# Dr Devadeep Gupta

## Quality Report

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

## Ratings

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

# Summary of findings

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## Overall summary

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

We carried out an announced comprehensive inspection at Dr Devadeep Gupta, Pennine Surgery on 19 February 2015. Overall the practice is rated as requires improvement.

Specifically, we found the practice to be good for providing effective, caring and responsive services. It required improvement for providing safe and well led services which impacted in other areas such as effective.

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

- Results from the latest national GP Survey rated the practice as one of the highest within the local Clinical Commissioning Group (CCG).
- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored and informally reviewed and addressed.
- Patients' needs were assessed and care was planned and delivered following best practice guidance.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- Patients said they found it easy to make an appointment with a GP and that there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.

The areas where the provider must make improvements are:

- Ensure that leaders have the required skills to effectively manage the practice, encourage staff to work as a team and ensure there are formal governance arrangements which staff are aware of.
- Ensure recruitment arrangements include all necessary employment checks for all staff.

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- Ensure that all staff have received suitable support and training appropriate to their role.

In addition the provider should:

- Ensure that risks are identified and documented appropriately with actions plans against each risk.

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

# Summary of findings

## The five questions we ask and what we found

We always ask the following five questions of services.

**Are services safe?**

**Requires improvement**

The practice is rated as requires improvement for providing safe services. Although risks to patients who used services were informally assessed, the systems and processes to address these risks were not implemented fully to ensure patients were kept safe. However staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learnt and informally communicated to support improvement. Information about safety was recorded, monitored, reviewed and addressed.

**Are services effective?**

**Good**

The practice is rated as good for providing effective services. Data showed patient outcomes were average for the locality. Staff referred to guidance from National Institute for Health and Care Excellence and used it routinely. Patient's needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health and staff worked with multidisciplinary teams. Some patients had care plans in place where they were required and most patients were offered and received health checks. However, due to staff shortages some of the services available to patients had not been offered pro-actively over the previous twelve month period. The practice had acknowledged this and an advanced nurse practitioner had been offered a position to improve the service.

There was evidence of appraisals and personal development plans for all staff. However staff had not received all training appropriate to their roles and not all training needs had been identified. Where training needs had been identified, training had not yet been undertaken to meet those needs.

**Are services caring?**

**Good**

The practice is rated as good for providing caring services. Data showed that patients rated the practice higher than others for several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information to help patients understand the services available was easy to understand. We also saw that staff treated patients with kindness and respect, and maintained confidentiality. Results from the national GP Survey

# Summary of findings

showed that the practice were rated second highest for overall satisfaction in the Clinical Commissioning Group and 76th overall in the Country.The GP Patient Survey is an independent survey run by Ipsos MORI on behalf of NHS England.

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

**Good**

The practice is rated as good for providing responsive services. It 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. Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day. The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised.

**Are services well-led?**

**Requires improvement**

The leadership, governance and culture within the practice did not always support the delivery of high-quality person-centred care. Not all leaders had the necessary skills to lead effectively. Leaders were not always clear about their roles and their accountability for quality.

Staff satisfaction was mixed. Staff did not always feel actively engaged or empowered and there was some evidence of divides between groups of staff. The practice did not hold regular staff meetings or events attended by all staff members. There was evidence of staff working individually rather than as a team in an effort to achieve the best possible outcomes for patients of the practice.

We were unable to review policies and procedures which govern the practice because of an IT failure which meant that they were not available to us or to staff.

However, the practice proactively sought feedback from patients which they acted upon and had an active patient participation group (PPG).

# Summary of findings

## The six population groups and what we found

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

**Older people**

Requires improvement

The practice is rated as requires improvement for the care of older people. Systems and processes to address risks were not implemented fully to ensure all patients were kept safe.

20% of the patient population was over the age of 60 years. Staff were able to recognise signs of abuse in older people and knew how to escalate or refer these concerns. The practice held a register of people who needed extra support and reviews of unplanned admissions and readmissions had taken place. The practice offered personalised care to meet the needs of the older people in its population for example, in end of life care where pre-planning had taken place. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs. Same day telephone consultations were also available when appropriate.

Some patients, particularly those in nursing homes and care homes required a care plan review or structured annual health check to ensure that their health and care needs were continuing to be met. There had been staff shortages which had had a negative impact on the care planning provided to this patient group. This had been acknowledged and was being addressed by the practice.

**People with long term conditions**

Requires improvement

The practice is rated as requires improvement for the care of people with long-term conditions. Systems and processes to address risks were not implemented fully to ensure all patients were kept safe.

However, the practice nurse looked after patients with chronic diseases and patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. Referrals were carried out in line with best practice and the practice used national guidelines to ensure patients received the most current treatment for their conditions.

**Families, children and young people**

Requires improvement

The practice is rated as requires improvement for the care of families, children and young people. Systems and processes to address risks were not implemented fully to ensure all patients were kept safe.

However 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

# Summary of findings

A&E attendances. Immunisation rates were relatively high for all standard childhood immunisations. Staff told us that children and young people were treated in an age-appropriate way and were recognised as individuals. Appointments were available outside of school hours and the premises were suitable for children and babies. We were given examples of joint working with midwives, health visitors and school nurses

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

**Requires improvement**

The practice is rated as requires improvement for the care of working-age people (including those recently retired and students). Systems and processes to address risks were not implemented fully to ensure all patients were kept safe.

However, the needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. On a Monday the practice stayed open until 8pm. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflected the needs for this age group. Health checks were available for patients between the ages of 40 and 74 although these were not pro-actively offered due to shortages of staff. Although staff had an understanding of equality and diversity they had received no formal training to support their understanding.

**People whose circumstances may make them vulnerable**

**Requires improvement**

The practice is rated as requires improvement for the care of people whose circumstances may make them vulnerable. Systems and processes to address risks were not implemented fully to ensure all patients were kept safe.

We were told there was facility on the electronic patient record to place a flag on patients records to identify vulnerable people for example patients with a learning disability. There were no homeless people or travellers registered at the practice. Longer appointments were available when required, for example, for patients with a learning disability and the practice regularly worked with multi-disciplinary teams in the management of the care of those patients. Vulnerable patients had access to useful information such as contact details of The Samaritans and staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding the escalation of concerning information. Only medical staff were responsible for information sharing or reporting safeguarding concerns outside of the practice. Reception and administration staff spoken with would escalate information of concern to the practice manager or lead GP.

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

Requires improvement

The practice is rated as requires improvement for the care of people experiencing poor mental health (including people with dementia). Systems and processes to address risks were not implemented fully to ensure all patients were kept safe.

However, patients experiencing poor mental health had received an annual physical health check. The practice had identified an issue with regard to coding of mental health patients and this had been addressed. (Codes are used in electronic health records to quickly identify and manage specific conditions.) The lead GP regularly worked with multi-disciplinary teams in the management of people experiencing poor mental health, including those with dementia. They carried out advance care planning for patients at the end of their life.

The practice had informed patients experiencing poor mental health how to access various support groups and voluntary organisations including MIND and SANE. They had a system in place to follow up patients who had attended accident and emergency (A&E) where they may have been experiencing poor mental health. Not all staff had received training on how to care for people with mental health needs and dementia needs.

# Summary of findings

## What people who use the service say

We spoke with two patients and reviewed comments from 42 Care Quality Commission (CQC) comments cards which had been completed. There was one card with negative comments received and we fed these back to the GP practice. Comments highlighted that all staff were very helpful, caring and understanding and couldn't do enough for the patients who responded. They had access to the GP of their choice and said that although the practice had required locum services, the locum had been consistent and able to provide continuity of care. Comments included the GP was the best they had had and they would not go anywhere else.

Patients knew they could have someone present at their consultation if required and were able to speak in a private area if necessary. They were satisfied with the cleanliness of the environment and the facilities available.

Patients reported that their care and treatment was consistent. They reported that treatment was explained in a way they understood, they were not rushed through appointments and relatives and carers were included where necessary whilst still maintaining the patient's privacy and dignity. Comments also reported that patients were referred on to other services and were well supported during transfer by the practice and its staff.

We reviewed the results from the latest GP Survey which showed that the practice scored 100% in several areas. For example 100% of respondents had confidence and trust in the last nurse they saw or spoke to against the local (CCG) average of 97%: 100% of respondents had confidence and trust in the last GP they saw or spoke to against the local (CCG) average of 95%: and 100% found the reception staff helpful. In addition, 99% said they would recommend the practice to their family and friends.

## Areas for improvement

**Action the service MUST take to improve**

- Ensure that leaders have the required skills to effectively manage the practice, encourage staff to work as a team and ensure there are formal governance arrangements which staff are aware of.
- Ensure recruitment arrangements include all necessary employment checks for all staff.
- Ensure that all staff have received suitable support and training appropriate to their role.

**Action the service SHOULD take to improve**

- Ensure that risks are identified and documented appropriately with actions plans against each risk.

# Dr Devadeep Gupta

**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 advisor and a Practice manager specialist adviser.

## Background to Dr Devadeep Gupta

Dr Gupta is the lead GP at Pennine Surgery which covers a population of approximately 2,900 patients within Littleborough and the surrounding areas. 20% of those patients are over the age of 60 years. It is a primary medical services (PMS) practice offering primary care services for the diagnosis and prevention of disease. The building complies with the Disability Discrimination Act 1995 (DDA). All consulting rooms are on the ground floor with corridors and doors wide enough for wheelchairs. Car parking is available on site. The practice offer an open list and welcomed new patients living or moving to the area.

Services offered include chronic disease management, childhood vaccinations, six week baby assessments, travel vaccinations, extended hour surgeries, smoking cessation services and drug dependency and counselling services.

Medical staff include a lead male GP, a salaried female GP and a long standing locum they provide 16 clinical sessions in total per week. The female GP is available on four of those sessions.

The practice is open Monday to Friday from 8.00am until 6.30pm and GP consulting hours are Monday to Friday 8.30am to 11.00am and Monday, Tuesday, Thursday and Friday 3.30pm to 5.30pm. There is no surgery on a Wednesday afternoon but the practice have buddied with another practice so that patients do not have to use the out of hours service on that afternoon. Extended hours are offered by appointment on a Monday from 6.30pm until 8.00pm.

There is currently only one part time nurse at the practice who is a nurse prescriber and a part time health care assistant who works two mornings per week. Recruitment of an advanced nurse practitioner once completed will enhance services offered to older aged patients, patients with chronic disease and patients with long term conditions such as asthma and diabetes.

The practice administration is managed by a practice manager and five reception staff. The practice have opted out of providing out of hours services to their own patients and the telephone lines are switched over to the out of hours service at from 6pm each day until 8am the following morning.

The CQC intelligent monitoring placed the practice in band 6. The intelligent monitoring tool draws on existing national data sources and includes indicators covering a range of GP practice activity and patient experience including the Quality Outcomes Framework (QOF) and the National Patient Survey. Based on the indicators, each GP practice has been categorised into one of six priority bands, with band six representing the best performance band. This banding is not a judgement on the quality of care being given by the GP practice; this only comes after a CQC inspection has taken place.

There were no previous performance issues or concerns about this practice prior to our inspection

# Detailed findings

## Why we carried out this inspection

The practice had been randomly selected for inspection as part of our new comprehensive inspection programme. We carried out the inspection under Section 60 of the Health and Social Care Act as part of our regulatory functions. This inspection was planned to check whether the provider was 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.

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.

## How we carried out this inspection

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

- 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 were:

- Older people
- People with long-term conditions
- Mothers, babies, children and young people
- The working-age population and those recently retired
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing poor mental health

Before our inspection we reviewed a range of information we held about the practice and asked other organisations to share what they knew. We asked Heywood, Middleton and Rochdale Clinical Commissioning Group (CCG) and the Local Healthwatch to tell us what they knew about the practice and the service provided. We reviewed some policies and procedures and other information received from the practice prior to the inspection. The information reviewed did not highlight any significant areas of risk across the five key question areas.

We carried out an announced inspection on 19 February 2015. During our inspection we spoke with all staff available on the day. This included the GP partner, salaried and locum GPs, the practice nurse, the practice manager and three administration staff. We also spoke to two patients and reviewed 42 CQC comments cards which had been completed.

We observed interaction between staff and patients in the waiting room and reviewed the premises.

Requires improvement

# Are services safe?

## Our findings

**Safe track record**

The practice had some systems in place to identify risks and improve patient safety. These included reporting incidents and national patient safety alerts as well as comments and complaints received from patients.

There had been one complaint in 2014/15 and we reviewed another two from 2011/12 and 2012/13. We saw three significant events recorded during 2014/2015. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. For example a choose and book referral appointment letter which had not been sent to the patient until after the actual event, had been recorded and reviewed with staff. Staff spoken with were aware of this incident and had received advice on how to ensure it did not reoccur.

We reviewed a folder which contained information about the recent 2014/2015 incidents but there were no recorded minutes of meetings where incidents were discussed. Dissemination of information and learning from incidents was undertaken in an informal way with no recorded evidence.

The practice manager informed us that incidents from previous years were held in the GPs appraisal information and were not routinely kept together. At the time of the inspection we were unable to review these and did not therefore see evidence that significant incidents were consistently managed over time to show a safe track record over the long term.

**Learning and improvement from safety incidents**

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. There were records of three significant events that had occurred during the last year and we reviewed them. Significant events were discussed only as and when they happened and there were no regular practice meetings where they were part of an agenda. We saw evidence, through discussions with staff, that the practice had learned from the events recorded and that the findings had been shared with staff. However, this had been done through informal discussions and we did not see specific evidence that records were completed in a comprehensive manner.

Staff, including receptionists, administrators and nursing staff, knew how to raise any issue for consideration but not all staff we spoke with felt encouraged to do so. Staff spoken with saw the completion of incident forms as part of the practice manager's role rather than something they felt encouraged to do themselves.

National patient safety alerts were received directly by the GPs, nursing staff and practice manager individually. Those were then shared or discussed when thought appropriate but there was no formal process by which to do this. Staff we spoke with were able to give examples of alerts that were relevant to the care they were responsible for. The locum GP told us that practice staff printed alerts and left them on his table for review.

**Reliable safety systems and processes including safeguarding**

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed that all staff had recently received relevant role specific training on safeguarding. Level 1 face to face training sessions had been booked to take place in April 2015 for all staff.

Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. Nursing and administration staff were aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Although administration staff said they would escalate any concerns to the practice manager or another staff member they did not see it as their responsibility to contact any agencies outside the practice. We did not see any safeguarding flow charts or contact information displayed in any of the treatment rooms or within administration areas showing what to do in the event of a concern or quick reference details of any of the various outside agencies that could be contacted.

The practice had appointed a GP lead in safeguarding vulnerable adults and children. They had been trained to the appropriate level 3 and could demonstrate they had

the necessary knowledge and experience to enable them to fulfil this role. All staff we spoke with were aware who the lead was and who to speak with in the practice if they had a safeguarding concern.

There was a system to highlight vulnerable patients on the practice's electronic patient records. This included information to make staff aware of any relevant issues when patients attended appointments; for example children subject to child protection plans or other safeguarding information. We were shown the alert system used for missed appointments, reminders about tests and any other information that may make a person vulnerable.

There was a chaperone policy, which was visible on the waiting room noticeboard and in consulting rooms. (A chaperone is a person who acts as an advocate for a patient and health care professional during a medical examination or procedure). Reception staff, previously used to chaperone, were no longer asked to carry out this role because they had not been trained to do so and did not have the appropriate checks such as disclosure and barring service (DBS) checks. The nurse had been trained and was aware of her responsibilities when acting as a chaperone including where to stand to be able to observe the examination. However we were told that she would stand outside the curtain if requested to do so by the patient. When the nurse within the practice was not available to chaperone, nurses from the other practice in the building were asked to do so. Although we were not informed of any problems with this arrangement it could leave patients in a position where there may not be someone available to chaperone if it were required.

**Medicines management**

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. The practice staff followed the policy.

Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

We saw records of practice meetings that noted the actions taken in response to a review of prescribing data. For example, patterns of antibiotic, hypnotics and sedatives and anti-psychotic prescribing within the practice. We saw an example where the practice identified all patients who were on a particular drug and these medicines were reviewed and stopped where appropriate.

The nurses and the health care assistant administered vaccines and took blood from patients using directions that had been produced in line with legal requirements and national guidance. We saw up-to-date copies of both sets of directions. The nurse was qualified as an independent prescriber. She received ad hoc support from the GPs and told us she only prescribed medicines which she felt comfortable with such as Ventolin for patients suffering asthma or repeat contraception medicine so that the patient did not have to wait to see the GP.

There was a system in place for the management of high risk medicines, which included regular monitoring in line with national guidance. Appropriate action was taken based on the results. We saw that patients receiving anti depressant medicines did not receive repeat prescriptions without a review with the GP.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times. One of the receptionists was responsible for this and would be covered by the practice manager if she was on leave. The practice did not hold controlled drugs on the premises.

**Cleanliness and infection control**

We observed the premises to be very clean, hygienic and tidy. We saw there were cleaning schedules in place and cleaning records were kept. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

The practice had a lead for infection control who had informally taken over the role when another member of staff had left. They had not yet received specific training to enable them to provide advice on the practice infection control policy and carry out staff training. However this training had been arranged for the future and would be

delivered by Rochdale Council. Other staff who had been with the practice many years had received induction training on infection control when they had joined the practice but they had not undertaken annual updates.

We saw an infection control policy which was available for staff to refer to, and enabled them to plan and implement measures to control infection. Personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these to comply with the practice's infection control policy. A member of staff explained what they would do in the event of any spillage of bodily fluids or other fluids deemed hazardous to health and we saw that spill kits were available and staff knew where they were.

Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms and in all patient and staff toilets.

Infection control relating to the building was managed independently by a company who were responsible for the cleaning and maintenance of the building.

**Equipment**

Overall maintenance of the building and its contents such as fire equipment, heating and lighting was the responsibility of an independent building management company. We spoke with the building manager who confirmed that all maintenance logs were up to date. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. A schedule of testing was in place.

Staff we spoke with told us they had enough equipment to enable them to carry out diagnostic examinations, assessments and treatments. We saw evidence of calibration of relevant equipment; for example weighing scales, spirometers, blood pressure measuring devices, ear syringing equipment, emergency equipment and the fridges. These were carried out routinely by the nursing staff.

**Staffing and recruitment**

Records we looked at did not contain evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks through the Disclosure and Barring Service (DBS). There were three medical, two nursing and five administration staff (including the practice manager) and all the staff had been employed by the practice in excess of five years. We were informed that proof of identification was required before staff were able to receive smart cards but evidence of this had not been retained on staff files. (Smart cards are a means of access control for clinical systems to maintain patient confidentiality).

We saw that references, CVs and Medical Protection Society paperwork had been obtained for the locum GPs.

For the newest member of nursing staff (offered a position to begin work in March 2015) we saw interview notes, an induction plan, NMC check, qualification certificates, and references. However there was no evidence of identification such as a copy of the nurse's passport or driving licence and the practice were waiting for the nurse to start before undertaking a DBS check. The practice had a recruitment policy that set out the standards that should be followed when recruiting clinical and non-clinical staff. This included the requirements of a DBS check to ensure a person was fit for employment before a position was offered.

Staff told us that where possible they would cover each other's planned and unplanned leave. However not all staff were trained to cover all duties which meant that some work could not be completed if staff were off. When this happened the workload fell on the practice manager which was not sustainable. Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe.

**Monitoring safety and responding to risk**

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included annual and monthly checks of the building which were carried out by an outside assessor. Medicines management was assessed by the Clinical Commissioning Group (CCG) and emergencies and equipment were managed by the building manager. The practice also had a health and safety policy. However, identified risks such as staff shortages had not been documented in a risk log where the impact to the practice and/or its patients had been assessed and rated.

Requires improvement

# Are services safe?

We saw that staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies. There were emergency processes in place for patients with long-term conditions and those experiencing a mental health crisis. Staff gave us examples of referrals made for patients whose health deteriorated suddenly.

The practice monitored repeat prescribing for people receiving medicines for mental ill-health. We saw that patients on repeat medicines for anti depressants for example, were called in for a review of their condition before a repeat was dispensed.

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

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly. There had been no medical emergencies noted.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

However, due to an IT failure we were unable to review the business continuity plan. A business continuity plan is required to deal with a range of emergencies that may impact on the daily operation of the practice such as power failure, adverse weather, unplanned sickness and access to the building. Most of these emergencies were covered by the building manager.

The IT failure had been caused when the practice were merging to a more recent version of their windows media and all the practice policies, procedures and protocols had been corrupted. The paper copies of the policies and procedures had previously been destroyed to make more space available within the offices and unfortunately the data pens had also corrupted. Business continuity had therefore failed, but the issue was being addressed by the practice manager and the relevant IT people so that policies, procedures and protocols would be made available to staff as soon as possible.

The practice had carried out a fire risk assessment that included actions required to maintain fire safety. Records showed that staff were up to date with fire training and that they practised regular fire drills. They were aware of what action to take if a fire occurred. One member of staff showed us how a list of attending patients could be very quickly printed so as to check there was no one left in the building.

We saw that there had been issues relating to staff shortages during the previous twelve months and these were now escalating into risks. We did not see a practice risk log which identified risks associated with service and staffing changes (both planned and unplanned) with mitigating actions that could have been put in place to manage this situation.

Good

# Are services effective?

(for example, treatment is effective)

## Our findings

**Effective needs assessment**

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. The practice did not hold regular practice meetings where new guidelines were disseminated and the implications discussed. However, they did get together informally when they felt it appropriate to do so. We found from our discussions with the GPs and the nurse that they completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate.

The lead GP took the lead for the practice in most clinical areas such as diabetes, heart disease and asthma and the practice nurse supported this work. The practice were in the process of employing a new advanced nurse practitioner (ANP) and one of their roles would be to initiate services such as health checks for the over 75s, new patient health checks, national health service health checks for all patients, and specific health checks for patients with a learning disability. The ANP would also support childhood checks, patients with chronic disease and initiate well man and well women clinics. These services had been done opportunistically or when required over the last twelve months due to staff shortages.

The GP made appropriate referrals for patients who required the assistance of other services. We were given an example by a patient where the GP had been more than helpful dealing with hospitals abroad and helping with transferring information. Care plans were in place for some nursing home and care home residents as well as people who were at risk of admission. The GP said that care plans should be reviewed on a three monthly basis, however, we were told this had not been done for some time. This review was to ensure that all care plans that were in place were up to date and still appropriate for those patients that required them.

Interviews with GPs showed that the culture in the practice was that patients were cared for and treated based on need and the practice took account of patient's age, gender, race and culture as appropriate.

**Management, monitoring and improving outcomes for people**

The practice showed us three clinical audits that had been undertaken in the last two years. One of these was a completed audit on pre-diabetes management where the practice was able to demonstrate the changes resulting since the initial audit. (Pre-diabetes is what people have before they develop type 2 diabetes). The practice targeted patients who were aged 40 with a BMI over 35 who had an associated increased risk of pre-diabetes or diabetes. The patients were sent an NHS health check invitation and through this the practice identified 26 new pre-diabetic patients. Lifestyle advice has now been given to a total of 34 patients who are continually monitored as they are now on a pre-diabetic register. This had been carried on and re-checked over a period of two years and demonstrated a full audit cycle.

An audit of cephalosporins was underway with the second cycle due to be undertaken next year (Cephalosporins are broad-spectrum antibiotics). The practice has reduced overall prescribing of this medicine. Other examples included an audit on dementia which was being carried out by the locum GP, avoidable attendances at A&E, children missing appointments and patients on Zoladex who were lost to urology follow up. (Zoladex is a medicine sometimes used to treat prostate or breast cancer).

The GPs told us clinical audits were often linked to medicines management information and safety alerts. Following an alert from the Medicines and Healthcare Products Regulatory Agency (MHRA) we saw an audit regarding the prescribing of domperidone which is used to treat stomach problems. Patients receiving this treatment were identified and a review of their medicine was undertaken and stopped if appropriate, in line with the guidance.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. For example, patients with diabetes had an annual medication review, and the practice met all the minimum standards for QOF in diabetes, asthma and chronic obstructive pulmonary disease (lung disease). This practice was unable to meet the QOF target for mental health due to staff shortages in the year previous to our inspection. The reasons for not achieving the targets were found to be due to a coding issue.

Good

# Are services effective?

## (for example, treatment is effective)

The practice had achieved and implemented the gold standards framework for end of life care. It had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss the care and support needs of patients and their families. The lead GP had undertaken end of life care training provided by the Clinical Commissioning Group which included areas around lasting power of attorney, the Mental Capacity Act (2005), court of protection orders, advanced directives and awareness of deprivation of liberty safeguards (DoLS). However other staff at the practice such as nursing and administration staff had not received any training or awareness courses on those subjects which would be of benefit to them and to the practice patients, specifically as 20 per cent of the practice population were over the age of 65.

**Effective staffing**

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as annual basic life support. All GPs were up to date with their yearly continuing professional development requirements and all either have been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

There were two male and one female GP to provide a gender mix but the salaried female GP only offered four sessions which meant that for half of the surgery times there was no female GP. The salaried GP and the locum GP did not undertake any lead roles within the practice.

We saw that staff received an annual appraisal which gave them an opportunity to discuss any issues they had and identify learning or training needs. Although the appraisals had been undertaken we found areas where training needs such as infection control, chaperoning and equality and diversity had either not been identified or had been identified and not implemented. Our interviews with staff did not highlight that the practice were proactive in providing training and/or funding for other relevant courses such as mental capacity act awareness, dementia awareness and customer service which would be of benefit for the patient population groups.

The practice nurse was expected to perform defined duties and was able to demonstrate that they were trained to fulfil these duties. For example the administration of vaccines, cervical cytology and ear syringing. However the lead role of infection control had recently been passed to the practice nurse and further training on this subject had not yet been undertaken.

Evidence received showed that where poor performance had been identified appropriate action had not always been taken to manage this.

**Working with colleagues and other services**

The practice worked with other service providers to meet patients' needs and manage patients with complex needs. They received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from communications with other care providers on the day they were received. The GP who saw these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well. The practice manager told us of an incident whereby all the electronic discharge letters had been "stuck" in the system and not actioned. However, this had been managed appropriately by the practice, raised as a significant incident and rectified with actions to avoid a repeat. There were no instances identified within the last year of any results or discharge summaries that were not followed up appropriately.

The practice was commissioned for the new enhanced service and had a process in place to follow up patients discharged from hospital. (Enhanced services require an enhanced level of service provision above what is normally required under the core GP contract). We saw that the policy for actioning hospital communications was working well in this respect. The practice had undertaken an audit of inappropriate admissions to A&E to ensure that they were managing patient care to avoid these. A patient we spoke with told us that the GP had visited them at home as soon as they had been discharged from hospital.

The lead GP attended monthly multidisciplinary meetings to discuss the needs of complex patients, for example those with end of life care needs. These meetings were

attended by palliative care nurses and decisions about care planning were shared. The lead GP felt this system worked well and remarked on the usefulness of the forum as a means of sharing important information. However there was no evidence that the information was shared with other medical and clinical staff through peer review of patients.

**Information sharing**

The practice used several electronic systems to communicate with other providers. There was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. Electronic systems were also in place for making referrals through the choose and book system. (Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital). One member of staff who used the system reported that it was easy to use but not all staff had been trained which meant that cover was not available when that person was on planned or unplanned leave.

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record (Vision) to coordinate, document and manage patients' care. All staff were fully trained on the system, and commented positively about the system's safety and ease of use. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

**Consent to care and treatment**

We were told that a consent policy was available to staff but we were unable to review the policy due to an IT failure at the time of the inspection. The practice were unable to provide evidence which explained all areas of consent such as expressed and implied consent and Gillick competency to assess young people's ability to understand or consent to treatment.

However, all the staff we spoke with understood the term consent and knew why it was required. The nursing and administration staff were aware of the term mental capacity but only the lead GP had received training under the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it.

Medical staff spoken with understood requirements around consent and decision making for people who attended the practice. The lead GP described situations where best interests or mental capacity assessment might be appropriate and was aware of what should be done in any given situation. We saw evidence that patients were supported in their best interests, with the involvement of other clinicians, families and/or carers where necessary.

Consent was discussed during consultation. Patient specific directives were used to obtain consent before any invasive treatment, such as joint injections, flu injections or child immunisations. Verbal consent was recorded in the patient record.

**Health promotion and prevention**

The lead GP attended a monthly cluster meeting within the Clinical Commissioning Group (CCG) on a regular basis. This meeting was used to discuss the needs of population. They also attended multi disciplinary meetings monthly to discuss ways to help patients with chronic illnesses and liaised with district nurses. The lead GP we spoke with said they used their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering opportunistic smoking cessation advice to smokers. The practice nurse offered advice on all lifestyle interventions such as weight loss, smoking cessation and the reduction of alcohol consumption.

The nurse at the practice carried out routine health checks and dealt with any lifestyle interventions. The nurse would refer the patient to the GP if she uncovered any illness that required medical treatment. The practice also offered NHS Health Checks to all its patients aged 40 to 75 years and these patients were identified by a pop up on the system which alerted the GP to offer the check opportunistically when they attended for other reasons.

The practice had highlighted ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice kept a register of all patients with a mental health condition. These patients were reviewed every two to three months and checks were carried out to make sure they were receiving their prescriptions and were compliant with their medicines.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with

Good

# Are services effective?

## (for example, treatment is effective)

current national guidance. Their performance for all immunisations was average for the Clinical Commissioning Group (CCG), and there was a clear policy for following up non-attenders by the practice nurse.

Good

# Are services caring?

## Our findings

**Respect, dignity, compassion and empathy**

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey 2014/2015, the patient participation group summary report for 2013/2014, the Friends and Family questionnaires introduced in December 2014. The evidence from all these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. Data from the national patient survey showed the practice was rated 'among the best' for patients who rated the practice as good or very good. The practice was also well above average for its satisfaction scores on consultations with doctors and nurses with 100% of practice respondents saying the GPs and nurse were good at listening to them and 99% describing their overall experience of the practice as good.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 42 completed cards and all of them were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. We also spoke with two patients on the day of our inspection. They told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Disposable curtains were used in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation / treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. We saw that staff offices were secure and organised with an area where phone calls could be taken in private. However most calls were taken at the reception area where patients booked appointments which could compromise patient privacy. However there was a note on reception asking people to stand back and respect the privacy of others. We also saw a notice informing patients to let reception know if they needed to speak to someone in private.

Staff told us that if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected, they would raise these with the practice manager.

Staff were very aware of patients whose circumstances may make them vulnerable such as the elderly and disabled. We observed elderly patients being treated in a sensitive manner.

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

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. This practice achieved the second highest results within the Clinical Commissioning Group (CCG) and were rated 76th in the country.

Comments we received confirmed that patients' health issues were discussed with them and they felt involved in decision making about the care and treatment they received. One patient commented that they always got to see their 'named' GP who had taken time to set up a care plan so the patient would have easier access to appointments and was known as a priority. Patients also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. Data from the national patient survey showed 94% of practice respondents said the GP involved them in care decisions and 98% felt that the GP gave them enough time. felt the GP was good at explaining treatment and results.

We saw evidence of care plans which were created via face to face consultations with the patient and the patient was involved in these. They had the opportunity to discuss end of life planning and whether they wanted their next of kin to be aware of their decisions.

There were not many non-English speaking patients registered at the practice but staff were aware of language

Good

# Are services caring?

line and how to access it. Language line is a telephone interpretation service. The practice have accessed British Sign Language (BSL) to help to communicate with a patient who cannot hear.

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

We saw evidence that all the staff were able to provide emotional support. GPs and administration staff described incidences when they had gone over and above expectation to support a person with their care or treatment. Patients feedback that they could make longer appointments if they needed them and they felt able to discuss any problems with the GP or nurse. We observed reception staff being helpful and supportive of patients.

Staff were aware of other services available to support patients with bereavement and end of life such as Macmillan Nurses and bereavement counselling services. We saw information in the practice about bereavement counselling services. The practice's computer system alerted GPs if a patient was also a carer and we saw information available for carers to ensure they understood the various avenues of support available to them.

The practice knew their patient population very well and staff were able to recognise patients who may be vulnerable or at risk of isolation. We were shown several examples where staff had gone over and above their required duties to help older or vulnerable patients. For example carrying out ad hoc visits, picking up and delivering prescriptions, reminding people about their appointments, and being aware of high risk and priority patients.

Good

# Are services responsive to people's needs?

(for example, to feedback?)

## Our findings

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

The practice was pro-active in contacting patients who failed to attend vaccination and screening programmes and worked to support patients who were unable to attend the practice. Patients who were housebound were identified and visited at home as required. The practice tried to call people on the telephone rather than writing letters and this included reminders about appointments, flu campaigns and blood tests. However there was only one part time nurse in attendance and a health care assistant who worked two mornings a week. This did not reflect the needs of the patients at the practice but this had been acknowledged and actioned by the practice.

We found the practice was responsive to patient's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered such as identifying high attendances at A&E and putting in systems to reduce them.

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG) such as access to local services.

**Tackling inequity and promoting equality**

The practice had recognised the needs of different groups in the planning of its services. There was little diversity within the practice population but the practice had registers for those patients who were carers or were cared for and those with mental health conditions or disabilities. Staff had access to online and telephone translation services when required, although it was seldom used.

There was no equality and diversity training offered to staff. Staff we spoke with confirmed understood the term equality and diversity but had not had training in the subject. They felt that they would benefit from it if it were offered.

The premises and services had been adapted to meet the needs of patient with disabilities. Changes had been made to the set up of the building and reception desks had been moved and adjusted so that they were lower (for patients using wheelchairs) and provided more confidentiality.

All consulting rooms were on the ground floor. There was ample space in the waiting area and corridors and doors were wide enough for access by wheelchairs, mobility scooters and prams. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities.

**Access to the service**

The practice was open on Monday to Friday from 8.00am until 6.30pm and GP consulting hours are Monday to Friday 8.30am to 11.00am and Monday, Tuesday, Thursday and Friday 3.30pm to 5.30pm. There is no surgery on a Wednesday afternoon but the practice have buddied with another practice so that do not have to use the out of hours service on that afternoon. Extended hours are offered by appointment on a Monday from 6.30pm until 8.00pm.

Urgent appointments and home visits were available on a daily basis and patients could book routine appointments two weeks in advance by telephone or on line. Allowances were made for patients with priority requirements, such as patients with mental health issues, recently discharged from hospital or chronic long term conditions, who may need an appointment when no appointments were available. These patients were fitted in when it was appropriate to do so, so that they did not have to wait. Longer appointments were also available for patients who needed them and these were allocated on request.

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits and how to book appointments through the website. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients.

Patients were generally satisfied with the appointments system. They confirmed that they could see a doctor on the same day if they needed to. They also said they could see another doctor if there was a wait to see the doctor of their choice. Comments received from patients showed that patients in urgent need of treatment had often been able to make appointments on the same day of contacting the practice.

**Listening and learning from concerns and complaints**

Good

# Are services responsive to people's needs?

## (for example, to feedback?)

The practice had a system in place for handling complaints and concerns. Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. There was a designated responsible person who handled all complaints in the practice.

We saw that information such as posters in the waiting room, a summary leaflet at the reception area and information on the website was available to help patients understand the complaints system. Patients we spoke with were aware of the process to follow if they wished to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice.

We looked at complaints received in the last 12 months and found that these were satisfactorily handled and dealt with in a timely way.

# Are services well-led?

Requires improvement

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

## Our findings

**Vision and strategy**

The practice vision and values were detailed in the practice charter and aimed to deliver high quality care and promote good outcomes for patients. The practice charter was available to patients and was clearly displayed in the reception. The vision and values included courtesy and respect by all practice personnel, seeing patients within 20 minutes of their appointment time, providing prescriptions within 48 hours, reviewing comments and suggestions, and making the surgery as accessible as possible to all patients. Staff we spoke with strove to deliver a high quality service and patients fed back that they were satisfied with the care and service provided. However the future business plan for the practice was not clear and we saw staff working in silo to achieve these objectives.

We spoke with seven members of staff who understood the vision and values of the practice and how they could help to deliver them. However there were no meetings where all staff got together to discuss these values and to ensure that they were still current.

**Governance arrangements**

The practice had a number of policies and procedures in place to govern activity and these were normally available to staff on the desktop on any computer within the practice. We were unable to look at these policies and procedures on the day of the inspection due to an IT failure. However we were able to review the recruitment policy prior to the inspection and we saw paper copies of a policy for infection control and the safeguarding of adult and children which were available and up to date.

There was a leadership structure with some named members of staff in lead roles for some things. For example the senior partner was the lead for safeguarding and one of the nurses had informally taken on the lead role for infection control.. Not all staff we spoke with were clear about their own roles and responsibilities and there was a general lack of peer support with staff again working in isolation to achieve their objectives. However, we saw the reception staff working as a team to provide a good service to the practice patients.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed it was performing in line with national standards showing 97.5% completeness which was 2.7% above the Clinical Commissioning Group (CCG) average. The lead partner and practice manager discussed QOF results informally and action plans to improve outcomes were considered. However the workload to achieve improvement was not proportionately shared causing undue stress on those required to complete it.

The practice nurse worked autonomously and liaised with the GPs only on an 'as and when' basis. They provided an example where they had quite quickly needed the advice of the GP. They explained how they and the GP had arranged an early morning joint appointment and had been able to work together so that a positive outcome was achieved for the patient. However the practice nurse did not receive any other regular clinical or peer review. Information was shared on a 'need to know basis' and patients were not routinely discussed. The practice nurse did not attend multi disciplinary team meetings about palliative care or vulnerable patients of the practice.

There was a system in place to identify, record and manage risk and a risk log was in place. However there were no identified risks and no formal meetings where risks were discussed. During the inspection we identified potential risks relating to staff shortage and increasing workload. We discussed these risks with the GP and the practice manager who acknowledged that they needed to be addressed. They told us they would take action. The practice did not hold regular governance meetings attended by all staff where risks such as these could be mitigated using a team approach.

**Leadership, openness and transparency**

There were no regular formal meetings held. GPs and nurses spoke to each other about patients on an 'as and when basis'. The administration/reception staff met informally with the practice manager a few times a year and a notebook of actions was kept in reception. The GP and the practice manager met for a short time twice a week to discuss any issues. However, some issues such as a shortage of staff due to sickness and maternity leave, increased workloads, and a lack of formal delegation had escalated into risks. These risks had been acknowledged by the lead GP and the practice manager but they had not been openly discussed in the presence of all staff, they had not been documented and there were no plans in place to address them.

# Are services well-led?

Requires improvement

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

The practice manager was responsible for human resource policies and procedures. We were unable to review policies such as disciplinary procedures and the management of sickness, which were in place to support staff. However we reviewed a human resources (HR) policy which included sections on equality, harassment and bullying at work as well as a section about open and honest communications between all staff. These policies would normally be available to staff on the computer desktops once issues were resolved.

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

The practice had gathered feedback from patients through suggestions, informal comments, patient surveys, the patient participation group (PPG) and complaints received. We were unable to speak to any of the PPG members. We reviewed the results from the practice patient participation group survey and saw that patients were concerned about privacy at the desk and noted that the counter top was too high. We saw on the day of inspection that structural changes had been made to the reception desk to deal with these issues. Patients had also provided feedback via the national GP survey and the practice had been rated as the 75th best in the country and the second best within the Clinical Commissioning Group (CCG). The GP Patient Survey is an independent survey run by Ipsos MORI on behalf of NHS England. Full details of the practice results are available on the internet.

The practice had not consistently or proactively gathered feedback from staff through any staff surveys, away days, staff meetings or appraisals and discussions. Staff we spoke with said they felt able to raise concerns or issues with their peers and leads, but evidence obtained and observations on the day proved contrary to those statements.

The practice had a whistleblowing policy which was available to all staff electronically and all staff spoken with were aware of it and what to do if they needed to escalate something. Staff told us they would escalate something if they had concerns about any other person's integrity.

**Management lead through learning and improvement**

All clinical staff maintained their own clinical professional development independently and we did not see evidence of peer support or encouragement to develop into roles which would enable delegation of workload. Administration staff received basic training and had not been encouraged to develop their roles to support them to cover each other's responsibilities and reduce workload through sharing of duties. We looked at staff files and spoke with staff about appraisals. Appraisals had taken place last year and discussions had identified training requirements. However because of workload, a desire to deliver the values of the practice and the prioritisation of patient care, these training needs had been left unresolved.

We found that leaders lacked the required capacity, experience, knowledge or capability to lead effectively. Some staff were not fully informed with the day to day running of the practice. Practice staff were not encouraged by its leaders to provide a team approach to problem solving.

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>Maternity and midwifery services<br>Surgical procedures<br>Treatment of disease, disorder or injury | Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed<br>Persons employed for the purposes of carrying on a regulated activity must have the qualifications, competence, skills and experience which are necessary for the work to be performed by them.<br>Information specified in Schedule 3 must be available in relation to each such person employed. |

| Regulated activity | Regulation |
|---|---|
| Diagnostic and screening procedures<br>Maternity and midwifery services<br>Surgical procedures<br>Treatment of disease, disorder or injury | Regulation 18 HSCA (RA) Regulations 2014 Staffing<br>All staff must receive appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform.<br>Staff must be enabled where appropriate to obtain further qualifications appropriate to the work they perform. |