local practice. These were available between 8am and 2pm every weekend, and 6:30pm and 8pm weeknights.
- The practice had good facilities and was equipped to treat patients and meet their needs.

Are services well-led?

Inadequate

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

- The practice had a number of policies and procedures to govern activity.
- The practice had a vision to deliver high quality care and promote good outcomes for patients, but this was not well documented or evidenced. The practice did not provide a business strategy.
- There was a leadership structure in place and most staff felt supported, but this was not always by management. All staff spoke positively about working at the practice.
- The practice did not have a practice specific patient participation group. They told us a group of patients and the practice manager met regularly with a local health forum.
- The practice did not demonstrate robust arrangements for identifying, recording and managing risks, issues and implementing mitigating actions.

Summary of findings

The six population groups and what we found

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

Older people

Inadequate

The issues identified as inadequate overall affected all patients including this population group. There were, however, examples of good practice.

- The practice offered proactive, personalised care to meet the needs of the older people in its population.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs.

People with long term conditions

Inadequate

The issues identified as inadequate overall affected all patients including this population group.

- The practice offered a range of services to people with long term conditions. This included clinics for diabetes, asthma and hypertension.
- Longer appointments and home visits were available when needed.
- Performance for diabetes related indicators were comparable to or slightly below the national average. For example, patients with diabetes who had a blood pressure reading in the preceding 12 months of 140/80mmHg or less was 67% compared with a national average of 78%; and the percentage of patients with diabetes who had a record of a foot examination and risk classification within the preceding 12 months was 82% compared with a national average of 88%.
- All these patients had a named GP and staff told us they received a structured annual review to check their health and medicines needs were being met. For those patients with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care. At the time of inspection the practice was not able to demonstrate that annual reviews were being completed.

Families, children and young people

Inadequate

The issues identified as inadequate 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

Summary of findings

example, children and young people who had a high number of A&E attendances. However, the practice did not demonstrate all staff had received safeguarding training at the suitable level for their role.
- We received two comment cards from patients who told us that children and young people received good care and treatment. They also said they were treated in an age-appropriate way and were recognised as individuals.
- The practice's uptake for the cervical screening programme was 79%, which was comparable to the national average of 82%.
- Appointments were available outside of school hours and the premises were suitable for children and babies.

Working age people (including those recently retired and students)

Inadequate

The issues identified as inadequate overall affected all patients including this population group.

- The practice did not offer extended hours. As part of the EPiC (Extended Primary Integrated Care) project, patients were offered pre-bookable appointments between 8am and 2pm every weekend, and 6:30pm and 8pm weeknights at another local practice.
- The practice offered online services and electronic prescribing service as well as a full range of health promotion and screening that reflects the needs for this age group.

People whose circumstances may make them vulnerable

Inadequate

The issues identified as inadequate overall affected all patients including this population group.

- The practice offered longer appointments and annual reviews, including a documented care plan, for patients with a learning disability.
- The practice regularly worked with multi-disciplinary teams in the case management of vulnerable patients, but this was not well evidenced.
- The practice informed vulnerable patients about how to access various support groups and voluntary organisations.
- Appointments were offered to patients with no fixed address. Staff told us they supported those patients by registering them with a temporary address, and they also signposted them to appropriate services.
- The practice did not provide evidence of an adult safeguarding policy providing practice specific guidance or details of responsible persons.

Summary of findings

- Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours. However, the practice was not able to demonstrate that all staff had completed relevant training for child and adult safeguarding.

People experiencing poor mental health (including people with dementia)

Inadequate

The issues identified as inadequate overall affected all patients including this population group.

- The practice completed dementia screening if required, for example if concerns had been raised by relatives. We saw examples where results were recorded, patients were referred for further investigation if necessary, and that the community mental health team were involved. Performance for dementia related indicators was higher than national averages; the percentage of patients diagnosed with dementia whose care had been reviewed in the preceding 12 months was 94%, compared to the national average of 84%. Of patients diagnosed with dementia, 79% had had their care reviewed in a face to face meeting in the last 12 months, which is comparable to the national average of 84%.
- Performance for mental health related indicators were comparable to the national average. For example, 89% of patients with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive, agreed care plan documented in the last 12 months compared with a national average of 88%.
- We received one comment card which related to a patient with mental health issues experiencing a lack of respect and understanding when calling the surgery.
- The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations.
- Staff we spoke with demonstrated a clear understanding of patient consent and they were able to provide evidence where this had been recorded. However, not all GPs we spoke with had a comprehensive understanding of the Deprivation of Liberty Safeguards (DOLs) and they had not all been trained.

Summary of findings

What people who use the service say

The national GP patient survey results were published on January 2016. The results showed mixed results against national averages. There were 247 survey forms were distributed and 111 were returned. This represented 1.26% of the practice's patient list and a response rate of 45%.

- 55% of patients found it easy to get through to this surgery by phone compared to a national average of 73%.
- 56% of patients that were always able to get an appointment to see or speak to someone the last time they tried (national average 36%).
- 70% of patients described the overall experience of their GP surgery as good (national average 85%).
- 69% of patients said they would recommend their GP surgery to someone who has just moved to the local area (national average 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 almost all positive about the standard of care received. Most patients stated they felt the practice offered an excellent service, and that GPs always listened and were friendly, empathetic and kind. However, there were 13 cards containing less positive comments (41%) which related to difficulty calling the surgery, making appointments, lack of respect and dignity, and length of appointment time.

We spoke with four patients during the inspection. All patients said they were happy with the care they received and thought GPs were caring.

Areas for improvement

Action the service MUST take to improve

- Ensure that there are robust processes for reporting, recording, acting on and monitoring significant events, incidents and complaints. Ensure that lessons learnt from complaints and significant events are communicated to the appropriate staff to support improvement at all levels.
- Ensure risk assessments are completed including health and safety, legionella, electrical safety, and fire risks. This includes that an assessment of cleanliness is regularly completed, and that cleaning undertaken is recorded and monitored.
- Ensure that information security policy and process is in place to ensure that confidential patient records are accessed and stored in accordance with national guidelines.
- Ensure that all documents and processes used to govern activity are practice specific and are up to date. This includes adult safeguarding arrangements, and the use of patient specific directives when authorising clinical staff to administer vaccines and immunisations.
- Ensure all the learning and development needs of all staff are identified through a system of comprehensive induction, annual appraisals, and meetings, which are recorded and monitored. Ensure all staff are up to date with attending mandatory training courses; including adult and child safeguarding, information governance, and Deprivation of Liberty safeguards as part of the Mental Capacity Act 2005.
- Ensure the practice has robust medicines management processes and policy, to include that national guidance is followed when storing vaccines and medicines, and to ensure medical equipment is monitored and fit for use. Improve policies and procedures to ensure the security and tracking of blank prescriptions at all times. Ensure all clinical waste is correctly documented and disposed of safely in order to minimise the risks of improper disposal.

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- Maintain records of all practice meetings including clinical, multidisciplinary, practice and significant events discussions to evidence the on-going care and treatment of patients and improvement of service.
- Ensure that recruitment checks, including proof of identification and references, are completed and retained as set out in the practice recruitment policy. Ensure that registration checks are completed with the appropriate professional body for clinical staff and in a timely manner.
- Ensure sufficient numbers of suitably qualified, competent, skilled and experienced staff are deployed in order to meet patients' care and treatment needs, particularly during periods of absence.
- Carry out an on-going audit programme to show that continuous improvements have been made to patient care in a range of clinical areas as a result of clinical audit.
- Ensure that all patients are treated with respect and dignity at all times, including on the telephone and at appointments. Review the availability of disposable curtains in treatment rooms and consultation rooms and ensure curtains are installed in rooms with sufficient space. Review patient privacy within the waiting area and reception desk.
- Review and improve the telephone booking system, availability of appointments and length of time allocated for appointments for patient consultations and treatment.
- Revise how the practice gathers feedback to ensure that patients and staff are involved with how the practice is run.
- Develop, document and communicate to all staff the practice governance, vision, strategy and supporting business plan. Clearly define the individual roles and responsibilities of each management staff member, including partners, within a leadership staffing structure. Revise the support mechanisms available to staff and provide arrangements for all staff to attend formal meetings and clinical supervision.

Action the service SHOULD take to improve

- Continue to ensure that all staff are either risk assessed or have received a disclosure and barring (DBS) check especially for staff who act as chaperones.

Hove Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector**.** The team included a GP specialist adviser, a second CQC inspector and a practice manager specialist adviser.

Background to Hove Medical Centre

Hove Medical Centre provides primary medical services to approximately 8784 patients. The practice also provides care and treatment for the residents of a nearby care home, which serves individuals with dementia or nursing needs.

The practice is located in a residential area of Brighton and Hove; plans to extend the building beyond the current two floors were submitted in March 2016.

There are five GP partners and one salaried GP (four male, two female). Collectively they equate to three full-time GPs. The practice is registered as a GP training practice, supporting medical students and providing training opportunities for doctors seeking to become fully qualified GPs.

There are five female members of the nursing team; one advanced nurse practitioner, two practice nurses, one health care assistant and one phlebotomist. GPs and nurses are supported by the practice manager, a deputy practice manager, and a team of reception/administration staff.

Data available to the Care Quality Commission (CQC) shows the practice serves a higher than average number of patients who are aged under 18 years when compared to the national average. The number of patients aged 65 or over is also higher than average. The data shows that 60% of patients registered at the practice have a long-standing health condition, which is higher than the national average of 54%. The number of registered patients suffering income deprivation is comparable to the national average.

The practice is open Monday to Friday between 8:30am to 6:30pm. The practice closes between 1pm and 2pm on Monday, Tuesday and Thursday. The practice telephone lines remained open during this time with a duty GP available. Appointments can be booked over the telephone, online or in person at the surgery. Patients are provided information on how to access an out of hours service by calling the surgery or by viewing the practice website.

The practice runs a number of services for its patients including; chronic disease management, new patient checks, smoking cessation, and holiday vaccines and advice.

Services are provided from the location of Hove Medical Centre, West Way, Hove, BN3 8LD.

The practice has a General Medical Services (GMS) contract with NHS England. (GMS is one of the three contracting routes that have been available to enable commissioning of primary medical services). The practice is part of NHS Brighton and Hove Clinical Commissioning Group.

The practice was previously inspected on 28 November 2013 and found to be non-compliant. A follow up inspection was completed on 18 September 2014 and was the practice was found to be compliant.

Detailed findings

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme.

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

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)

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 31 March 2016. During our visit we:

- Spoke with a range of staff including; three GP partners, one salaried GP, two practice nurses, one health care assistant, one phlebotomist, the practice manager, the deputy practice manager, and five receptionists/ administrators. We also spoke with four patients who used the service.
- Observed how people were being cared for and talked with carers and/or family members and reviewed 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.
- Made observations of the internal and external areas of the building.
- Reviewed documentation relating to the practice including policies and procedures.

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

There was a system in place for reporting and recording significant events, but we found significant weaknesses.

- Staff told us they would inform the practice manager of any incidents. There was a recording form available both on the practice's computer system and hard-copy.
- The practice told us they carried out a thorough analysis of the significant events.
- The practice did not demonstrate that significant events were always thoroughly recorded, analysed and appropriately stored. It was not clear who had responsibility for the oversight of significant events. The practice provided evidence of two significant events that had been recorded and investigated. There was little evidence that learning was always shared with appropriate staff.
- Staff gave us an example of an incident had taken place two weeks prior to inspection. A patient experiencing poor mental health had attended the surgery requesting to speak to one of the GPs. The patient displayed violent and aggressive behaviour to the reception staff and one of the nursing staff. We spoke with two of the staff present during the incident who told us that the patient received appropriate care and treatment. They told us a significant event was recorded and a meeting took place a week later to discuss the incident, and they told us learning had been identified to improve safety in the practice. This included that the location of the panic button at reception was shared with all staff and displayed on posters.
- It was noted that none of the nursing, reception/ administrative staff were aware of any recent significant events appropriate to their role, aside from those they had raised themselves. We reviewed minutes of four practice meetings that had taken place in the last year and there was no evidence that significant events were discussed. Staff told us that meetings did not take place regularly.

Overview of safety systems and processes

The practice had defined and embedded systems, processes and practices in place. However, some of these were not implemented well enough to keep patients safe and safeguarded from abuse.

- One of the GP partners was the lead for safeguarding. Staff told us there were policies accessible to them for both child and adult safeguarding, and we saw the child safeguarding policy which had recently been reviewed. Within treatment rooms we saw local authority safeguarding posters displayed, which provided information on safeguarding with contact details for external agencies. We were not shown an adult safeguarding policy providing practice specific guidance or details of responsible persons. Staff told us that information that children and adults were at risk was entered into the patient notes, for example those at risk of harm, subject to safeguarding procedures or on a child protection plan. The GPs attended safeguarding meetings when possible with other agencies, but always provided reports when necessary. The practice told us they had strong links with other agencies with regards to information sharing; for example reports of children who attended A&E were reviewed by the safeguarding lead GP and action was taken where necessary. In addition, the practice acted on information from the police and other agencies regarding victims of domestic abuse, and updated patient notes accordingly.
- Staff demonstrated they understood their safeguarding responsibilities and those we spoke with had received training relevant to their role. The practice told us all GPs were trained to safeguarding level three for children. However, the practice did not collate information of completed training centrally, therefore they were not able to provide evidence that child and adult safeguarding training had been completed by all staff. Since our inspection the practice has provided detail of safeguarding training completed. This does not distinguish adult and child safeguarding separately.
- Notices in treatment rooms and in the waiting room advised patients that chaperones were available if required. We spoke with five staff who were chaperones and had received in-house training and they demonstrated that they understood the role. Out of these staff, three had not received a Disclosure and Barring Service check (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). However, this was in accordance with the practice risk assessment to determine which staff required a DBS check. Non-clinical staff that did not have lone contact with patients were assessed as not

eligible for a check; this included chaperones. We looked at the records for two nursing staff and saw DBS checks had been completed in accordance to the practice risk assessment.

- The practice maintained appropriate standards of cleanliness and hygiene in most areas. We observed the premises to be tidy however we saw some areas that required further cleaning, for example; blinds and shelves that were dusty, and areas of carpets were worn and unclean. We reviewed the practice cleaning schedule and we asked to see the cleaning log but the practice did not provide this.
- The lead practice nurse was the infection control clinical lead. There was infection prevention and control protocol in place and this was reviewed annually. Staff had received up to date training, which included hand hygiene standards and infection control prevention. The lead nurse provided evidence that all staff had completed this training, and staff we spoke with demonstrated their understanding. Annual infection control audits were undertaken, the most recent audit was completed in July 2015, and we saw evidence that action was taken to address any improvements identified as a result.
- Not all staff had received training on information governance, and staff did not always demonstrate a comprehensive understanding of their responsibilities. Through staff interviews and our observations we found that information was not always being kept securely. This included that Smartcards were not always removed and computers systems were not always locked, to prevent unauthorised access to information. (Smartcards allow authorised persons to access secure and confidential patient data, including personal and healthcare details). Additionally, not all GPs had access to the practice email system and correspondence, including meeting minutes containing medical details of patients, was sent to personal email addresses. We noted that a risk assessment for this activity had not been undertaken and not all GPs had signed a confidentiality agreement.

There were arrangements for managing medicines, including emergency medicines and vaccines, but some of these were not implemented well enough to keep patients safe (including obtaining, prescribing, recording, handling, storing and security).

- The practice carried out regular medicines audits, with the support of the local CCG pharmacy teams, to ensure prescribing was in line with best practice guidelines for safe prescribing. The practice GPs told us that high risk medicines were monitored and medication reviews were completed annually if the patient's condition was stable, or six monthly if it was not. Repeat prescriptions were checked by a GP prior to them being issued, but not all staff could describe the system to automatically highlight high risk medicines to ensure tests were conducted prior to the medicines being issued. For example, a blood test conducted prior to issuing a medicine used to treat cancer.
- Medicines and vaccines were stored securely. The practice did not hold any controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse). The practice did not demonstrate systems to monitor equipment and medicines to ensure they were in date and fit for use. We found equipment that was past expiry date, which included; oxygen masks (three adult, three children), equipment used for cervical smears, needles, and blood collection tubes.
- The practice had two refrigerators used to store medicines and vaccines. One refrigerator was storing vaccines in a treatment room and one storing stock/ backup in the administration office. We asked to see the records of checks carried out for both refrigerators. Staff told us temperature checks for the vaccine refrigerator had been carried out, and records of those checks were made. We saw that the maximum temperature of the vaccines refrigerator was outside of the recommended storage range (between two and eight degrees centigrade) between August 2015 and the date of our inspection March 2016. The practice did not demonstrate what action had been taken when the temperature of the vaccine refrigerator was recorded as being outside of the recommended limit. The practice staff told us that it was a new fridge and they did not fully understand how to correctly monitor the temperature. We also saw that specimens were being stored in the vaccine refrigerator, which can pose a cross-contamination risk. We asked to see the temperature records of the second refrigerator. Staff told us that monitoring was not taking place, as temperatures were recorded electronically onto a memory card in the refrigerator. The practice did not

demonstrate a process to routinely check the information recorded. In addition, at the time of inspection the memory card was not present in the refrigerator. The practice was therefore unable to demonstrate that the vaccines and medicines stored in either refrigerator were safe to use, or that the effectiveness of vaccines had not been compromised. We asked the practice to inform Public Health England and to ensure the vaccines and medicines were not used until advice was sought. The practice responded quickly to the concerns and an investigation is underway.

- There were some systems for safely handling, storing and disposing of clinical waste. Clinical waste was stored securely in locked, dedicated containers whilst awaiting collection from a registered waste disposal company. However not all sharps bins were correctly assembled, labelled and disposed of. We found one sharps bin had been assembled in February 2014 and therefore had not been disposed of after the recommended three months. We also found one sharps bin that had not been correctly labelled.
- We saw that blank prescription pads were not always securely stored. We saw that treatment and consultant room doors were not always closed or locked, and in one room we found blank prescription papers in view. At the time of inspection the practice was not able to demonstrate that there were systems in place to routinely record, track and monitor prescriptions.
- One of the nurses had qualified as an Independent Prescriber and could therefore prescribe medicines for specific clinical conditions. This nurse received support from other medical staff for this extended role. The nursing team met informally each week and this meeting was not minuted. Patient Group Directions (PGDs) had been adopted by the practice to allow nurses to administer medicines in line with legislation. We viewed the PDGs and these had been completed correctly. The practice had a system for production of Patient Specific Directions (PSDs) to enable Health Care Assistants to administer vaccines after specific training when a doctor or nurse were on the premises. However, PSDs were not completed in line with legislation, as they were not signed by an authorised person prior to each patient being administered the medicine.
- We reviewed the practices' recruitment policy and three personnel files, where we found in most cases there had been appropriate recruitment checks undertaken prior to employment. This included; proof of identification, references, qualifications and registration with the appropriate professional body. However we found two files that did not contain proof of identification and one did not contain a record of the interview summary, as per the practice policy. We reviewed four GP personnel files and found that in two cases a registration check had been completed with the appropriate body on or near the renewal date. In the remaining two we found the check date had lapsed. We also found that a check had not been completed for any of the nursing team.
- There were systems in place to ensure results were received for all samples sent for the cervical screening programme. The practice followed up women who were referred as a result of abnormal results.

Monitoring risks to patients

Risks to patients were not fully assessed and not well managed.

- There were some procedures in place for monitoring and managing risks to patient and staff safety. There was a health and safety policy available which identified local health and safety representatives, but it was not dated and therefore it was not possible to determine whether it had recently been updated.
- The practice had not completed a recent fire risk assessment. We saw and were told that the practice did not have fire alarms. The fire brigade had attended to conduct fire awareness and fire warden training day in March 2014 for all staff. Three staff members that we spoke with told us that the fire brigade had made recommendations to improve fire safety, and we were shown that emergency lighting was installed. The practice told us they had made the decision not to have alarms installed, as they were planning an extension of the building. We saw that the planning application had been submitted in March 2016. The practice carried out regular fire drills; we saw the fire/fire drill instructions for staff, and saw a report from the drill in January 2016. In order to raise the alarm staff were instructed to shout fire and to use a telephone alarm by dialling a specific number, the panic alarm button at reception and the intruder alarm. We noted that not all rooms had telephones. Nurses were told to use the emergency/ panic alarm in case GPs were on their phones.

Inadequate

Are services safe?

- The practice staff told us that an electrical safety test had not been completed within the recommended five years, to ensure the safety of the power supply and hard wiring.
- The practice had not completed a recent legionella risk assessment (Legionella is a term for a particular bacterium which can contaminate water systems in buildings).
- The practice told us that all electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly. We asked to see a report of the portable appliance testing (PAT), but the practice did not provide this as they had not received a report. We viewed a random sample of equipment and saw that recognised PAT stickers had been placed, confirming the check had been completed.
- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system in place for all the different staffing groups to ensure that enough staff were on duty but this system was not working well enough to cover all staff on leave. The GPs covered each other's leave in order to minimise the use of locums. However, some nursing and administrative staff told us that there was not always enough staff to cover leave. We were given examples of tasks that were not completed when the staff member responsible was absent, as no other staff member had been allocated and/or trained to undertake these roles. This included tasks which caused delay in patient treatment. Staff told us they took personal responsibility to catch up on the workload that had not been covered in their absence.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to respond to emergencies and major incidents.

- There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency. The practice also had a panic button at the reception desk and a telephone alerting system.
- Staff we spoke with told us they had received annual basic life support training, but the practice did not provide evidence of this, as training records were not collated centrally. Since our inspection the practice has provided evidence that, with the exception of one non-clinical staff member, all staff had completed this training.
- The practice had a defibrillator available on the premises and oxygen with adult and children's masks. A first aid kit and accident book were available.
- Emergency medicines were available and 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 fit for use.
- The practice had a business continuity plan in place for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff.

Inadequate

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 some systems in place to keep all clinical staff up to date. The practice cascaded information to clinical staff by email, including national patient safety alerts. Staff had access to guidelines from NICE and used this information to deliver care and treatment that met patients needs.
- GPs and nurses told us they took personal responsibility to keep themselves up to date, for example by viewing information online and communication with peer networks. Staff told us that clinical meetings had not taken place regularly and were not minuted. One of the nursing team had recently begun to organise clinical meetings and we saw evidence of the most recent meeting minutes.
- The practice monitored that NICE 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 recent published results were 95% of the total number of points available. This practice was not an outlier for most QOF (or other national) clinical targets. Data from 2014/15 showed:

- Performance for diabetes related indicators were comparable or below to the national average. For example, patients with diabetes had a blood pressure reading in the preceding 12 months of 140/80mmHg or less was 67% compared with a national average of 78%; and the percentage of patients with diabetes who had a record of a foot examination and risk classification within the preceding 12 months was 82% compared with a national average of 88%.
- The percentage of patients with hypertension having regular blood pressure tests was 79% which was comparable to the national average 84%.
- Performance for mental health related indicators were comparable to the national average. For example, 89% of patients with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive, agreed care plan documented in the last 12 months compared with a national average of 88%.

Clinical audits demonstrated some quality improvement.

- The practice did not have a method to log and monitor completed audits and their recommendations centrally. They provided evidence of three clinical audits that had been completed in the last two years. Findings were used by the practice to improve services. For example, an audit was completed in April 2015 to determine whether GPs were completing observations as recommended by a National Institute of Health and Care Excellence (NICE) clinical assessment tool of children under five at risk of serious illness. Following the first phase of data collection from consultations, the findings were presented to clinical staff and GPs were provided with their individual performance. The NICE guidance was also circulated. Following the second phase of data collection, many improvements were shown. For example; the temperature of a child was obtained in 63% of cases in the first cycle, which improved to 80% in the second cycle. The audit also showed that record keeping improved. We saw that the NICE guidance had been displayed in all consultation rooms.
- The practice participated in local audits, national benchmarking, accreditation, peer review and research. For example an audit of acute coughs was completed following the clinical commissioning group (CCG) prescribing incentive scheme. As a result of the audit, GPs completed an e-module and offered a leaflet to patients with information on how to treat their infection. The audit showed a reduction in the prescribing of antibiotics was achieved.

It was noted that staff within the nursing team felt they had little or no involvement with audits conducted at the practice.

Effective staffing

Inadequate

Are services effective?

(for example, treatment is effective)

Staff had the skills, knowledge and experience to deliver effective care and treatment.

- The practice did not demonstrate a comprehensive induction programme for all newly appointed staff. Staff who had recently started with the practice told us they felt the induction programme could be improved, including a lack of formal training and development reviews. We also saw feedback from a previous trainee GP that aligned with these views.
- The practice did not demonstrate how they ensured role-specific training and updating for relevant staff. Staff told us they had a commitment to their own continued development and learning.
- 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 informal discussions.
- The learning and development needs of staff were identified through a system of appraisals and meetings, but staff told us this occurred inconsistently and was not always effective. Staff told us they felt able to request appropriate training to meet their learning needs and to cover the scope of their work. This included ongoing support during sessions, one-to-one meetings, coaching and mentoring, clinical supervision and facilitation, and support for revalidating GPs. Records of appraisals were not held or reviewed centrally, and copies of appraisals were not stored in personnel files; therefore it was not possible to determine whether all staff had an appraisal within the last 12 months. Non-clinical records of appraisals were kept off-site at a staff member's home. We asked ten staff whether they had an appraisal within the last 12 months and whether it was effective and/or useful. Out of these staff; four told us they had not had an annual appraisal or ever, and five told us they had an appraisal - but three of these told us it was not effective/ useful. One staff member who had been in post less than 12 months had not received an appraisal or formal supervision yet.
- Staff we spoke with had received training that included: safeguarding, fire procedures, and basic life support.

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. We saw examples of care plans that had been comprehensively assessed and followed up. These included; patients with long term conditions, learning disabilities, and dementia.
- Information such as NHS patient information leaflets were available.
- 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 services to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. This included when patients moved between services, including when they were referred, or after they were discharged from hospital. For example, the practice received a report from A&E that a 14 year old patient was repeatedly taking an overdose. As a result the lead safeguarding GP saw the patient every two days to ensure good care and support was provided.

The GPs we spoke with told us that multi-disciplinary team meetings took place on a monthly basis but we did not see recent evidence of this. The practice had a palliative care lead and we saw they had a palliative care register (16 patients). The practice also attended a palliative care meeting to discuss and review end of life cases with complex medical needs. The practice received a list of the cases that had been chosen for the agenda, and were sent the minutes electronically.

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 2005. However, not all GPs we spoke with had a comprehensive understanding of the Deprivation of Liberty Safeguards (DOLs) and they had not all been trained. (The Deprivation of Liberty Safeguards are part

of the Mental Capacity Act 2005. The safeguards are used to protect the rights of people who lack the ability to make certain decisions for themselves and make sure that their freedom is not inappropriately restricted.)

- 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.

- These included patients in the last 12 months of their lives, carers, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation. Patients were then signposted to the relevant service.
- Advice on patients' diet and smoking cessation advice was available from the health care assistant.
- We saw evidence that the practice had identified patients who may be in need of extra support on separate lists that were recorded on the practice computer system. This included patients with a learning disability (36), and patients suffering poor mental health (78). The practice also completed dementia screening if required, for example if concerns had been raised by relatives. We saw examples where results were recorded, patients were referred for further investigation if necessary, and that the community mental health team were involved. Performance for dementia related indicators was higher than national averages; the percentage of patients diagnosed with dementia whose care has been reviewed in the preceding 12 months was 94%, compared to the national average of 84%.

The practice's uptake for the cervical screening programme was 79%, which was comparable to the national average of 82%. There was a policy to offer text message reminders for patients who did not attend for their cervical screening test. The practice demonstrated how they encouraged uptake of the screening programme by using information in different languages and they ensured a female sample taker was available. The practice also encouraged its patients to attend national screening programmes. The practice's uptake for bowel cancer screening within 6 months of an invitation was 59%, which was slightly above the national average of 55%. The uptake for breast cancer screening within 6 months of an invitation was 56%, which was below the national average of 73%.

Childhood immunisation rates for the vaccinations given to under two year olds ranged from 66% to 92% and five year olds from 71% to 76%.

Patients had access to appropriate health assessments and checks. These included health checks for new patients and NHS health checks for patients aged 40–74. Appropriate follow-ups for the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.

Inadequate

Are services caring?

Our findings

Kindness, dignity, respect and compassion

Throughout our inspection we observed that members of staff were courteous, friendly and attentive with patients both in person and on the telephone. The reception area was open and although the waiting area was located away from the reception desk, it was possible to hear conversations taking place at the desk. Staff told us that a room could be made available if patients wanted to speak confidentially away from the reception area, and we saw a notice displayed advising this was available. We noted that consultation and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard. We noted that the majority of treatment and consulting rooms did not have curtains provided; to ensure that patients' privacy and dignity was maintained during examinations, investigations and treatments. We saw in meeting minutes from November 2015 that staff had requested curtains, but management staff said this was not possible for all rooms due to a lack of available space. We saw that the practice was considering installing curtains in rooms with sufficient space. Where curtains were not provided, staff told us they left the room to protect patients' privacy and dignity.

Out of the 32 patient Care Quality Commission comment cards we received, 30 patients stated they were happy about the care and treatment provided by the practice. They said GPs and nurses were helpful, caring and supportive.

However there were 13 cards which contained less positive comments (41%) which related to difficulties with appointment booking and waiting times (eight), a lack of privacy, respect and dignity (two), and not being given enough time at their appointment (three).

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

- 78% of patients said the GP was good at listening to them compared to the Clinical Commissioning Group (CCG) average of 87% and the national average of 89%.
- 70% of patients said the GP gave them enough time (CCG average 84%, and national average 87%).
- 94% of patients said they had confidence and trust in the last GP they saw (CCG average 95%, and national average 95%).
- 72% of patients said the last GP they spoke to was good at treating them with care and concern (national average 85%).
- 87% of patients said the last nurse they spoke to was good at treating them with care and concern (national average 91%).
- 84% of patients said they found the receptionists at the practice helpful (CCG average 88% and national average 87%).

There were two comment cards we received that related to a lack of privacy, respect and dignity. One patient commented on improvements needed at the reception area due to a lack of privacy at the reception desk. The other card related to a patient with mental health issues experiencing a lack of respect and understanding when calling the surgery.

The practice told us that feedback was monitored both verbally and in writing, to inform practice development and training needs. The practice told us they planned to set up their own patient participation group, and to commence a programme of staff training and performance review.

Care planning and involvement in decisions about care and treatment

On the day of our inspection we spoke with four patients who told us they felt involved in decision making about the care and treatment they received. They told us they felt listened to and supported by staff. However, they all had mixed feelings with regard to being given sufficient time during consultations, in order to make an informed decision about the choice of treatment available to them. We received three comment cards from patients who felt they were not always given enough time during appointments, but almost all were positive about the care received.

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

Inadequate

Are services caring?

- 78% of patients said the last GP they saw was good at explaining tests and treatments compared to the Clinical Commissioning Group (CCG) average of 84% and national average of 86%.
- 68% said the last GP they saw was good at involving them in decisions about their care (national average 82%).
- 85% said the last nurse they saw was good at involving them in decisions about their care (national average 85%).

Staff told us that translation services were available for patients who did not have English as a first language and could give examples where they had booked services for patients. We saw notices in the reception areas informing patients this service was available.

Patient and carer support to cope emotionally with care and treatment

Notices in the patient waiting room told patients how to access a number of support groups and organisations.

The practice proactively identified patients who were carers on the new patient registration form, and the practice's computer system alerted GPs if a patient was also a carer. The practice had identified 150 patients that were carers, which is 1.71% of the practice list. 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. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service.

Inadequate

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. As part of the EPiC (Extended Primary Integrated Care) project within Brighton and Hove, patients were offered pre-bookable appointments between 8am and 2pm every weekend, and 6:30pm and 8pm weeknights at another local practice. The EPiC project is dedicated to improving access to primary healthcare services in Brighton and Hove.

- There were longer appointments available for patients with a learning disability.
- Home visits were available for older patients and patients who had difficulty attending the practice.
- Appointments were offered to patients with no fixed address. Staff told us they supported those patients by registering them with a temporary address, and they also signposted them to appropriate services.
- Same day appointments were available for children and those with serious medical conditions.
- Patients were able to receive travel vaccines available on the NHS as well as those only available privately.
- There were disabled facilities and baby changing facilities available.
- The practice had translation services available and equipment to assist patients with a hearing impairment. This included a hearing loop and a screen showing next appointments in the waiting room, which alerted patients with an audible buzzer.
- Patients were able to book appointments and order repeat prescriptions on the practice website.
- All patients had been allocated to a designated GP to oversee their care and treatment requirements. One GP did not have a patient list in order to provide cover in case of staff absence.
- The practice had a digital check in system. This could be used in a variety of languages.

Access to the service

The practice was open every Monday to Friday from 8:30am to 6:30pm. The practice closed between 1pm and 2pm every Monday, Tuesday and Thursday. A duty GP was available every day from 12:30pm. In addition to pre-bookable appointments that could be booked up to six weeks in advance, urgent appointments were also available for patients that needed them.

Results from the national GP patient survey showed that patient's satisfaction with how they could access care and treatment was comparable or worse than national averages.

- 67% of patients were satisfied with the practice's opening hours compared to the national average of 78%.
- 55% of patients said they could get through easily to the surgery by phone (national average 73%).
- 72% of patients said they usually get to see or speak to the GP they prefer (national average 76%).

Patients told us on the day of the inspection that they were able to get urgent appointments when they needed them and non-urgent appointments within a week to three weeks.

Out of the 32 comment cards we received, there were eight less positive comments which related to difficulties with appointment booking and waiting times. They commented that they found it difficult to get an appointment (four), that there was sometimes a long wait to reach the surgery by telephone (two) and the waiting times for the reception desk along with a lack of seating (two).

Listening and learning from concerns and complaints

The practice did not demonstrate a thorough system in place for handling complaints and concerns.

- The complaint policy and procedures were in line with recognised guidance and contractual obligations for GPs in England.
- It was not clear whether a designated responsible person was in place to handle all complaints in the practice.
- We saw that information was available to help patients understand the complaints system on notice boards in the waiting rooms and on the practice website.

We asked to see examples of complaints received in the last 12 months. Due to a lack of record keeping, it was only possible to review two complaints. The practice staff told us that complaints were not all dealt with centrally, and it was not clear who held the responsibility. Investigations of complaints were not well documented and the practice did

Inadequate

Are services responsive to people's needs?

(for example, to feedback?)

not provide evidence that lessons were learnt from concerns, and that complaints were shared appropriately to improve the quality of care. The practice did not provide evidence that all complaints were dealt with satisfactorily or in a timely way.

Are services well-led?

Inadequate

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

Our findings

Vision and strategy

The practice had a vision to deliver high quality care and promote good outcomes for patients, but this was not well documented or evidenced. The practice did not provide a business strategy.

Governance arrangements

The governance arrangements were not robust or effectively implemented;

- There was a staffing structure, but we received conflicting evidence between the management and partners regarding the individual roles and responsibilities held.
- There were some practice specific policies that had been implemented, reviewed and made available to all staff. However, we found that there were key policies not in place or recently reviewed including; adult safeguarding, health and safety, clinical governance.
- A comprehensive understanding of the performance of the practice was not maintained. This included that we found; risk assessments had not all been completed and little evidence of a regular clinical audit programme. We were also not provided with sufficient information to evidence the recording, analysis and learning from significant events.

Leadership and culture

The partners in the practice had the experience to run the practice. They prioritised high quality and compassionate care. However, we found issues that threatened the delivery of safe, high quality care were not all identified or adequately managed.

We received mixed views from staff and GPs at the practice. Staff told us that most of the partners were visible in the practice, and almost all were approachable and took the time to listen to all members of staff.

The provider was aware of and complied with the requirements of the Duty of Candour. The partners encouraged a culture of openness and honesty. The practice had systems in place for knowing about notifiable safety incidents.

When there were unexpected or unintended safety incidents:

- The practice gave affected people support, truthful information and a verbal and written apology.
- They did not always keep written records of verbal interactions as well as written correspondence.

There was a leadership structure in place and most staff felt supported, but this was not always by management.

- Staff told us that monthly management meetings were held, but we saw that minutes were not always taken. We were told by administrative/secretarial and nursing staff there were no regular formal practice meetings they attended. Staff we spoke with were unaware of any recent significant events aside from those they recorded themselves, complaints, or changes within the practice. For example, the practice had submitted plans to extend the building but, when asked, some staff were not clear on why this was taking place and had only been informed of these changes from other team colleagues.
- All staff said they felt respected, valued and supported by colleagues, however not always by all partners and management at the practice. For example, an incident had taken place two weeks prior to inspection. A patient experiencing poor mental health had attended the surgery requesting to speak to one of the GPs. The patient displayed violent and aggressive behaviour to the reception staff and the nursing staff. We spoke with staff present during the incident who told us they had been emotionally and/or physically affected by this incident but had not received immediate support, and had returned to their duties. We were told that a meeting took place a week later regarding the significant event.
- It was noted that all of the staff spoke positively about working at the practice, and showed commitment to the practice.
- Staff told us they were not involved in discussions about how to run and develop the practice. They told us they would be supported if they were to identify opportunities to improve the service delivered by the practice.

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

The practice valued feedback from patients, the public and staff. The practice sought patients' feedback and engaged patients in the delivery of the service.

Are services well-led?

Inadequate

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

- The practice did not have its own patient participation group. They told us a group of patients and the practice manager met regularly with a local health forum.
- The practice told us they regularly viewed feedback made available through external means such as NHS choices and the friends and family test. They also recorded verbal feedback. We heard from staff that this information was used to inform staff training or to make improvements at the practice.
- Staff told us they would discuss any concerns or issues with colleagues and management.

Continuous improvement

We did not see evidence of a focus on continuous learning and improvement within the practice.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **How the regulation was not being met:** The provider did provide evidence of risk assessments for health and safety, and legionella. This was in breach of regulation 12(1)(2)(a)(b)(d)(e)(f)(g)(h) 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 Surgical procedures Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect **How the regulation was not being met:** The registered provider did not do all that was reasonably practicable to ensure the privacy of service users, and that patients were treated with respect and dignity. This included that not all treatment rooms had curtains provided and that conversations could be heard at the reception desk. This was in breach of regulation 10 (2)(a) 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 Surgical procedures	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints **How the regulation was not being met:**

This section is primarily information for the provider

Requirement notices

Treatment of disease, disorder or injury	The provider did not provide evidence that the complaints policy and procedure was adequately implemented, that complaints were recorded or investigated thoroughly in a timely manner, or that complaints were shared with staff to provide an opportunity for learning. This was in breach of regulation 16 (1)(2) 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 Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **How the regulation was not being met:** The provider did not have adequate systems or processes in place to ensure that risks were assessed, monitored, improved or mitigated in relation to the quality and health and safety of patients and staff in carrying on the regulated activity. For example, the provider had not:- • Conducted regular clinical audits to improve patient safety and outcomes. • Maintained adequate records of multidisciplinary meetings. • Ensured that significant events were reported, recorded, acted on and monitored. Lessons learnt from significant events were not communicated to the appropriate staff to support improvement at all levels. • Securely stored and maintained adequate records of persons employed including appraisals and completed training.

This section is primarily information for the provider

Requirement notices

The provider had not maintained records necessary to the management of the regulated activity:-

- By not ensuring that all policies and procedures used to govern activity were practice specific or are up to date.
- The provider had not sought feedback from patients or staff for the purpose of continually evaluating or improving the service.
- The provider had not ensured that their information security and governance systems were effective.

This was in breach of regulation 17 (1)(2)a)(b)(d)(e)(f) 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 Surgical procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **How the regulation was not being met:** The provide had not ensured sufficient numbers of suitably qualified, competent, skilled and experienced staff were deployed in order to meet patients' care and treatment needs. The provider had not ensured that persons providing care or treatment to service users had the qualifications, competence, skills and experience to do so safely. Persons employed by the service provider in the provision of a regulated activity had not received such appropriate support, professional development, supervision and appraisal as was necessary to enable them to carry out the duties they were employed to perform.

This section is primarily information for the provider

Requirement notices

Regulation 18(1)(2)(a)(b) 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 Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **How the regulation was not being met:** The provider had not ensured that there was adequate infection control. For example, the provider had not ensured cleanliness was monitored and there was a lack of completed and reviewed cleaning logs. The provider had not ensured that vaccines were stored in line with Department of Health guidance, and that stocks of medical equipment were monitored and fit for use. The provider had not ensured the proper and safe management and disposal of medicines. The provider had not ensured that blank prescriptions were tracked throughout the practice. The provider had not ensured that Patient Specific Directives (PSDs) were correctly authorised for clinical staff to administer vaccines and immunisations in line with national requirements. The provider had not completed risk assessments for electrical safety and fire. This was in breach of regulation 12(1)(2)(a)(b)(d)(e)(f)(g)(h) 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 Surgical procedures	Regulation 17 HSCA (RA) Regulations 2014 Good governance **How the regulation was not being met:**

This section is primarily information for the provider

Enforcement actions

Treatment of disease, disorder or injury	The provider did not demonstrate that good governance processes were in place and strong leadership. The provider had not defined the individual roles and responsibilities of each management staff member, including partners. This was in breach of regulation 17 (1) (2)(a)(b)(c)(d)(e)(f) 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 Surgical procedures Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed **How the regulation was not being met:** The provider had failed to ensure that persons employed for carrying out the regulated activities were of good character, that processes were in place to ensure staff have appropriate and current registration with a professional body, and had not ensured that information specific to schedule three was in place. This was in breach of regulation 19 (1)(a)(2)(a)(b)(3)(a)(b)(4)(a)(b) the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.