# Easthampstead Surgery

## Quality Report

23 Rectory Lane
Easthampstead
Berkshire
RG12 7BB
Tel: 01344 457535
Website: www.easthampsteadsurgery.co.uk

Date of inspection visit: 14 April 2016
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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

## Ratings

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

# Summary of findings

## Contents



## Overall summary

**Letter from the Chief Inspector of General Practice**

We carried out an announced comprehensive inspection at Easthampstead Surgery on 14 April 2016. The practice was rated as inadequate for safe, effective and well led services and requires improvement for caring and responsive care. Overall the practice is rated as inadequate.

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

- Staff were not clear about reporting incidents, near misses and concerns and there was no evidence of learning and communication with staff. When incidents and complaints had been identified reviews and investigations were not thorough enough. Patients did not always receive an apology and some incidents had not been identified or escalated.
- Risks to patients were inconsistently assessed and managed, including those relating to fire risk assessments, staffing levels and safeguarding adults.
- Measures to monitor and improve patient outcomes were inconsistent. Limited audits were undertaken to support quality improvement. However, there was no evidence that the practice was comparing its performance to others or sharing learning internally.
- The majority of patients said they were treated with compassion, dignity and respect. However, not all felt cared for, supported and listened to.
- There were no translation facilities and no hearing loop for hearing impaired patients.
- The practice had a number of policies and procedures to govern activity, but some were not localised or lead persons identified. Some documents referred to processes that were not taking place, some were unavailable and some were newly established but not yet implemented or embedded in practice. Many staff were unable to find the policies quickly and easily.
- Appointment systems were not working well so patients found it difficult to access appointments by telephone. Same day appointment requests were dealt with by a telephone triage system that resulted in long delays for call back times.

# Summary of findings

- The practice had an informal leadership structure, insufficient leadership capacity and limited formal governance arrangements.
- Patients were positive about their interactions with staff and said they were treated with compassion and dignity.

The areas where the provider must make improvements are;

- Ensure adult safeguarding policy, processes and procedures are implemented and embedded in practice for all staff.
- Improve the system to identify, capture and manage issues and risk. Review the risk assessment of emergency equipment requirements. Ensure that health and safety policies are in place, regular testing of the fire alarm system and fire drills are documented. Ensure adequate levels of staffing to support the care and treatment of patients
- Implement a formal induction process and improve the monitoring of training to ensure all staff receive training and updates relevant to their role, including safeguarding and basic life support.
- Respond to patient feedback and implement quality improvements to services. Consider changes to the appointment system to ensure this meets patient needs and demand. For example, additional time for complex or enhanced needs such as patients with learning difficulties. Addressing concerns raised regarding the telephone triage system, GPs listening, giving enough time, involving in decisions, explaining tests and treatments, and treating them with care and concern during consultations.
- Implement formal governance arrangements including systems for assessing and monitoring risks and the quality of the service provision, providing staff with appropriate policies and guidance to carry out their roles in a safe and effective manner which are reflective of the requirements of the practice.
- Identify and investigate safety incidents and complaints thoroughly and ensure that patients affected receive reasonable support and an apology. Ensure learning and identified areas for improvement is shared with all staff.

In addition the provider should:

- Consider the location of emergency medicines and equipment, so as to be readily available and accessible for all staff. Ensure the GP bag is regularly checked.
- Consider how best to identify and support carers.
- Review recalls and processes for ensuring routine screening rates for patients improves.
- Consider how best to provide a translation service for patients whose first language is not English and how to support patients who are hard of hearing.

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

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

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

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

# 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 and improvements must be made.

- Many staff were unclear of their responsibilities to raise concerns, and to report incidents and near misses. When things went wrong reviews and investigations were not thorough enough and lessons learned were not communicated widely enough to support improvement. Patients did not always receive a verbal and written apology. We saw some significant events that had not been formally investigated or documented. Complaints had not been identified as serious incidents and some had been mismanaged.
- Patients were at risk of harm because systems and processes were not in place to keep them safeguarded from abuse. The lead GP had a limited understanding of their role and responsibilities in relation to adult safeguarding. There was no adult safeguarding policy embedded in practice. Staff were unable to identify who the lead for safeguarding was.
- Patient safety alerts from the Medicines and Healthcare Regulatory Agency (MHRA) were reviewed, but there was no audit trail to show if these had been acted on or completed.
- Although the practice had recruited nine of the 12 staff in the last six months, there were not enough staff to keep patients safe. For example, the lead GP and locum advanced nurse practitioner took all the telephone triage calls between clinics and this could delay a call back by a number of hours, despite the practice leaflet suggesting a call back would be within one hour. The practice used locum GPs to cover unfilled sessions.
- The premises was clean and tidy and suitable for all patients.
- The practice had good prescribing systems and had liaised with the clinical commissioning group to ensure prescribing was safe.

**Are services effective?**

Inadequate

The practice is rated as inadequate for providing effective services and improvements must be made.

- Three repeat audits had been undertaken in the last 12 months. However, outcomes and learning points had not been shared and there was no evidence of an ongoing programme of audit to improve patient outcomes.

# Summary of findings

- The practice were unable to demonstrate staff had the skills, knowledge and experience to deliver effective care and treatment, as there were significant gaps in training. There was an informal, undocumented induction process for staff and an information pack was available which did not contain policies for staff to refer to.
- Mental capacity act training was not evident although clinical staff were aware of local and national guidance. There was no formal monitoring of consent through patient record checks.
- Screening data showed the practice had a lower uptake for breast cancer and bowel cancer screening figures compared to local and national averages.
- Data from the Quality and Outcomes Framework (QOF) showed patient outcomes were mostly good compared to the national average and the practice had achieved a QOF score of 96% overall in 2014/15.
- Baby immunisations rates were better than the CCG average for all standard childhood vaccines.
- Staff assessed needs and delivered care in line with current evidence based guidance.
- Staff worked with other health care professionals to understand and meet the range and complexity of patients' needs.

**Are services caring?**

**Requires improvement**

The practice is rated as requires improvement for providing caring services as there were areas where improvements must be made.

- Data from the national GP patient survey showed patients rated the practice lower than others for many aspects of care, in particular with GP treatment and care.
- The majority of patients said they were treated with compassion, dignity and respect. However, they did not all feel cared for, supported or listened to.
- Although patients had been coded as carers, there was no formal carer's register or system alert to identify them to staff. Carer's were offered minimal care and support.
- The practice did not provide translation services for patients who did not have English as their first language. There was no hearing loop for patients who were hard of hearing.
- Comments we received highlighted that staff responded compassionately when patients needed help.

**Are services responsive to people's needs?**

**Requires improvement**

The practice is rated as requires improvement for providing responsive services as there were areas where improvements must be made.

# Summary of findings

- Appointment systems were not working well so patients found it difficult to access appointments by telephone. Same day appointment requests were dealt with by a telephone triage system that often resulted in long delays for call back times.
- The practice offered 10 minute appointment slots for all patients. We were told there was no concession for patients who may require additional time. The practice informed us after the inspection double appointments were available. Some patients told us they felt rushed during appointments and many were unaware they could book a double appointment, if required.
- Feedback from patients reported that access to a named GP and continuity of care was not always available quickly, although urgent appointments were usually available the same day.
- Patients could get information about how to complain in a format they could understand. However, complaints had been inconsistently managed and learning from complaints had been shared with staff.
- Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice.
- There was suitable access for disabled patients and all the consultation rooms were on the ground floor.

**Are services well-led?**

**Inadequate**

The practice is rated as inadequate for being well-led and improvements must be made.

- The practice had no clear vision or strategy and not all staff were aware of these and their responsibilities in relation to it. There was an informal leadership structure with no practice manager in post. Most staff felt supported by the lead GP but at times they were not sure who to approach with issues.
- There was a limited governance framework which required significant improvement. This included arrangements to monitor and improve quality and identify risk.
- The practice had a number of policies and procedures to govern activity, but some of these were overdue a review and some were missing or not implemented and embedded in practice.
- Staff told us they had received inductions and regular performance reviews. However, induction checklists were missing and there were gaps in training, such as safeguarding, health and safety and fire safety.

# Summary of findings

- Attendance at staff meetings and events was inconsistent with some staff not attending any and other staff attending most of them.
- The practice did not hold regular governance meetings and issues were discussed at adhoc meetings.
- The patient participation group met regularly but had not been kept informed of developments in the practice.
- The practice had identified there were issues with governance arrangements and had made attempts to stabilise them through the recruitment of additional staff and ensuring lead roles were assigned.

# Summary of findings

## The six population groups and what we found

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

### Older people

**Inadequate**

The practice is rated as inadequate for the care of older people. The provider was rated as inadequate for safe, effective and well-led care. The issues identified as inadequate overall affected all patients including this population group. However, there were some areas of good practice.

- The safety of care for older people was not a priority and there were limited attempts at measuring safe practice.
- The care of older people was not managed in a holistic way.
- Care and treatment of older people did not always reflect current evidence-based practice, and some older people did not have care plans where necessary.
- Nationally reported data showed that outcomes for patients for conditions commonly found in older people were similar to local and national averages. For example, 93% of patients with chronic obstructive pulmonary disease had a review including an assessment or breathlessness compared to the CCG average of 94% and national average of 90%.
- Patients over the age of 75 were automatically given a same day appointment without needing to go through the triage process.

### People with long term conditions

**Inadequate**

The practice is rated as inadequate for the care of people with long-term conditions. The provider was rated as inadequate for safe, effective and well-led care. The issues identified as inadequate overall affected all patients including this population group. However, there were some areas of good practice.

- Diabetes indicators for 2014/15 showed the practice achieved 89% compared to the CCG average of 95% and national average of 89%.
- Home visits were available when needed and double appointments could be booked, although not all patients were aware of this.
- All these patients had a named GP. The recall system, for an annual review to check their health and medicines needs were being met, had been disrupted by poor staffing in the latter part of 2015. The practice had recruited additional staff to overcome this.

# Summary of findings

- 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**

Inadequate

The practice is rated as inadequate for the care of care of families, children and young people. The provider was rated as inadequate for safe, effective and well-led care. The issues identified as inadequate overall affected all patients including this population group. However, there were some areas of good practice.

- 78% of women aged 25 to 64 had a cervical screening test in the last five years compared to the CCG average of 85% and national average of 82%.
- The appointment system for same day triage made it difficult for children and young people to get an appointment, although under one year olds were automatically offered an appointment when requested. There were no extended hours available at the practice, which also disadvantaged young families who were required to travel to another practice if they wanted an appointment out of the practice standard opening hours.
- 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. Immunisation rates were relatively high for all standard childhood immunisations.
- Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this.
- Appointments were available outside of school hours and the premises were suitable for children and babies.
- We saw positive examples of joint working with midwives and health visitors.

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

Inadequate

The practice is rated as inadequate for the care of care of working-age people (including those recently retired and students). The provider was rated as inadequate for safe, effective and well-led care. The issues identified as inadequate overall affected all patients including this population group. However, there were some areas of good practice.

# Summary of findings

- The age profile of patients at the practice is mainly those of working age, students and the recently retired but the services available did not fully reflect the needs of this group.
- Same day appointments could only be booked by speaking to the GP or nurse via a telephone triage system.
- Health promotion advice was offered but there was limited accessible health promotion material available through the practice.
- There was a low uptake for both health checks and health screening. For example, screening uptake for breast cancer in females aged 50 to 70 (in the last 36 months) was 66% which was lower than the CCG average of 74% and national average of 72%. Screening uptake for bowel cancer in patients aged 60 to 69 was 50% which was lower than the CCG average of 58% and national average of 58%.
- The practice was proactive in offering online services.

**People whose circumstances may make them vulnerable**

Inadequate

The practice is rated as inadequate for the care of people whose circumstances may make them vulnerable. The provider was rated as inadequate for safe, effective and well-led care. The issues identified as inadequate overall affected all patients including this population group. However, there were some areas of good practice.

- The practice could only identify carers from the coding of patient notes.They did not have a carers champion or system alerts to identify carers to clinicians.
- The practice did not offer longer appointments for patients who were vulnerable or required enhanced care, such as patients with a learning disability or those requiring translation services.
- The practice held a register of patients living in vulnerable circumstances, such as patients in palliative care and those with a learning disability. It was unable to identify the percentage of patients with a learning disability who had received an annual health check.
- Some staff knew how to recognise signs of abuse in vulnerable adults, but they were not aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies out of normal working hours.
- The practice would register patients who were of no fixed abode, such as homeless people and travellers.

# Summary of findings

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

Inadequate

The practice is rated as inadequate for the care of people experiencing poor mental health (including people with dementia). The provider was rated as inadequate for safe, effective and well-led care. The issues identified as inadequate overall affected all patients including this population group. However, there were some areas of good practice.

- 77% of patients diagnosed with dementia had their care reviewed in a face to face meeting in the last 12 months, which was worse than the CCG average of 83% and national average of 84%.
- The practice had not told patients experiencing poor mental health about how to access various support groups and voluntary organisations including MIND and SANE.
- Not all staff had received training on how to care for people with mental health needs, including mental capacity act training.
- The practice worked with multi-disciplinary teams in the case management of people experiencing poor mental health and dementia. Regular cluster meetings were held to discuss complex cases.
- 92% of patients with a diagnosed mental health condition had a comprehensive care plan in the last 12 months compared to the CCG average of 92% and national average of 88%.

# Summary of findings

## What people who use the service say

The national GP patient survey results published in January 2016 showed the practice was performing below local and national averages, for many areas of care. 327 survey forms were distributed and 103 were returned. This represented 2% of the practice patient list.

- 68% found it easy to get through to this surgery by phone compared to a CCG average of 72% and a national average of 73%.
- 75% were able to get an appointment to see or speak to someone the last time they tried compared to a CCG average of 86% and a national average of 76%.
- 74% described the overall experience of their GP surgery as fairly good or very good compared to a CCG average of 82% and a national average of 85%.
- 69% said they would definitely or probably recommend their GP surgery to someone who has just moved to the local area compared to a CCG average of 74% and a 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 24 comment cards which were all positive about the standard of care received. All the cards expressed positive views of staff care and attitude. Nine cards offered a mixed response with dissatisfaction with the appointments system, no continuation of care as unable to see the same GP and some clinicians making them feel rushed and not listened to.

We spoke with two patients during the inspection. Both patients said they were satisfied with the care they received and thought staff were approachable, committed and caring. The latest friends and families test results showed 67% of patients would recommend this practice to someone new to the area.

## Areas for improvement

**Action the service MUST take to improve**

- Ensure adult safeguarding policy, processes and procedures are implemented and embedded in practice for all staff.
- Improve the system to identify, capture and manage issues and risk. Review the risk assessment of emergency equipment requirements. Ensure that health and safety policies are in place, regular testing of the fire alarm system and fire drills are documented. Ensure adequate levels of staffing to support the care and treatment of patients
- Implement a formal induction process and improve the monitoring of training to ensure all staff receive training and updates relevant to their role, including safeguarding and basic life support.
- Respond to patient feedback and implement quality improvements to services. Consider changes to the appointment system to ensure this meets patient needs and demand. For example, additional time for complex or enhanced needs such as patients with learning difficulties. Addressing concerns raised regarding the telephone triage system, GPs listening, giving enough time, involving in decisions, explaining tests and treatments, and treating them with care and concern during consultations.
- Implement formal governance arrangements including systems for assessing and monitoring risks and the quality of the service provision, providing staff with appropriate policies and guidance to carry out their roles in a safe and effective manner which are reflective of the requirements of the practice.
- Identify and investigate safety incidents and complaints thoroughly and ensure that patients affected receive reasonable support and an apology. Ensure learning and identified areas for improvement is shared with all staff.

**Action the service SHOULD take to improve**

- Consider the location of emergency medicines and equipment, so as to be readily available and accessible for all staff. Ensure the GP bag is regularly checked.
- Consider how best to identify and support carers.

# Summary of findings

- Review recalls and processes for ensuring routine screening rates for patients improves.
- Consider how best to provide a translation service for patients whose first language is not English and how to support patients who are hard of hearing.

# Easthampstead Surgery

**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 Easthampstead Surgery

Easthampstead Surgery provides primary medical services to over 5,200 patients in an area of medium to low deprivation in Bracknell. This means that some of their patient list are affected by social and economic deprivation locally. The practice population has a lower number of patients from ethnic minority backgrounds and a lower percentage of unemployed and incapacity benefits claimants than local and national reported figures.

The practice is a converted house in a residential area. There is a small car park on site and parking is available in surrounding streets. The practice has a large waiting area accessible from the main reception. All the GP and nurse consultation rooms are on the ground floor with wide doorways for disabled access. There are four GP consultation rooms and one nurse treatment room. In addition, there are two patient toilet facilities, of which one offers disabled access, a call bell and baby change facilities.

The practice has two practice partners (one female GP and one male business manager), one salaried GP (male), one practice nurse (female), one health care assistant (female), three receptionists, two administration staff, one prescription clerk and one summariser. The practice have a regular locum Advanced Nurse Practitioner (ANP) (female) and a locum GP (male). There is a recruitment vacancy for a salaried GP and another practice nurse. There is no practice manager currently in post and the business manager has assumed this role part time for the past four months. Following the inspection, the practice made arrangements for one of the previous GP partners to return in a human resources role whilst a full time practice manager is sought.

The practice is open between 8.30am and 6pm Monday to Friday, except Thursdays when the practice closes at 1pm. The practice also closes for lunch at 1pm daily and re-opens at 1.50pm. Telephone lines are open from 7am to 6.30pm daily. Appointments are from 8.30am to 10.30am every morning and 4pm to 6pm daily (except Thursdays). When the practice is closed on Thursday afternoons, the practice has an arrangement with another local GP practice to provide cover. Patient calls are directed to the other practice.

Extended surgery hours are offered via another practice hub every evening from 6.30pm to 8pm and Saturdays from 8am to 2pm.

The practice has opted out of providing out of hours services to their patients. Out of hours services are provided by East Berkshire Primary Care Out of Hours Services. A message on the practice telephone system advises patients to call this number when the practice is closed. The arrangements in place for services to be provided when the surgery is closed are displayed at the practice and in the practice information leaflet.

All services are provided from:

Easthampstead Surgery

23 Rectory Lane

Easthampstead

Berkshire

RG12 7BB

# Detailed findings

There have been no previous CQC inspections of Easthampstead Surgery.

The CQC were aware of many recent changes to the partnership at Easthampstead Surgery. However, the practice remains registered with the CQC as a partnership with three GPs and a non-clinical partner. The CQC have been advised the practice have submitted documents to remove two GP partners from the partnership, leaving a partnership between Dr Suresh and Mr Suresh only. Dr Suresh remains accountable as the registered manager for the practice.

## 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, such as the Clinical Commissioning Group and NHS England. We carried out an announced visit on 14 April 2016. During our visit we:

- Spoke with a range of staff (two GPs, two nurses, one healthcare assistant, the business manager and three administration staff).
- We spoke with patients who used the service.
- Observed how patients were being cared for and talked with carers and/or family members
- Reviewed an anonymised sample of the personal care or treatment records of patients.
- Reviewed 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**

There was a system in place for reporting and recording significant events, although these were not robust and some significant events had been missed or dealt with as complaints.

- Staff told us they would inform the lead GP of any incidents. A recording form was available on the practice's computer system, which was used by the lead GP for writing up incidents.
- There was no evidence to support how patients were advised of the event or if they received reasonable support, truthful information, an apology or were told about any actions to improve processes to prevent the same thing happening again.

We reviewed safety records, incident reports and minutes of meetings where these were discussed. We saw a review of six significant events in the past 12 months. Only three had been documented and discussed in a clinical meeting in June 2015, where actions to be taken had been identified. The remaining three had not been documented, investigated or outcomes identified. In addition, one complaint about a clinical issue had not been identified or escalated as a serious event. None of these had been shared with staff for learning, despite all the incidents having a potential impact on staff at all levels. This meant staff were unaware of actions required to be taken to improve safety in the practice.

**Overview of safety systems and processes**

Arrangements for safeguarding children and adults from abuse were inconsistent. The practice had child safeguarding policy and processes available, although most staff were unable to identify where these were kept and were not embedded in practice. There was no adult safeguarding policy:

- The lead GP was unaware of the safeguarding referral processes for adults and could not describe their role and responsibility in safeguarding vulnerable adults. The staff we spoke with on the day of inspection were aware of the signs of abuse but unable to describe how to escalate concerns.They were unable to find their adult safeguarding policy and not all could identify who the practice's safeguarding lead was. A newly written policy was submitted by the practice within two days of the inspection.
- The lead GP offered positive examples of child safeguarding processes and had been involved in a case reviews locally. The GP attended monthly child protection meetings with multi-agency teams. However, the child safeguarding policy we were shown was limited and not localised to the practice. There were no contact details in the policy and a contact list in each room had not been updated to reflect recent new guidance and processes.
- Non clinical staff were unable to demonstrate they understood their role and responsibilities for safeguarding. Only one member of non-clinical staff had received training on safeguarding children and vulnerable adults relevant to their role. We were told both GPs were trained to child protection or child safeguarding level three. The practice nurse was trained to child safeguarding level two and the locum advanced nurse practitioner to level three.
- A notice in the waiting room advised patients that chaperones were available if required. One member of the non-clinical staff was trained to act as a chaperone and had received a Disclosure and Barring Service (DBS) check. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable). The practice chaperone policy stipulated that a clinician should be sought in the first instance and if unavailable, to ask a non-clinical staff member who is trained to assist. The policy did not refer to DBS checks for staff undertaking chaperone duties.
- The practice maintained appropriate standards of cleanliness and hygiene. We observed the premises to be clean and tidy. The practice nurse had recently been appointed as the infection control clinical lead. The practice liaised with the local infection prevention teams to keep up to date with best practice. There was an infection control protocol in place but not all staff had received up to date training. Annual infection control audits were undertaken and we saw evidence that action was taken to address any improvements identified as a result.

Inadequate

# Are services safe?

- The arrangements for managing medicines, including emergency medicines and vaccines, in the practice kept patients safe (including obtaining, prescribing, recording, handling, storing, security and disposal). 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 the local CCG pharmacy teams, to ensure prescribing was in line with best practice guidelines for safe prescribing. Blank prescription forms and pads were securely stored and there was a policy in place to ensure prescription security. The locum advanced nurse practitioner (ANP) was qualified as an Independent Prescriber and could therefore prescribe medicines for specific clinical conditions. The ANP received mentorship and support from the medical staff for this extended role.
- Alerts from the Medicines & Healthcare products Regulatory Agency (MHRA) were emailed to the lead GP who printed them and placed them on a notice board. However, there was no follow up to check if these had been dealt with and who had been responsible for ensuring they were acted upon.
- Patient Group Directions (PGDs) had been adopted by the practice to allow the nurse to administer medicines in line with legislation. At the time of the inspection some of the travel vaccine PGDs available from NHS England (South) had expired in March 2016. The practice nurse was aware of this and was monitoring the website regularly. Following the inspection, the practice initiated patient specific directions (PSDs) for the travel vaccines as an interim measure until the PGDs were available again. The Health Care Assistant was trained to administer vaccines and medicines against a patient specific prescription or direction from a prescriber.
- We reviewed five personnel files and found appropriate recruitment checks had been undertaken prior to employment. For example, photographic identification was evident through SMART cards and references and registration with the appropriate professional body had been checked and updated, although a qualification check for one nurse was missing.

**Monitoring risks to patients**

Risks to patients were inconsistently assessed and managed.

- The procedures in place for monitoring and managing risks to patient and staff safety were inconsistent. For example, the health and safety policy shown to the inspection team was only a reference guide for best practice in making a health and safety policy. There was a health and safety poster available in one of the offices which identified the lead in the practice. The practice had a fire risk assessment undertaken in April 2016, which identified high priority actions, including regular checks of the fire alarm system and installation of an automated fire alarm system. The practice could not recall when they had carried out any fire drills as they were not documented. All electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly. The practice had undertaken other risk assessments to monitor safety of the premises such as control of substances hazardous to health and legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings).
- The practice had recruited nine of the 12 staff in the last six months. Whilst arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs, there were still gaps and limited cover for holidays or sickness absence. The practice were using locum GPs and a locum advanced nurse practitioner to cover unfilled sessions. There was a rota system in place for all the different staffing groups to ensure enough staff were on duty and to identify where future absences required additional cover. The practice were still actively recruiting a practice manager, salaried GP and practice nurse to fill all the vacancies. The lead GP and ANP (when rostered to work) undertook the patient triage telephone consultations during surgery time. This could be up to 60 calls per day. The patient leaflet assured patients telephone calls would be dealt with within one hour. However, patients reported that the call back was sometimes delayed by up to six hours. The lead GP often stayed late in the evening to ensure all telephone messages had been responded to.

**Arrangements to deal with emergencies and major incidents**

The practice did not have adequate arrangements in place to respond to emergencies and major incidents.

Inadequate

# Are services safe?

- All staff had been booked to receive annual basic life support (BLS) training on the day of inspection, which had been cancelled and rearranged for May 2016. We noted only two of the four clinical staff (one GP and one nurse) were up to date with BLS training.
- The practice did not have a defibrillator available on the premises and had risk assessed this to reflect a low probability of occurrence and that an ambulance station was within one mile of the practice. The risk assessment did not consider that ambulances were not often on station and the additional time to reach the practice could impact upon the care and treatment of the patient and a sucessful outcome. Oxygen was available with adult and children's masks. A first aid kit and accident book were available.
- Emergency medicines were available to staff in a secure area of the practice and all staff knew of their location. The inspection team identified concerns with accessing the emergency medicines. The locked cupboard was behind a curtain rail area where patients were examined. When the room was not in use the key was kept upstairs which increased the risk of a delay in accessing the equipment during an emergency situation. All the medicines we checked were in date and stored securely, with the exception of one GPs grab bag which had out of date adrenaline (April 2014) contained within it. There was no processes in place for the checking of medicines and equipment stored in the GP bag.
- There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency.
- The practice had a comprehensive business continuity plan in place for major incidents such as power failure or building damage. The plan included emergency contact numbers for senior staff and local agencies.

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 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 peer review and random sample checks of patient records. For example, all specialist referrals were discussed between GPs to ensure they were appropriate and timely.

**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 96% of the total number of points available, with 7% exception reporting, which was lower than the national average of 9%. (Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects).

This practice was not an outlier for any QOF (or other national) clinical targets. Data from 2014/15 showed mixed results. For example;

- 92% of patients with a diagnosed mental health condition had a care plan documented in the record, in the preceding 12 months compared to the CCG average 92% and national average of 88%.
- Performance for diabetes related indicators was 89% compared to the CCG average of 95% and national average of 89%.
- The percentage of patients with hypertension having regular blood pressure tests was 85% which was below the CCG average of 92% and national average of 98%.

The lead GP was aware of the mixed results and reflected the issues with staffing in the past nine months had an effect on the systems for recalls and patient outcomes. With staffing issues stabilising the practice were concentrating on QOF for 2016/17.

There was limited evidence of clinical improvement initiatives, such as clinical audits. Although some audits had been undertaken, findings were not shared and therefore not used by the practice to improve services;

- There had been three clinical audits undertaken the last 12 months. All of these were repeat audits of previously identified outcomes from 2013/14. Whilst outcomes and learning points had been identified, learning had not been shared with staff and no improvements were implemented or monitored. For example, an audit of patients taking a medicine for blood pressure showed not all had been offered a routine blood test at the correct interval. The learning highlighted vigilance was required with these patients when authorising repeat prescriptions and a blood test appointment should be made at the time of commencing the medicine. Another recommendation was to ensure they were followed up during blood pressure clinic appointments to see if blood tests were required. The learning had not been shared and the subsequent audit showed another patient had not been recalled.
- The locum advanced nurse practitioner had also undertaken clinical audits which were being used for revalidation evidence. These had also not been shared with the practice.
- There was no evidence of a future programme of audit and one GP had not participated in any clinical audits since commencing this post in November 2015.

**Effective staffing**

Staff skills, knowledge and experience was varied and the practice had not applied effective processes to ensure training was undertaken or up to date.

- Staff told us they had received inductions and regular performance reviews. However, induction checklists were missing and there were gaps in training that which were not covered on induction, such as safeguarding, health and safety and fire safety. This did not follow the practice's induction protocol.

Inadequate

# Are services effective?

## (for example, treatment is effective)

- An information pack was available outlining roles and responsibilities of all personnel and general information about the practice. The information pack did not cover topics such as safeguarding, infection prevention and control, health and safety and confidentiality, although it did outline emergency fire procedures. The lead for clinical governance and information governance was named as a locum clinician who was not permanently employed by the practice. In addition, many staff we spoke to on the day of inspection were unaware they had been assigned a lead role as described in the information pack and had not received any additional training to support their new responsibility. For example, two personnel were listed as fire marshals but had not received formal training for this.
- Staff had access to e-learning training modules and there were plans for in-house training. The practice had a training matrix to identify when training or an update was required. However, there was an ineffective process for ensuring training had been undertaken and record keeping was inconsistent. Many staff's training certificates were missing from personnel files. The training matrix was incomplete and showed some training was overdue. For example, out of 12 staff, seven had not received health and safety training, 10 staff had not undertaken moving and handling training, nine staff required fire training and infection control training and 10 had not received information governance training. Staff were encouraged to undertake e-learning on the practice computer system and time was being set aside for them to do this. However, with staff numbers so small, it was often difficult to get protected time without impacting on the staff schedule for cover.
- The learning needs of staff was in the process of being identified through a system of meetings and reviews of practice development needs. Nine out of 12 regular staff had been employed within the last six months and were not yet due to receive their appraisal. The practice had a list of dates when these were due and we were told staff received an end of probation three month review. There was support available for revalidating GPs and nurses.
- 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.

**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 ongoing care and treatment. This included when patients moved between services, including when they were referred, or after they were discharged from hospital. Twice-monthly cluster meetings enabled GPs to discuss patients with enhanced clinical needs with multi-agency teams to ensure their care needs were maximised.

**Consent to care and treatment**

Clinical staff sought patients' consent to care and treatment in line with legislation and guidance, although there was no formal mental capacity act training documented as being offered to staff.

- Clinical staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 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.
- Although we saw evidence of gained consent on two patient records, there was no formal process for monitoring consent through formal audit.

**Supporting patients to live healthier lives**

Inadequate

# Are services effective?

## (for example, treatment is effective)

The practice identified patients who may be in need of extra support. For example, patients receiving end of life care, those at risk of developing a long-term condition and those requiring advice on their diet, smoking or alcohol cessation. Patients were signposted to the relevant service.

The practice's uptake for the cervical screening programme was 78% which was comparable to the national average of 82%. The practice offered reminders for patients who did not attend for their cervical screening test. There were 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. The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening. However, screening figures showed the practice was below CCG and national averages. For example, 66% of females aged 50 to 70 had been screened for breast cancer in the last 36 months compared to the CCG average of 74% and national average of 72%. In addition, 50% of patients aged 60-69 had been screened for bowel cancer in the last 30 months compared to the CCG average of 58% and national average of 58%. The low uptake of screening was apportioned to the lack of permanent staff in the last nine months. Locum practice nurses and GP locums were used for a number of months until permanent personnel had been recruited. The practice had asked the practice nurse and healthcare assistant to pick up patient screening as part of their role.

Childhood immunisation rates for the vaccinations given were comparable to or higher than the CCG. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 85% to 100% (CCG average 85% to 95%) and five year olds from 92% to 100% (CCG average 87% to 95%).

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

Requires improvement

# 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.

Most of the 24 patient Care Quality Commission comment cards we received expressed positive views about the service experienced. Nine comment cards reflected a mixed response of positive and negative views, such as, dissatisfaction with clinician attitude, feeling rushed during appointments and delays in response with the telephone triage system. Most patients said they felt the practice staff were helpful, caring and treated them with dignity and respect.

We spoke with five members 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. However, they were unaware of some of the staffing changes at the practice, such as the practice manager position being temporarily filled and GP cover arrangements on Thursday afternoons. Comment cards highlighted that staff responded compassionately when they needed help and provided support when required.

Results from the national GP patient survey showed patients felt they were not always treated with compassion, dignity and respect. The practice was below average for its satisfaction scores on consultations with GPs and were consistent with local and national averages for nurses. For example:

- 78% said the GP was good at listening to them compared to the CCG average of 86% and national average of 89%.
- 76% said the GP gave them enough time compared to the CCG average of 84% and national average of 87%.
- 89% said they had confidence and trust in the last GP they saw compared to the CCG average of 94% and national average of 95%.
- 75% said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 83% and national average of 85%.
- 90% said the nurse was good at listening to them compared to the CCG average of 88% and national average of 91%.
- 93% said the nurse gave them enough time compared to the CCG average of 88% and national average of 91%.
- 97% said they had confidence and trust in the last nurse they saw compared to the CCG average of 97% and national average of 97%.
- 89% said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 88% and national average of 91%.
- 88% said they found the receptionists at the practice helpful compared to the CCG average of 84% and national average of 87%.

**Care planning and involvement in decisions about care and treatment**

Many patients told us they felt involved in decision making about the care and treatment they received. Most patients 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 also positive and aligned with these views. We also saw that care plans were personalised.

Results from the national GP patient survey showed patients responses were mixed for questions about their involvement in planning and making decisions about their care and treatment. Results were below local and national averages for GPs and in line with local and national averages for nurses. For example:

- 72% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 83% and national average of 86%.

Requires improvement

# Are services caring?

- 67% said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 79% and national average of 82%.
- 89% said the last nurse they saw was good at explaining tests and treatments compared to the CCG average of 87% and national average of 90%.
- 87% said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average of 83% and national average of 85%.

The practice was aware of the patient national GP survey results and apportioned most of the concern to their use of locum GPs and nurses in the latter part of 2015. They were still attempting to recruit a second salaried GP and practice nurse.

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

- There were no translation services available for patients who did not have English as a first language. Patients were encouraged to bring a relative or friend who could translate for them.
- There was no hearing loop for patients who were hard of hearing.
- A limited selection of information leaflets were available in easy read format.

**Patient and carer support to cope emotionally with care and treatment**

A limited number of patient information leaflets and notices were available in the patient waiting area which told patients how to access a number of support groups and organisations. Information about support groups was also available on the practice website.

Through a search of coding the practice were able to identify 47 patients as carers (less than 1% of the practice list). However, the practice had no processes or arrangements in place for this vulnerable group. There was no alert on the record system to identify a carer to GPs or nurses so they could offer or implement additional support and information. There was no designated member of staff to look after carers and we saw only one information leaflet in the waiting room offering support and advice to carers.

Staff told us that if families had suffered bereavement, their usual GP contacted them or sent them a sympathy card. This contact 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.

Requires improvement

# Are services responsive to people's needs?

(for example, to feedback?)

## Our findings

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

There was limited evidence of how the practice had reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements.

- Telephone triage system was available from 7am to 10am weekdays and offered patients the opportunity to leave a message which was emailed to the GP for a call back. The GP or locum advanced nurse practitioner responded to calls according to priority and during clinic sessions, which often led to delays in call back times.
- Longer appointments of over 10 minutes were not available for patients with enhanced needs, such as a learning disability or patients who required assistance with translation.
- Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice.
- The practice made same day appointments available for all children under one year old and patients over 75 years with medical problems that required same day consultation.
- Patients were able to receive travel vaccinations available on the NHS. The practice were in the process of applying to supply vaccines for those only available privately and nursing staff had already undertaken training for these.
- There were disabled facilities including toilets accessible to wheelchair users and automatic opening doors at the main entrance. All treatment and consultation rooms were on the ground floor.

**Access to the service**

The practice was open between 8.30am and 6pm Monday to Friday, except Thursdays when the practice closed at 1pm. The practice also closed for lunch at 1pm daily and re-opened at 1.50pm. Telephone lines were open from 7am to 6.30pm daily. This included dedicated lines for same day triage (where same day urgent appointments were offered by the GP or Advanced Nurse Practitioner) between 7am and 10am. Appointments were from 8.30am to 10.30am every morning and 4pm to 6pm daily (except Thursdays). When the practice was closed on Thursday afternoons, the practice had an arrangement with another local GP practice to provide cover, which was two miles away. Patients calls were directed to the other practice, although not all patients were aware of this arrangement and was less accessible to patients unable to drive or take public transport. The practice website had not been sufficiently updated to reflect the changes to same day appointments system and the arrangements for when the practice was closed. This made it confusing for patients who were attempting to find information about out of hours services or access the surgery when it was closed.

Extended surgery hours were offered via another practice hub every evening from 6.30pm to 8pm and Saturdays from 8am to 2pm. The lead GP was reluctant to let patients attend the out of hours service as she felt a duty to her patients and often stayed after 6.30pm to see additional patients or to undertake home visits. All GP appointments were for 10 minutes with no provision for extending the time. Patients were advised to make additional appointments for each clinical concern. A few patients we spoke with on the day and some comment cards received had expressed concern over appointments feeling rushed.

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

- 62% of patients were satisfied with the practice's opening hours compared to the CCG average of 70% and national average of 75%.
- 68% of patients said they could get through easily to the practice by phone compared to the CCG average of 72% and national average of 73%.
- 21% of patients said they always or almost always see or speak to the GP they prefer compared to the national average of 36% (no CCG data available).

The practice had recently changed their telephone line service in response to the feedback about access. This included a new triage process for patients wanting a same day appointment. Whilst most patients told us on the day of the inspection that they were able to get appointments when they needed them, many expressed dissatisfaction with the new telephone triage system and felt uncomfortable leaving a message. Waiting time for a call back was raised as a concern, with some patients waiting a whole day for a response. The practice had established a once only call back process, meaning if a patient did not

Requires improvement

# Are services responsive to people's needs?

## (for example, to feedback?)

answer the phone when called back, there was no second attempt to establish contact. Some patients told us this limited them to waiting at home for the call back meaning they were unable to leave until this had happened.

**Listening and learning from concerns and complaints**

The practice had an inconsistent approach for handling complaints and concerns.

- The complaints policy stated at least a quarterly review meeting to discuss them. These meetings were scheduled to include all staff, however, we saw no evidence that these were reviewed in this timescale and staff had not been made aware of learning from complaints. We saw evidence of a yearly review for 2015/16.
- The complaints policy and procedures were newly established and not embedded in practice. The policy had not been localised to include details of personnel responsible for dealing with complaints. There were no details for escalating an unresolved complaint to the clinical commissioning group, health ombudsmen or CQC in line with recognised guidance and contractual obligations for GPs in England.
- We saw that information was displayed to inform patients of the complaints system and a form was available at reception.

We looked at six complaints documented in the last 12 months which had been detailed in a yearly review with learning points highlighted. However, one of the complaints contained clinical issues that had not been escalated as a serious event and only two complaints had a documented apology as an action taken. Action points for learning were identified but not escalated to all staff. For example, a review of blood thinning medicines was undertaken after a wrong dose was prescribed which resulted in a patient having high levels in their system. Delayed referrals were reviewed and found to be due to time pressures on clinical staff meaning the referrals were not requested in a timely way for the administration team to respond.

# 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 was unable to demonstrate a clear vision to deliver good quality care and promote positive outcomes for patients. Discussions with staff had not been optimised and the lack of a practice manager meant sharing of information was disjointed. There was no clear vision or guiding values and staff were unclear about their responsibilities in relation to the practice strategy and objectives.

**Governance arrangements**

The governance arrangements and their purpose were unclear. Documents to support the governance arrangements were inappropriate, were not always practice specific or embedded systems or processes.

- There was a newly established staffing structure, although staff were unaware of their own roles and responsibilities. Some staff named as lead roles within the policies were not aware of the responsibility, or had been sufficiently trained for the role. For example, those with fire marshal duties.
- Many practice policies were available, although most were not practice specific and the majority of staff were unable to access them. Some policies were missing, such as Safeguarding adults, Mental capacity act and best interest decisions, medicines management and harassment and bullying. The health and safety policy shown to the inspection team was a managers guide to implementing a health and safety policy.
- Complaints and serious incidents were inconsistently managed, not adequately identified and threatened the delivery of safe and effective care. Where incidents were investigated learning from these events was not shared with staff or relevant individuals.
- There was limited evidence of a programme of continuous clinical and internal audit used to monitor quality and to make improvements. Audits that had been undertaken had not been shared to reflect changes in processes to enhance patient outcomes. There was no planned programme of audit within the practice.
- There were inconsistent arrangements for identifying, recording and managing risks, issues and implementing mitigating actions. For example, serious concerns were identified with the systems and processes to safeguard adults, which were reported to the clinical commissioning group immediately after the inspection. Medicine and patient safety alerts were not always processed effectively to ensure appropriate action had taken place.
- Processes to monitor and improve the quality and safety of the practice were weak. Fire risks and actions were not undertaken, robust health and safety procedures and polices were not in place and the practice had not ensured they had adequate indemnity insurance to cover all clinical members of staff.

**Leadership and culture**

The lead GP and non-clinical partner did not have the necessary experience, capacity or capability to lead effectively and ensure sustainable change. The two partners could not demonstrate they prioritised the provision of safe and responsive care through effective quality monitoring and oversight for the whole practice. The practice had inconsistent systems in place for identifying and handling notifiable safety incidents and complaints. Details of outcomes had not been disseminated to staff and learning had not been shared.

- The practice did not always give affected people reasonable support, truthful information and a verbal or written apology. For example, of the six identified and reviewed complaints reviewed, four patients had not received an apology or explanation.
- The practice kept written records of verbal interactions as well as written correspondence.

The lead GP was the overall designated responsible person for all systems and processes and staff told us they felt supported by management. However, lead roles for clinical and information governance, complaints, fire marshals, health and safety and first aid had been designated to individual staff, but they had not been made aware or received training relevant to the role.

# Are services well-led?

Inadequate

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

- There was some confusion over the frequency of staff meetings with some staff informing us that the practice held bi-weekly whole team meetings and others who had not been to a meeting in many months. These were inconsistently evidenced through meeting records.
- Staff told us that there was an open culture within the practice and they had the opportunity to raise any issues individually or at team meetings, felt confident in doing so and were supported if they did.
- Staff said they felt respected, valued and supported, particularly by the provider in the practice, but were not always involved in discussions about how to run and develop the practice.

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

The practice received feedback from patients, the public and staff. However, the practice did not always respond to what the patients said. For example, patients had reported concerns with clinician attitude, feeling rushed during appointments and delays in response with the telephone triage system.

- The practice had a patient participation group (PPG) who met regularly with the lead GP. The PPG were unable to offer any evidence where their input had affected changes that the practice had implemented. Communication was not consistent and the PPG members we spoke with were unaware of some of the changes to the practice in recent months, such as the recruitment of a business manager to oversee the role of a practice manager whilst a full time practice manager was sought. They were also unaware that the Thursday afternoon closure arrangementsincluded accessing care with another GP practice. As the practice had been closed on Thursday afternoons for a long time, it was felt there would be no point in telephoning the practice at this time.
- The practice had gathered feedback from staff through staff meetings and discussion. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt part of a team and were keen to engage with the practice to improve how it was run.

**Continuous improvement**

There was little evidence of innovation or service development to improve services. The practice had been through a significant period of challenge and recognised the need to improve. The practice had recruited nine new personnel in the last six months to support this. The monitoring of training in the practice was weak. Staff were not uptodate with some elements of mandatory training and there were gaps in the evidence to identify training had been completed.

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<br>Family planning services<br>Maternity and midwifery services<br>Surgical procedures<br>Treatment of disease, disorder or injury | Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment<br>**How the regulation was not being met:**<br>The registered person did not do all that was reasonably practicable to assess, monitor, manage and mitigate risks to the health and safety of service users. They had failed to document fire drills and could not recall when the last one had taken place. The provider had not implemented an effective health and safety policy. They were not ensuring compliance with patient safety alerts, recalls and rapid response reports issued from the medicines and healthcare products regulatory agency, as there was no system in place to document actions (or omissions) taken and the resulting impact.<br>This was in breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. |

| Regulated activity | Regulation |
|---|---|
| Diagnostic and screening procedures<br>Family planning services<br>Maternity and midwifery services<br>Surgical procedures<br>Treatment of disease, disorder or injury | Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment<br>**How the regulation was not being met:**<br>The provider did not ensure all staff had received safeguarding training at a suitable level for their role. Staff were unaware of their role and responsibilities towards preventing, identifying and reporting safeguarding. Information about current procedures and guidance was not accessible to all staff.<br>This was in breach of regulation 13(1)(2)(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 |

This section is primarily information for the provider

# Requirement notices

| Regulated activity | Regulation |
| --- | --- |
| Diagnostic and screening procedures<br>Family planning services<br>Maternity and midwifery services<br>Surgical procedures<br>Treatment of disease, disorder or injury | Regulation 18 HSCA (RA) Regulations 2014 Staffing<br>**How the regulation was not being met:**<br>We found the registered provider did not operate effective systems to ensure staff received appropriate induction, training and professional development.<br>This was in breach of regulation 18(1)(2)(a) 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<br>Family planning services<br>Maternity and midwifery services<br>Surgical procedures<br>Treatment of disease, disorder or injury | Regulation 17 HSCA (RA) Regulations 2014 Good governance<br>**How the regulation was not being met:**<br>The registered provider did not have effective systems to enable them to identify and assess risks to the health, safety and/or welfare of people who use the service. Where risks were identified, the provider did not introduce measures to reduce or remove the risk within a timescale that reflected the level of risk and impact on people using the service. This included the risks associated with not having an automated defibrillator on site, health and safety and fire risk recommendations.<br>The registered provider did not maintain records in relation to people employed or the management of regulated activities. This included recruitment check documentation, induction and training records.<br>Policies and procedures for significant events and complaints were not effective. The provider was not ensuring that improvements were being made without delay, once identified and did not have systems in place to communicate how feedback has led to improvements.<br>The registered provider was not ensuring their audit and governance systems remained effective.<br>This was in breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. |