Brooks Bar Medical Centre

Quality Report

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There is no practice website

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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?	Inadequate
Are services well-led?	Inadequate

Summary of findings

Contents

Summary of this inspection

Page

Overall summary 2

The five questions we ask and what we found 5

The six population groups and what we found 8

What people who use the service say 11

Areas for improvement 11

Detailed findings from this inspection

Our inspection team 12

Background to Brooks Bar Medical Centre 12

Why we carried out this inspection 12

How we carried out this inspection 12

Detailed findings 14

Action we have told the provider to take 25

Overall summary

Letter from the Chief Inspector of General Practice

We first carried out an announced comprehensive inspection at Brooks Bar Medical Centre, Old Trafford on 10th November 2015 when the practice was rated inadequate overall and was placed into special measures. At that time we also issued the provider with a warning notice because the practice did not have adequate systems to keep patients safe.

We carried out a focused inspection of the practice on 14th June 2016 to review the actions the provider had taken in terms of the Warning Notice. At that inspection there was evidence that systems had been introduced in order to reduce risk but they were not yet embedded. If these systems were embedded into every day practice and followed consistently then users of the service would be kept safe.

Although governance arrangements had improved, many of the key medical staff, who were instrumental in making improvements, had left, or were leaving the practice and this left overall responsibility with one main lead GP. This was in addition to their clinical responsibilities and other lead areas such as safeguarding, significant events, infection control, policies and procedures, human resources, staff meetings and communication.

We carried out a further announced comprehensive re-inspection of Brooks Bar on 30th August 2016 in line with our enforcement policy of services placed into Special Measures. The practice had introduced a number of protocols and business processes to manage the practice. However, we found that these were not embedded well enough and were not consistently followed to sufficiently reduce the risks that had been previously identified.

The practice had been unable to recruit substantive GPs and clinical sessions were predominantly covered by locum staff. We found that safety, effectiveness, care and responsiveness had deteriorated since our last inspection because locum staff were not involved in the governance and administration elements at the practice and communication was ineffective. The practice is therefore still rated as inadequate overall.

Summary of findings

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

- Patients were at risk of harm because not all staff fulfilled their responsibilities to raise concerns, and to report and discuss incidents and near misses.
- We found that where risks were identified and escalated to the lead GP they were not dealt with in a timely manner in order to reduce or prevent reoccurrence.
- Patients care plans were in place but they were not patient specific to be able to meet individual needs and preferences. There were repeated prescribing errors, and READ coding inconsistencies. (READ coding is a way of grouping specific conditions so that they can be easily identified and monitored)
- Data showed that some patient outcomes had improved since our last visit. However the practice were still outliers for some of the QOF (or other national) clinical targets and there was no evidence that they were being dealt with.
- The practice had implemented a system of audit and monitoring and had carried out some checks on patients to ensure they were receiving the most appropriate treatment.One audit cycle had been completed.
- Feedback from patients was mixed.Some patients were satisfied with the service they had received.We spoke to seven patients on the day of the inspection.Some were very dissatisfied with the service and identified confidentiality issues.
- There was good information for patients in the waiting room about the different services available to them within and outside the practice. Information was transferrable into different languages.
- The practice had implemented a patient participation group and the group met regularly.
- The practice had a number of policies and procedures to govern activity. These were not yet embedded into every day practice to ensure that they were effective. For example, to ensure that appropriate action was taken when things went wrong.

The areas where the provider must make improvements are:

- Ensure that all events of significance are reported and action is taken to ensure they are not repeated.
- Ensure there is a responsible person, with the required authority, to make sure that action is taken when things go wrong.
- Monitor that all staff receive patient safety alerts and ensure they are actioned.
- Ensure that policies and procedures are embedded and appropriate actions are taken when things go wrong.
- Ensure that all complaints, verbal and written, are dealt with appropriately.
- Ensure that all staff receive training in order to effectively carry out their role.
- Ensure that medicines management is effective.
- Ensure that care planning, system alerts and READ coding on patient records is consistent to identify patients at the end of their life, those receiving palliative care, those who are carers and patients in need of extra support.
- Protect patients' privacy at all times, specifically in the reception area.

In addition the provider should:

- Review the needs of the practice population and make changes where appropriate.
- Continue to review, update and embed procedures and guidance into day-to-day practice.
- Continue to develop a quality improvement system to include regular full cycle audits and reviews.
- Introduce a system to identify carers and offer them support

This service was placed in special measures in February 2016. Insufficient improvements have been made such that there remains a rating of inadequate for Safe, Effective, Responsive and Well Led. Therefore we are taking 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

Summary of findings

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 six months, and if there is not enough improvement we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Inadequate

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

- Patients were at risk of harm because not all staff fulfilled their responsibilities to raise concerns, and to report and discuss incidents and near misses. Opportunities to prevent or minimise harm were missed due to ineffective risk identification and poor management.
- We found that where risks were identified and escalated to the lead GP, they were not dealt with in a timely manner in order to reduce or prevent reoccurrence.There were a number of issues identified, including prescribing medication errors.
- Although the practice carried out investigations when there was unintended or unexpected safety incidents, lessons learned were not communicated effectively to staff.
- There were continual issues relating to medicines management. The practice was high prescribers for hypnotic medicines and there was no system in place to ensure these prescriptions were safely reviewed.
- Patients did not receive reasonable support or a verbal and written apology. We were aware of three complaints received in the preceding three weeks that had not yet been dealt with.
- There was not enough consistent medical staff to ensure adequate continuity of patient care and adequate clinical support for the nursing staff.

Are services effective?

Inadequate

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

- Data between July 2014 and June 2015 showed that care and treatment was not delivered in line with recognised professional standards and guidelines. There were very large variations in the following items and no evidence of plans to address them :
  - The number of Ibuprofen and Naproxen Items prescribed as a percentage of all Non-Steroidal Anti-Inflammatory drugs;
  - The number of hypnotic medicines prescribed;
  - The percentage of antibiotic items prescribed that are Cephalosporins or Quinolones
  - The ratio of reported versus expected prevalence for Coronary Heart Disease (CHD)

Summary of findings

- Patient outcomes were hard to identify as little or no reference was made to audits or quality improvement.The practice pointed out that they had a higher than average population of patients between the ages of 16 and 64 but there was no specific targeted approach to the needs of this group.
- There was minimal engagement with other providers of health and social care.
- Staff had been appraised but there was limited recognition of the benefit of additional training that may be required.
- Basic care and treatment requirements were not met. The practice held care plans for most conditions but these were only used by the nurses and health care assistant with no clinical input from a GP. There were no current care plans for patients receiving mental health, end of life or palliative care.
- Clinical coding was inconsistent making it difficult to identify and monitor specific groups of patients such as carers, vulnerable patients, and patients on palliative care.

Are services caring?

Requires improvement

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

- Patients' privacy was compromised in the reception area because conversations could be overheard.
- There was good information for patients about the services available to patients in different languages if required.
- Not all staff actively identified carers or knew how to record them on the clinical system.
- A number of patients we spoke to said they were not treated with compassion, dignity and respect. Not all patients said they felt cared for, supported and listened to.
- Data from the national GP patient survey showed patients rated the practice lower than others for some aspects of care. For example, 76% of respondents said the last GP they saw or spoke to was good at listening to them compared to the CCG average of 90% and the National average of 89%.

Are services responsive to people's needs?

Inadequate

The practice is rated as requires improvement for providing responsive services and improvements must be made :

- There were a limited number of substantive GPs to ensure that every clinical session was covered and the practice were unable

Summary of findings

to recruit GPs. Locum staff were used consistently but there was no guarantee that those locum staff would always be available when required as they were requested on a week by week basis.
- 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, there was no evidence that learning from complaints had been shared with staff.
- There was no designated person responsible for handling complaints and staff did not fully progress concerns and complaints from patients. When concerns were progressed they were not always dealt with appropriately.
- The practice had a patient participation group but it was not being used to implement changes within the practice.

Are services well-led?

Inadequate

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

- One GP was responsible for providing the entire leadership of the practice and all its associated business needs in addition to their clinical duties and lead roles such as safeguarding, medicines management, significant events and governance protocols.
- There was limited clinical support available for the nursing staff and health care assistant (HCA).
- The future of the practice was wholly dependent on whether or not the practice could recruit additional GPs. There were no succession plans in place.
- Meetings to discuss significant events were not frequent enough to ensure appropriate and timely action was taken to reduce any associated risks. The practice held regular governance meetings which were mostly attended by administration staff and the practice manager.
- The practice had a vision and a strategy but not all staff were aware of this and their responsibilities in relation to it. There was a documented leadership structure and most staff felt supported by management. Although they felt able to escalate issues, at times they felt that nothing could or would be done to effect change.
- The practice had a number of policies and procedures to govern activity, but some of these were overdue a review and not reflected in day to day practice.

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 provider was rated as inadequate for safe, effective, responsive and well led and requires improvement for caring. The issues identified as inadequate and requiring improvement overall affected all patients including this population group. We also found:

- 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.
- Over 75 health checks had recently been implemented and were being carried out by the Health Care Assistant.

People with long term conditions

Inadequate

The provider was rated as inadequate for safe, effective, responsive and well led and requires improvement for caring. The issues identified as inadequate and requiring improvement overall affected all patients including this population group. We also found:

- Nursing staff held lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. There were appropriate systems in place for the call, recall and review of patients with long term conditions.
- The percentage of patients with COPD who had a review undertaken, including an assessment of breathlessness in the preceding 12 months was 91% which was higher than the local and national averages of 89%.
- Indicators for all diabetes interventions were lower than average (full detail in the main body of the report) with high exception reporting. Exception reporting is where a practice does not include a patient in the overall data submission for specific reasons.
- Longer appointments and home visits were available when needed but there was evidence that home visits were not regular occurrences.

Families, children and young people

Inadequate

The provider was rated as inadequate for safe, effective, responsive and well led and requires improvement for caring. The issues identified as inadequate and requiring improvement overall affected all patients including this population group. We also found:

Summary of findings

- 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 lower than average for standard childhood immunisations.
- Staff 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.
- Although data showed that cervical screening rates were lower than average, they had improved.
- Appointments were available outside of school hours and the premises were suitable for children and babies.

Working age people (including those recently retired and students)

Inadequate

The provider was rated as inadequate for safe, effective, responsive and well led and requires improvement for caring. The issues identified as inadequate and requiring improvement overall affected all patients including this population group. We also found:

- Appointments were available from 7.30 am on two mornings a week and until 7.30pm on three evenings a week.
- There were daily "sit and wait" appointments but these were not suitable for patients who were working because of waiting times of up to an hour or more.
- Prescriptions could be requested by email.
- There was no practice website and it was not easy to book appointments on-line

People whose circumstances may make them vulnerable

Inadequate

The provider was rated as inadequate for safe, effective and well led and requires improvement for caring and responsive. The issues identified as inadequate and requiring improvement overall affected all patients including this population group. We also found:

- The practice held a register of patients living in vulnerable circumstances such as children on the "at risk" register.
- The practice offered longer appointments for patients if they needed one.
- The practice informed vulnerable patients about how to access various support groups and voluntary organisations.
- Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours. There were no recent safeguarding incidents.

Summary of findings

People experiencing poor mental health (including people with dementia)

Inadequate

The provider was rated as inadequate for safe, effective and well led and requires improvement for caring and responsive. The issues identified as inadequate and requiring improvement overall affected all patients including this population group. We also found:

- The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who had a comprehensive, agreed care plan documented in the record, in the preceding 12 months was 48% which was lower than the local and national averages of 85% and 88% respectively.
- Data showed that 87% of patients with dementia had received a face to face review in the previous twelve months but there was no evidence that the practice carried out advanced care planning for patients with dementia.

Summary of findings

What people who use the service say

The national GP patient survey results were published in July 2016. The results showed the practice performance as varied, with some responses much lower than the local and national averages. 363 survey forms were distributed and 90 were returned. This was a 24% completion rate and represented 1.55% of the practice's patient list.

- 82% of patients found it easy to get through to this practice by phone compared to the Trafford CCG average of 79% and the national average of 73%.
- 62% of patients were able to get an appointment to see or speak to someone the last time they tried compared to the Trafford CCG average of 63% and the national average of 59%.
- 73% of patients described the overall experience of this GP practice as good compared to the Trafford CCG average of 86% and the national average of 85%.
- 66% of patients said they would recommend this GP practice to someone who has just moved to the local area compared to the Trafford CCG average of 81% and the national average of 88%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 22 comment cards with mixed responses about the standard of care received. Some patients were very pleased with their care and treatment; some were happy with the GPs but had concerns about the reception area and the staff at reception. Some comments highlighted concerns about the environment and others were very positive about the entire practice.

We spoke with seven patients during the inspection. There were mixed responses. Some patients said they were satisfied with the care they received and thought staff were approachable, committed and caring. Others were dissatisfied with the services or with the way they had been treated and responded to when they had complained or provided feedback for consideration.

Areas for improvement

Action the service MUST take to improve

- Ensure that all events of significance are reported and action is taken to ensure they are not repeated.
- Ensure there is a responsible person, with the required authority, to make sure that action is taken when things go wrong.
- Monitor that all staff receive patient safety alerts and ensure they are actioned.
- Ensure that policies and procedures are embedded and appropriate actions are taken when things go wrong.
- Ensure that all complaints, verbal and written, are dealt with appropriately.
- Ensure that all staff receive training in order to effectively carry out their role.
- Ensure that medicines management is effective.
- Ensure that care planning, system alerts and READ coding on patient records is consistent to identify patients at the end of their life, those receiving palliative care, those who are carers and patients in need of extra support.
- Protect patients' privacy at all times, specifically in the reception area.

Action the service SHOULD take to improve

- Review the needs of the practice population and make changes where appropriate.
- Continue to review, update and embed procedures and guidance into day-to-day practice.
- Continue to develop a quality improvement system to include regular full cycle audits and reviews.
- Introduce a system to identify carers and offer them support

Brooks Bar Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector**.** The team included a GP specialist adviser and a practice nurse specialist adviser.

Background to Brooks Bar Medical Centre

Brooks Bar Medical Practice is a purpose built building based in Chorlton Road, Old Trafford and offers services under a General Medical Services contract to 5,800 patients in the Trafford and surrounding areas. The practice lies on the boundary of four areas and the information systems available to the practice do not link with all the secondary care services where patients can be referred.

The level of deprivation within the practice population group is two (on a scale of one to ten with 10 being lowest). The practice also has a higher population of patients under the age of 18 compared to the rest of the CCG as well as high minority ethnicity such as non-English speaking patients.

There were two partners at the practice. One of the partners is responsible for the entire leadership of the practice and all its associated business needs in addition to their clinical duties.

The practice are contracted to supply 19 clinical sessions per week and four administration sessions. One of the partners and a locum GP regularly undertake eight clinical sessions. The other clinical sessions are covered by the lead GP and other locum GPs when they can be secured. There are male and female GPs.

Nursing staff consist of two female practice nurses working part time, a male health care assistant (assistant practitioner in training), 10 administration staff and a practice manager.

The surgery opening times are listed as 8am to 7.30pm on Mondays, Tuesdays, Thursdays and Fridays, closing between 1pm and 2pm for lunch. On Wednesdays the surgery opens at 8.30am until 12.30pm and does not re-open that day. On Saturdays and Sundays the practice is closed. It is also closed between 12.30pm and 3pm each Thursday for protected learning time.

When the practice is closed the patients are directed to the Out of Hours Services. The practice tries not to turn any patients away and sometimes appointments are booked when the reception or surgery is closed. There is an emergency “sit and wait” facility each day and extended morning hours are offered on a Tuesday and Thursday morning with appointments from 7.30am.

We initially carried out an announced comprehensive inspection at Brooks Bar Medical Centre, Old Trafford on 10th November 2015 when the practice was rated inadequate and was placed into special measures. We took enforcement action and issued requirement notices in relation to Regulations 12 (Safe Care and Treatment), 13 (Safeguarding), 18 (Staffing) and 19 (Fit and proper persons employed). At that time we also issued the practice with a warning notice against Regulation 17 (Good Governance) because there was a lack of systems in place to keep the practice safe. We carried out a focused inspection of the practice on 14th June 2016 to check that they had met the terms of the Warning Notice. At that inspection we were satisfied that adequate systems had been introduced to reduce risks. We were satisfied that if these systems were embedded into every day practice and followed consistently then risks would be well managed.

Detailed findings

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 held about the practice and asked other organisations to share what they knew. We carried out an announced visit on 30th August 2016. During our visit we:

- Spoke with a range of staff including the two GP partners, the nurses and health care assistant (HCA), the medicines manager and the practice manager, some of the reception/administration staff and to patients who used the service.
- Observed patients in the waiting area and how they were being treated by staff
- Reviewed an anonymised sample of parts 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

At our inspection on 10th November 2015 the practice was rated Inadequate for Safe. We found that when safety incidents occurred, reviews and investigations were not thorough enough. Lessons were not communicated widely enough to support improvement. There were no clearly defined and embedded systems and processes in place to keep people safe and safeguarded from abuse. When risks were assessed the systems and processes in place to address those risks were not implemented well enough to ensure patients were kept safe for example in relation to training, health and safety, recruitment checks and Disclosure and Barring Service (DBS) checks. At our inspection on 30th August 2016 we found the practice remained unsafe.

At this inspection we found :

Safe track record and learning

The system for reporting and recording significant events was still not effective.

- The practice had implemented a system and carried out analysis of significant events. However we saw that the responsible person for taking action in many of the reported cases was the practice manager with limited clinical guidance or support to ensure that action was taken.
- Staff told us they would inform the practice manager of any incidents and there was a recording form available on the practice's computer system but the evidence to support this was inconsistent.We were told about incidents which had not been reported or recorded.
- The time between reporting an event and meeting to discuss and take action could be up to three months and locums GPs did not attend these meetings.
- Patients did not always receive reasonable support with information and written apology when things went wrong.Three patients told us that when they complained nothing was done.

We reviewed safety records, incident reports, patient safety alerts and minutes of meetings where these were discussed. We were not satisfied that lessons were shared and action was taken to improve safety in the practice. There were repeated incidents of the same issues, particularly in relation to prescription errors.

Overview of safety systems and processes

The practice had introduced systems, processes and practices to keep patients safe and safeguarded from abuse but these were not all embedded well enough to be effective.

- Arrangements were in place to safeguard children and vulnerable adults from abuse.

  These arrangements reflected relevant legislation and local requirements. The safeguarding policy was dated 2015 and was available to all staff on the computer system.

The policy outlined who to contact for further guidance if staff had concerns about a patient's welfare. There was a lead member of staff for safeguarding who said they attended safeguarding meetings and provided reports where necessary for other agencies.

Most of the staff we spoke to demonstrated they understood their responsibilities and all had received training on safeguarding children and vulnerable adults relevant to their role. GPs were trained to child protection or child safeguarding level 3 and nursing staff were also trained to the appropriate level.

- A notice in the waiting room advised patients that chaperones were available if required. All staff who acted as chaperones had received guidance and had 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 maintained appropriate standards of cleanliness and hygiene. We observed the premises to be clean and tidy. The practice nurse was the infection control clinical lead and liaised with the local infection prevention teams to keep up to date with best practice. There was an infection control protocol in place and staff had received up to date training. There was a recent infection control audit and the results had been fed back to the team.

Inadequate

Are services safe?

- The arrangements for managing medicines in the practice were not safe. There were continuing issues relating to missing prescriptions and patients receiving repeat prescriptions that were incorrect. There were no regular medicine audits to ensure that prescribing was in line with best practice guidelines for safe prescribing.The practice was a high prescriber of Hypnotic medicines which can be addictive; there was no process in place to review, monitor and reduce the amount prescribed.
- Emergency medicines and vaccines, ordering, storing, security and disposal of medicines were managed effectively by the nursing staff. Blank prescription forms and pads were securely stored and there were systems in place to monitor their use. Patient Group Directions had been adopted by the practice to allow nurses to administer medicines in line with legislation. Health Care Assistants were trained to administer vaccines and medicines against a patient specific prescription or direction from a prescriber.
- We reviewed personnel files and found appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service.

Monitoring risks to patients

Risks to patients were still not assessed and well enough managed.

- Although there were procedures in place for monitoring and managing risks to patient safety they were not embedded sufficiently to be effective.
- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system in place for all the different staffing groups but it was not always possible to ensure enough medical staff to cover the contractual services required to meet patient demand. The practice had been unable to recruit full time medical staff and most of the sessions were covered by locums. Where locums could not be secured the lead GP filled in. The rota showed no GP cover on a number of Fridays meaning a delay in support for nursing staff and any nursing decisions having to wait until Monday the followingweek.
- There was a health and safety policy available and the practice manager was responsible for health and safety within the practice. There was an up to date fire risk assessment and fire drills were carried out. There had recently been a successful trial evacuation. 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 a variety of other risk assessments in place to monitor safety of the premises such as control of substances hazardous to health and infection control and legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings).

Arrangements to deal with emergencies and major incidents

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

- There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency.
- All staff received annual basic life support training and there were emergency medicines available in the treatment room.
- The practice had a defibrillator available on the premises and oxygen with adult and children's masks. A first aid kit and accident book were available in reception.
- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and stored securely.
- The practice had a business continuity plan in place for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff.

Inadequate

Are services effective?

(for example, treatment is effective)

Our findings

At our inspection on 10th November 2015 the practice was rated Requires Improvement for Effective. Knowledge of and reference to national guidelines were inconsistent. Care was not always planned and delivered following best practice guidance such as National Institute for Health and Clinical Excellence (NICE) guidance for referrals. There was no evidence that clinical audit was being carried out and patient outcomes remained lower than average. Staff were not effectively appraised and there was little support for additional required training. At our inspection on 30th August 2016 we found that the practice had deteriorated for providing effective services. Invalidated QoF data showed that outcomes had deteriorated, there were no processes to ensure that guidance was being followed, staffing levels were not sufficient and staff training was still required.

At this inspection we found :

Effective needs assessment

The practice told us they reviewed relevant and current evidence based guidance and standards, including Institute for Health and Care Excellence (NICE) best practice guidelines.

- The clinical staff we spoke with could outline the rationale for their approaches to treatment. However, they had no process to ensure that these guidelines were being followed, through risk assessments, audits and random sample checks of patient records.
- There was a system to disseminate medical alerts but it was not consistent. There was no evidence that two of the most recent alerts had been received, disseminated and acted upon.

Management, monitoring and improving outcomes for people

Information about the outcomes of patients' care and treatment was collected and recorded electronically in individual patient records. The practice could provide no evidence of informal or formal clinical peer review and support to discuss issues and potential improvements in respect of clinical care. This included information about their assessment, diagnosis, treatment and referral to other services. The computer systems were not used effectively by all the clinicians and there was a heavy reliance on the medical secretary or other staff members to undertake clinical coding and to type up notes which were either dictated in person or via Dictaphone. As a result of this patient requests were not always being dealt with in a timely manner.

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 (2014/2015) were 90% of the total number of points available and the clinical exception was 10%. A practice's achievement payments, are based on the number of patients on each disease register, known as 'recorded disease prevalence'. In certain cases, practices can exclude patients which is known as 'exception reporting'. The non-validated QoF figures for 2015/2016 were 72%. This was in line compared to the Locality average of 74% and the CCG average of 80%.

This practice was an outlier for several QOF and other national clinical targets. Data from 2014/2015 showed:

- The percentage of patients on the diabetes register, in whom the last IFCC-HbA1c was 64 mmol/mol or less was 71% compared to the local figure of 77% and the national figure of 78%.14% of patients had been excepted.
- The percentage of patients with diabetes, on the register, who had an influenza immunisation was 89% compared to the local figure of 95% and the national figure of 94%.19% of patients had been excepted.
- The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who had a comprehensive, agreed care plan documented in the record was 48% compared to the local figure of 88% and the national figure of 89%. 5% of patients had been excepted, which was lower than average.

The practice explained that medical staffing issues were a major contributor to the low QoF figures and were trying to recruit medical staff into substantial positions. They had so far been unsuccessful and were heavily reliant on locum GPs to cover clinical sessions. This reduced the practice's overall effectiveness.

The practice had an audit register and a number of small audits had been undertaken such as a review of patients on

Inadequate

Are services effective?

(for example, treatment is effective)

Lithium medicines and a review of patients on Domperidone. When identified, information about patients' outcomes was used to make changes such as new protocols to reduce the reoccurrence of significant events. However, we found repeats of the same issues despite this intervention.

Effective staffing

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

- The practice had an induction programme for all newly appointed staff. This covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality. No new staff had been recruited in the last six months.
- The practice could demonstrate how they ensured role-specific training and updating for relevant staff. For example the nursing staff and health care assistant had the required knowledge to administer vaccines and take samples for the cervical screening programme. They had received specific training which included an assessment of competence. Staff who administered vaccines could demonstrate how they stayed up to date with changes to the immunisation programmes, for example by access to on line resources and discussion at practice meetings.
- The learning needs of other staff were identified through a new system of appraisal and all staff had recently received an appraisal.The GP who had conducted the appraisals for the nursing staff and the practice manager had now left the practice, and there was no plan in place to ensure that any issues and/or identified training needs would be met.
- Administration and nursing staff had access to appropriate training to meet their learning needs and to cover the scope of their work. A new on-line education system had been introduced and two hours of protected learning time per week had been introduced.The training included safeguarding, fire safety awareness, basic life support and information governance.
- Other training needs such as conflict resolution, good customer service and medicines management had been identified through significant events and complaints that had been recorded.Despite this we found that issues were repeated and we were told of continual complaints that had not been recorded.
- There was not enough substantive medical staff to cover the contractual requirements of the practice and they were heavily reliant on locum staff. Where locum staff could not be secured the lead GP would cover the sessions.

Coordinating patient care and information sharing

The full information needed to plan and deliver care and treatment was not completed in patient records.

- There were care plans in place for most conditions but these were only being utilised by the nursing staff and health care assistant.We were informed care plans required by patients over 75 years of age had recently commenced with consultations taking place by the health care assistant.
- No documented care plans had been developed for patients with mental health issues. Coding errors had resulted in a patient receiving a dementia related care plan when they did not have dementia.
- One of the GPs was unable to evidence any end of life care plans stating that there were no patients currently on the plan. This was inconsistent to information from received from other staff.
- A system was in place for hospital discharge letters and specimen results to be reviewed by a GP who would initiate the appropriate action in response.
- Risk assessments and patient profiling were not maintained by clinicians. Although clinical meetings were in place, they were not regular enough and did not include GP locum staff. The practice shared relevant information with other services but not always in a timely way, such as when referring patients to other services, where there had been delays resulting in significant events.
- We were told that clinicians from other multi-disciplinary teams such as health visitors, McMillan Nurses and community matrons could attend meetings if they wanted to.

Consent to care and treatment

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

- < >taff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005.

Inadequate

Are services effective?

(for example, treatment is effective)

When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance.

- Where a patient's mental capacity to consent to care or treatment was unclear the GP or practice nurse assessed the patient's capacity and, recorded the outcome of the assessment.

Supporting patients to live healthier lives

The practice identified patients who may be in need of extra support but did not always take the required action. For example, when we asked one of the GPs about care plans and treatment of patients in the last 12 months of their lives they could not produce any care plans. They said they had no patients on the plan at present. Action from a significant event that happened in January 2016 was to consider an audit after 6 months to check that all staff were aware of every patient who was identified as dying at home. This had not been done.

There was a register of patients on palliative care and a "watch list" but there was no evidence that these patients were being "watched" as there were no alerts on the system to identify them and no care plans in place.

There was a register with 74 patients who were at risk of unplanned admissions. Care plans were in place and were reviewed by the nursing staff but they were not utilised or updated by the medical staff. Patients with learning disabilities had had a clinical review within the last twelve months. There were 21 patients on the register and the register was maintained by the nursing team.

The practice's uptake for the cervical screening programme had improved but was still well below the local and national averages at 58% (CCG and national average 74%). The nursing staff were pro-actively following up patients to improve the uptake. The nurses were also monitoring any inadequate results and following those up.

The uptake for bowel and breast cancer screening was very low. Females aged 50-70 screened for breast cancer in the last 3 years was 55% compared to the local average of 68% and the national average of 72%. Persons screened for bowel cancer in the last three years was 38% compared to the local and national average of 58%. There was no evidence that the practice were doing anything about this.

Cervical cancer screening

Childhood immunisation rates for the vaccinations given were comparable to CCG/national averages. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 91-97% and five year olds from 83-96%. The CCG averages were 95-99% and

92-96% respectively.

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

At our inspection of 10th November 2015 the practice were rated Good for caring. The staff at the practice were very caring and were providing a responsive service for the population groups which were associated with their practice such as patients with mental health problems. Data showed that patients rated the practice higher than others for some aspects of care such as care and treatment offered by the nurse at the practice. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information for patients about the services available was easy to understand and accessible. We also saw that staff treated patients with kindness and respect, and maintained confidentiality. At the inspection on 30th August 2016 we found that the practice had deteriorated in caring and required improvement. Patient privacy was not being maintained, survey results were worse than they had been before and the practice were not doing enough to identify and support carers.

At this inspection we found :

Kindness, dignity, respect and compassion

We observed members of staff being courteous and very helpful to patients in difficult circumstances. However, we received information from some patients we spoke to that this was not always the case.

- Although reception were aware that patients could be taken to a private room to discuss matters, this was rarely done due to time constraints or staffing arrangements.We overheard difficult and/or private conversations taking place in reception between staff and patients in front of other patients. We were also told about difficult and/or private conversations being overheard by other patients.
- 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.

We received 22 patient Care Quality Commission comment cards. 16 of those were positive about all aspects of the service experienced. Six cards had comments where patients expressed dissatisfaction about the GPs and/or reception staff.

We spoke with six patients. Three of them were satisfied with the overall service. All of them mentioned issues with regards to privacy at reception. Three were dissatisfied with the care or treatment provided and also with the responses offered when they complained. We spoke to a member of the patient participation group. They told us that the group were engaged with the practice and received information about the services and asked for suggestions for improvement.

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

- 76% of patients said the GP was good at listening to them compared to the clinical commissioning group (CCG) average of 90% and the national average of 89%. This was less than the previous year's results of 87%.
- 79% of patients said the GP gave them enough time compared to the CCG average of 88% and the national average of 87%. This was less than the previous year's results of 87%.
- 91% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 96% and the national average of 95%. This figure had not changed.
- 78% of patients said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 86% and the national average of 85%. This was less than the previous year's results of 82%.
- 83% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 92% and the national average of 91%. This was less than the previous year's results of 90%.
- 87% of patients said they found the receptionists at the practice helpful compared to the CCG average of 89% and the national average of 87%. This was less than the previous year's results of 90%.

Requires improvement

Are services caring?

The patient survey results had not been discussed at the patient participation group to ask for ways in which the patients might effect improvement.

Care planning and involvement in decisions about care and treatment

Some patients we spoke with told us they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them. Three of the patients said the GPs seemed disinterested in their views and they felt they were not receiving the appropriate treatment. Patient feedback from the comment cards was also mixed and aligned with these views.

Results from the national GP patient survey showed patients views were mixed when responding to questions about their involvement in planning and making decisions about their care and treatment. Results were lower than local and national averages. For example:

- 84% of patients said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 86% and the national average of 86%. This figure had not changed.
- 75% of patients said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 83% and national average of 82%. This was better than the previous results of 74%.
- 76% of patients said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average of 86% and national average of 85%

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

- Staff told us that translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patients this service was available.We were also told that relatives were regularly used to assist with translation because it was difficult to book translators when appointments were emergency or “sit and wait”.
- Information leaflets were available in easy read format and could be printed in different languages if required.One of the GPs and the health care assistant spoke some of the preferred languages of the patients.
- We saw that there was an appointment checking-in system available in ten different languages.Unfortunately the system was not utilised and patients still came to the reception desk when arriving for their appointments.This caused unnecessarily long queues at reception and patient confidentiality issues.

Patient and carer support to cope emotionally with care and treatment

There was a good selection 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.

The computer system did not alert the GPs if a patient was also a carer and therefore they could not be pro-actively offered assistance when they attended for treatment. 20 patients had been identified as having a carer and were coded as vulnerable patients. The GPs spoken with said that they did not pro-actively identify carers during consultations. The practice manager, nurses and health care assistant said that they asked patients if they were carers. 10 patients had been identified as being carers which was 0.17% of the practice population.

Staff told us that if families had suffered bereavement they received support in the way of telephone consultations and information about other services available to them. One of the patients we spoke to said they had received excellent support recently when they experienced bereavement.

Inadequate

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Our inspection of 10th November 2015 found the practice to be inadequate for responsive services. Although the practice had reviewed the needs of its local population, it did not have a plan to secure improvements for all of the areas identified. For example there was a large number of patients with mental health problems which the practice responded to, but this had not been discussed with the Clinical Commissioning Group to secure improvements. Patients responded differently when asked about making appointments. Some patients said they could easily make an appointment with a GP of their choice but when they got to the surgery there were long waiting times. Information about how to complain was available if required. Learning from complaints was not consistently shared and reviewed to ensure it was effective. There was evidence that the same issues kept arising despite changes to protocol. The practice manager was the person responsible for handling complaints but staff did not fully understand how to process informal concerns from patients. At the inspection on 30th August 2016 we found that the practice remained inadequate for providing responsive services.

At this inspection we found :

Responding to and meeting people's needs

The practice was engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Areas identified included staffing issues and a possible move to new premises.

To meet the demands of the population the practice told us they offered :

- The practice offered a "Sit and wait" sessions on a daily basis.
- Longer appointments for patients that needed them.
- Home visits when required.
- Emergency appointments for children and those patients with medical problems that require same day consultation.
- Travel vaccinations available on the NHS. Patients were referred to other clinics for vaccines available privately such as yellow fever.
- There were disabled facilities, a hearing loop and translation services available.
- A lift for patients with difficulty to reach the upstairs rooms.
- An email service to request prescriptions.

Access to the service

The surgery opening times were listed as 8am to 7.30pm on Mondays, Tuesdays, Thursdays and Fridays, closing between 1pm and 2pm for lunch. On Wednesdays the surgery opened at 8.30am until 12.30pm and did not re-open that day. On Saturdays and Sundays the practice was closed. When the practice was closed the patients were directed to the Out of Hours Services. The practice tried not to turn any patients away and sometimes appointments were booked when the reception or surgery was closed. There was an emergency "sit and wait" facility each day and extended morning hours were offered on a Tuesday and Thursday morning with appointments from 7.30am.

Patients did not routinely use on line services to book appointments and there was no practice website.

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

- 83% of patients were satisfied with the practice's opening hours compared to the local average of 77% and national average of 78%.
- 82% of patients said they could get through easily to the practice by phone compared to the local average of 79% and national average of 73%.

Responses from the seven patients we spoke with on the day were mixed with two saying it was easy to get an appointment when they wanted it and the others finding it very difficult to get through to the practice on the telephone.

The system to assess whether a patient required a home visit was not clear. There were telephone consultations available and we were told that patients always received a call back if there was any doubt. There were home visit appointment slots available each day. We were told of examples where staff had correctly identified that a patient should access accident and emergency rather than coming in to the surgery. We also had evidence that the number of patients attending A&E between April 2015 and March 2016 was 430. This was higher than the local average of 419 and CCG average of 374.

Inadequate

Are services responsive to people's needs?

(for example, to feedback?)

Data we held also showed that more patients from this practice (95) had a face to face or telephone contact with the out of hours services. This was higher when compared with the CCG average of 76.

The practice was commissioned to provide 21 clinical and 4 administration sessions per week. There was not enough medical staff to ensure that these sessions were continually covered on a week by week basis. Administration staff told us that they found it difficult to manage the appointment system because they did not always know far enough in advance whether a doctor would definitely be available to cover the sessions. This meant it was not always possible to book appointments in advance. One of the salaried GPs covered three sessions, a long-term locum covered two sessions and the lead GP covered three to nine sessions (dependant on whether locums were available). The remaining ten sessions were covered either by the lead GP or by locum GPs.

Listening and learning from concerns and complaints

The practice did not have an effective system in place for handling complaints and concerns.

- The complaints policy and procedure was in line with recognised guidance and contractual obligations for GPs in England but it was not being followed.
- The practice manager appeared to be the responsible person who handled all complaints in the practice. If they were unable to deal with them they delegated action to the lead GP. There was evidence that the required action was not always taken.
- There was information to help patients understand the complaints system but the practice did not encourage and record verbal complaints in a way that they could be discussed and analysed to ensure that they were not repeated.

We looked at a summary of eight complaints that had been recorded between January and June 2016. We saw that:

- They were discussed within the practice and action was identified and we saw evidence that some action, such as staff training, was undertaken.
- We saw repeated issues had been raised to the practice with no plan to resolve these issues.
- There was no evidence that all patients that complained received a satisfactory response.We spoke to patients who had made a complaint and were not happy with the response.
- The lead GP told us that there was only one "on-going" complaint. However we were made aware of three complaints that had recently been received. These complaints were about repeated issues and had not yet been discussed although a meeting had been planned at the request of the practice manager.

Are services well-led?

Inadequate

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

Our findings

Our inspection of 10th November found the practice to be inadequate for Well Led. The leadership structure was fragmented and the GPs worked in isolation. However, there was new and impressive leadership coming from the one of the newly appointed partners and improvements were being made. There was a vision to provide responsive, effective, safe and well led care, and the values of staff were in line with that vision, but lack of effective leadership made that impossible to sustain. Staff felt supported by management and listened to, but unable to effect change. The practice had a number of policies and procedures to govern activity, most of which were overdue a review. Feedback from patients had recently been initiated by way of a patient participation group (PPG) and work to develop that relationship was in its initial stages. The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. However, staff did not have access to appropriate training to meet those needs. At the inspection on 30th August 2016 we found that the practice remained inadequate for being well led.

At this inspection we found :

Vision and strategy

The lead GP had a vision to deliver high quality care and promote good outcomes for patients and shared this expectation with the other staff. However there was no medical support to sustain this vision. The administration and nursing staff shared the vision but felt unable to effect change.

Governance arrangements

The overarching governance framework in the practice was weak and did not support the delivery of safe and effective clinical care. All the partners at the practice had either retired or were due to retire at the end of the year and there was no immediate solution for their replacement other than locum GPs. The lead GP remained with overall responsibility for all clinical and business decisions. A new governance structure and new policies and procedures had been introduced by one of the new partners the previous year. This partner had now left and since then the structure had not been maintained throughout the practice despite the efforts of the practice manager to continue what had been started. The practice had been unable to evidence that the new system was being used and was effective.

- There was a staffing structure in place and staff were aware of their own roles and responsibilities.
- The lead GP was responsible for all lead areas within the practice. This included safeguarding, clinical support, appraisal, training, significant events, risk management, audit and overall decision making. This was in addition to their clinical duties, and cover for any clinical sessions that could not be met by locum staff.
- Whilst a system of clinical audit was in place there was a lack of internal checks and audits to monitor the quality of the services and a lack of clinical and medical staff to carry out clinical audits.Where issues were identified there was a lack of action taken to make improvements.
- Arrangements for monitoring risks were not effective.

Leadership and culture

The lead GP did not share the concerns of CQC about the risks in relation to the practice and maintained that risks were well managed and controlled. Staff told us the partners were approachable and always took the time to listen to all members of staff. However, they felt that action was not always taken to make improvements. Although there were two partners at the practice we were told that one was salaried, and only the lead GP had the authority to make decisions.

The practice did not always support people who complained, and did not deal with complaints in an open and transparent way. Not all patients who had complained received reasonable support, information about what went wrong and why, and a verbal and/or written apology. Complaints were not encouraged so that they could be analysed in an open way to reduce repeated issues.

There was a clinical structure in place and staff said they felt supported. Lines of communication had improved and administration staff specifically felt more empowered having received protected learning time and better training to help them in their role.

- Staff told us the practice had started to hold regular team meetings.

Are services well-led?

Inadequate

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

- Staff told us there was an open culture within the practice and they had the opportunity to raise any issues and felt confident in doing so.
- Staff said they felt respected, valued and supported by the partners in the practice.

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

The practice said they encouraged and valued feedback from patients, the public and staff.

- They had gathered feedback from patients through the patient participation group (PPG) and through surveys and complaints received. The PPG met regularly, and received information about the practice but we did not see anything to evidence any improvements had been brought about because of feedback from this group. The group were not entirely representative of the patient population because there was no website to display information and present minutes from meetings.
- We spoke to members of the PPG who told us that they felt unable to help the practice and unable to effect change.
- The practice had gathered feedback from staff through a recent survey and had identified that staff satisfaction had improved. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management, although they said action was not always taken to change things.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect **How the regulation was not being met:** The practice did not ensure that patient privacy was maintained at all times. **Regulation 10(1)**

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints **How the Regulation was not being met:** Complaints were not always responded to and appropriate action was not always taken to come to a satisfactory resolution. Patients did not always receive support , appropriate information and a verbal and/or written apology. **Regulation 16(1) and (2)**

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **How the Regulation was not being met:** Although the practice had introduced adequate policies and procedures, and systems to manage risk they were not sufficiently embedded and consistently followed to ensure that patients were kept safe.

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **How the regulation was not being met:** There was not enough substantive medical staff to cover all the clinical sessions and ensure continuity and safe care for patients. The practice manager did not receive appropriate support, training, professional development and supervision to enable them to carry out the duties they were employed to perform. **Regulation 18(1) and (2)**

The practice did not have effective systems or processes in place for clinical review and care planning or patient profiling. This was evident in relation to patients receiving palliative care and carers.

Clinical IT systems were not used effectively to identify patients with in need of extra support.

Systems to manage medicines were not maintained and effective to keep patients safe. We identified continuing issues relating to prescription errors, with no suitable arrangements in place for the safe monitoring of Hypnotic medicines, Non-Steroidal anti-inflammatory drugs and antibiotics.

The system to disseminate patient safety alerts was not effective.

Significant events were not dealt with appropriately and action was not taken in a timely manner to prevent repeated issues. There was no responsible person with appropriate authority who ensured that action was taken when things went wrong.

Regulation 17(1) and (3)

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.