Oulton Medical Centre

Quality Report

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

Ratings

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

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We visited Oulton Medical Centre on 2 March 2015 and carried out an announced responsive, comprehensive inspection. The provider had previously been inspected on 22 August 2014 and we were following up to see if improvements had been made.

The overall rating for this practice is inadequate. We found that the practice required improvements in order to provide a caring service. We found the practice was inadequate for providing a safe, effective, responsive and well led service.

We examined patient care across the following population groups: older people; those with long term medical conditions; mothers, babies, children and young people; working age people and those recently retired; people in vulnerable circumstances who may have poor access to primary care; and people experiencing poor mental health. We found the provider required improvement for caring for each of these population groups. They were rated as inadequate for safe, effective, responsive and well led. The concerns which led to these ratings apply to all the population groups.

Our key findings were as follows:

- Patients told us they were involved in their care and treatment and were satisfied with the care and treatment that they received from the practice. However we were made aware of concerns by NHS England in relation to the quality of the clinical care provided.
- Some patients were satisfied with the appointment system. Some patients reported that it was difficult to get through on the telephone and some patients were dissatisfied with the length of time they waited after arriving for their appointment. Patients at Marine Parade Surgery (branch site) told us they were not satisfied that they could not pre book appointments there and that they had arrived for an appointment, to be told it was at the other practice location.

Summary of findings

- The two GP partners were working hard to cover Oulton Medical Centre and the branch surgery Marine Parade Surgery. The practice had been unable to recruit a permanent GP which placed many demands on the two GP partners.
- The practice had no clear leadership structure, insufficient leadership capacity and limited formal governance arrangements.
- There were inadequate processes to ensure patient information was accurately coded, which meant that patients may be at risk of not receiving appropriate care and treatment. Patient correspondence was not always reviewed by a GP.
- There were limited systems in place to monitor and ensure the safety of the service provided to patients, staff and visitors. There was a risk to staff and patients where a surgery was open for patients to attend and no clinical cover was provided.
- The majority of staff reported feeling unsupported and had not received an induction, training or an appraisal.

There were areas of practice where the provider needs to make improvements.

The provider must:

- Implement effective systems for the management of risks to patients and others against inappropriate or unsafe care. This should include arrangements for managing significant events, safety alerts, health and safety, fire safety and staff safety.
- Ensure that robust arrangements are in place for the effective recruitment of staff.
- Ensure that processes are in place for sharing the learning from significant events and complaints with all staff.
- Ensure that there is an appropriate standard of cleanliness at the practice, with documented checks of the cleaning that is undertaken. Infection control audits need to be undertaken, with actions identified and completed. Actions from the legionella risk assessment must also be implemented.
- Ensure that effective information governance processes are in place. This includes ensuring that that all patient correspondence is reviewed by a GP and actioned in a timely way and that clinical coding of patients is accurate.
- Ensure that records relating to the undertaking of the regulated activity can be located promptly when required. This includes for example training records, clinical meetings, infection control audits.
- Ensure that staff are supported, with inductions being completed for new staff and appropriate training and appraisals completed for all staff.
- Ensure there are sufficient numbers of clinical staff when the surgery is open for patients to attend.

In addition the provider should:

- Ensure that policies and procedures are up to date and reviewed regularly.
- Ensure that effective processes are in place to check emergency medicines and equipment and refrigerator temperatures when the staff member who normally does this is not at work.

On the basis of the ratings given to this practice at this inspection, I am placing the provider into special measures. This will be for a period of six months. We will inspect the practice again in six months to consider whether sufficient improvements have been made. If we find that the provider is still providing inadequate care we will take steps to cancel its registration with CQC.

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. Staff were aware of the reporting process for incidents and concerns but some staff told us they were discouraged from raising them. Although there was some evidence that the practice completed a review when things went wrong and identified lessons learned, these were not shared with the practice team so that safety was improved. Patients were at risk of harm because no processes were in place to keep them safe. This included managing safety alerts, health and safety, fire safety, staff safety and recruitment of staff. There was a risk to staff and patients where a surgery was open and no clinical cover was provided. A patient with urgent care needs might attend, expecting to be seen by a clinician. Given that the surgery at times had no clinical cover for a morning or afternoon period of time, there was a significant risk that a patient's condition could deteriorate considerably. Patient correspondence was not always reviewed by a GP. There was insufficient information to enable us to understand and be assured about safety because the process for continuous monitoring and improvement could not be evidenced.

Are services effective?

Inadequate

The practice is rated as inadequate for effective. Data showed that patient outcomes vary, with some being below and some being average for the locality. National Institute for Health and Care Excellence (NICE) guidance was referenced and used routinely. NICE is the organisation responsible for promoting clinical excellence and cost-effectiveness and producing and issuing clinical guidelines to ensure that every NHS patient gets fair access to quality treatment. This included assessment of capacity and the promotion of good health. There was evidence of multidisciplinary working. The majority of staff had not received an induction and training appropriate to their role. One member of staff had received an annual appraisal and development plans for staff were not in place.

Are services caring?

Requires improvement

The practice is rated as requires improvement for caring. Nationally reported data showed patients rated the practice lower than others for several aspects of care, however some patients we spoke with did speak positively about the practice. Some patients said they were treated with compassion, dignity and respect and they were involved in care and treatment decisions. Accessible information was provided to help patients understand the care available to

Summary of findings

them. We also observed that staff treated patients with kindness and respect. Although the practice told us they supported bereaved patients, we saw two complaints where patients had not felt supported at this time.

Are services responsive to people's needs?

Inadequate

The practice is rated as inadequate for providing responsive services. Although the practice was aware of the needs of its local population, it did not have the capacity or plans to secure improvements. Feedback from patients indicated that they were able to obtain appointments and that they would be seen the same day. However there was dissatisfaction from some patients that it was not always easy to get through on the telephone and there was often a wait to be seen after their appointment time. Patients at Marine Parade Surgery reported that they were not able to make advance appointments at this site.

Complaints leaflets were not easily available for patients and had to be requested from reception. There was evidence that ten of the eleven complaints we looked at had been appropriately investigated and responded to. However in some cases, this was following intervention by NHS England.

Are services well-led?

Inadequate

The practice is rated as inadequate for being well-led. It did not have a clear vision and strategy. Staff we spoke with were not clear about their role in achieving the goals of the service. The leadership and management structure of the practice was not clear and effective governance processes were not in place. The majority of staff reported feeling unsupported and had not received an induction or training to undertake their role effectively or an appraisal. Systems to support staff development and training were not in place. Practice meetings, including staff meetings and governance meetings were not established and there was limited evidence of a learning culture. The practice missed opportunities to seek feedback from staff. The patient participation group (PPG) had recently been re-established and were not able to give recent examples of where the practice had responded to their feedback.

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

Patients over the age of 75 had a named GP who was responsible for the coordination of their care. Home visits were available to older patients who were unable to attend the practice. Longer appointments were available when needed. The provider was rated as requires improvement for caring and this includes for this population group. The provider was rated as inadequate for safe, effective, responsive and well led. The concerns which led to these ratings apply to everyone using this practice, including this population group.

People with long term conditions

Inadequate

All patients with long term conditions had annual reviews and were called into the practice to be seen by a GP to check their health and medication needs were being met. Separate clinics were not held and these appointments were made during GP usual consultation times. Nationally reported data showed that outcomes for patients with long term conditions were mixed. Longer appointments and home visits were available when needed. The provider was rated as requires improvement for caring and this includes for this population group. The provider was rated as inadequate for safe, effective, responsive and well led. The concerns which led to these ratings apply to everyone using this practice, including this population group.

Families, children and young people

Inadequate

Appointments were available outside of school hours. The premises were suitable for families, children and young people because there was easy access to the waiting room and consultation rooms. There was also a children's play area and baby changing facilities were provided. The provider was rated as requires improvement for caring and this includes for this population group. The provider was rated as inadequate for safe, effective, responsive and well led. The concerns which led to these ratings apply to everyone using this practice, including this population group.

Working age people (including those recently retired and students)

Inadequate

Appointments at Marine Parade Surgery could not be pre booked by all patients. This was only available for those patients aged over 60. Patients we spoke with told us that they found this unsatisfactory as this made it difficult to plan ahead. Extended hours appointment were available on Tuesday evenings until 8.00pm, on an alternating

Summary of findings

basis at each site and these could be pre booked. Appointments and repeat prescriptions could be booked online. A range of health promotion and screening that reflects the needs for this age group was available. The provider was rated as requires improvement for caring and this includes for this population group. The provider was rated as inadequate for safe, effective, responsive and well led. The concerns which led to these ratings apply to everyone using this practice, including this population group.

People whose circumstances may make them vulnerable

Inadequate

The practice held a register of patients with a learning disability and 59% of these patients had received an annual health check. Longer appointments were offered for people with a learning disability. A process was in place to follow up vulnerable patients if they did not attend for their appointment. 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. The provider was rated as requires improvement for caring and this includes for this population group. The provider was rated as inadequate for safe, effective, responsive and well led. The concerns which led to these ratings apply to everyone using this practice, including this population group.

People experiencing poor mental health (including people with dementia)

Inadequate

There was an effective system in place for controlling medicine prescribing for patients with substance abuse and medication misuse needs. A process was in place to follow up patients experiencing poor mental health, including people with dementia if they did not attend for their appointment. 61% of people with dementia had received an annual physical health check. The provider was rated as requires improvement for caring and this includes for this population group. The provider was rated as inadequate for safe, effective, responsive and well led. The concerns which led to these ratings apply to everyone using this practice, including this population group.

Summary of findings

What people who use the service say

We spoke with nine patients during our inspection. All of the patients we spoke with informed us they were involved in decisions about their care and treatment and were satisfied with the clinical care provided. Most of the patients told us that they were able to get an urgent appointment, although three patients reported difficulty in getting through to the practice by telephone to make an appointment. Three patients we spoke with told us that they had to wait a long time to see the GP once they had arrived for their appointment and one patient felt that an apology would be appropriate. Two patients we spoke with at Marine Parade Surgery were dissatisfied with not being able to book appointments in advance. One patient reported that they had attended for an appointment and were informed that this was at the other practice.

We collected eight Care Quality Commission comment cards from a box left in the practice two days before our inspection. The majority of the comments on the cards were positive about the practice. Patients reported that all the staff were friendly and helpful and they were happy with the care that they received. One patient had mainly positive comments but also commented negatively on the length of wait to be seen, after the allocated appointment time. Another patient was dissatisfied as they stated their registration information had been lost and they have had repeated difficulty getting through on the telephone.

Areas for improvement

Action the service MUST take to improve

- Implement effective systems for the management of risks to patients and others against inappropriate or unsafe care. This should include arrangements for managing significant events, safety alerts, health and safety, fire safety and staff safety.
- Ensure that robust arrangements are in place for the effective recruitment of staff.
- Ensure that processes are in place for sharing the learning from significant events and complaints with all staff.
- Ensure that there is an appropriate standard of cleanliness at the practice, with documented checks of the cleaning that is undertaken. Infection control audits need to be undertaken, with actions identified and completed. Actions from the legionella risk assessment must also be implemented.
- Ensure that effective information governance processes are in place. This includes ensuring that that all patient correspondence is reviewed by a GP and actioned in a timely way and that clinical coding of patients is accurate.
- Ensure that records relating to the undertaking of the regulated activity can be located promptly when required. This includes for example training records, clinical meetings, infection control audits.
- Ensure that staff are supported, with inductions being completed for new staff and appropriate training and appraisals completed for all staff.
- Ensure there are sufficient numbers of clinical staff when the surgery is open for patients to attend.

Action the service SHOULD take to improve

- Ensure that policies and procedures are up to date and reviewed regularly.
- Ensure that effective processes are in place to check emergency medicines and equipment and refrigerator temperatures when the staff member who normally does this is not at work.

Oulton Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC lead inspector and a GP specialist advisor. The team also included a practice manager specialist advisor, a CQC inspection manager and an expert by experience (a person who has experience of using a range of health services).

Background to Oulton Medical Centre

Oulton Medical Centre, in the Great Yarmouth and Waveney Clinical Commissioning Group (CCG) area, provides a range of primary medical services to approximately 5300 registered patients living in Oulton and the surrounding villages. They have a branch surgery called Marine Parade Surgery, which is approximately three miles away.

According to Public Health England information, the patient population has a slightly lower number of patients under 18 compared to the practice average across England. It has a slightly higher proportion of patients aged 65 and over, aged 75 and over and aged 85 and over, compared to the practice average across England. Income deprivation affecting children and older people is slightly higher than the practice average across England. A slightly lower percentage of patients have a caring responsibility and a slightly higher percentage of patients have a long standing health condition compared to the practice average across England.

There are two GP partners, one male and one female who hold financial and managerial responsibility for the practice. The practice employs a GP locum for half a day per week, on a Wednesday afternoon, who alternates between the two sites. A locum emergency care practitioner has very recently started and works 8am to 4pm, two days a week, under the supervision of the GP who is working that day. There is one health care assistant, who works 9am until 1pm, four days a week and alternates between the sites. There are also five administration/ reception staff, 1 medical secretary and one administrator/ note summariser/relief medical secretary and a practice manager.

The practice operates weekdays between the hours of 8am and 6.30pm, with extended hours until 8pm on Tuesdays, alternating between the two sites. Outside of practice opening hours a service is provided by another health care provider (South East Health) by patients dialling the NHS 111 service.

We previously inspected this location on 22 August 2014 and found they were not meeting the Health and Social Care Act Regulations (2008) in relation to assessing and monitoring the quality of service provision, requirements relating to workers and complaints.

Why we carried out this inspection

We inspected this service as we had received information of concern which indicated that patients may be at risk. We carried out a responsive inspection of this service under Section 60 of the Health and Social Care Act 2008 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, to update on previous non-compliance with the Health and Social Care Act 2008 Regulations and to provide a rating for the service under the Care Act 2014.

Detailed findings

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

Before our inspection, we reviewed a range of information we held about the practice and other information that was available in the public domain. We also reviewed information we had received from the service and asked other organisations to share what they knew about the service. We talked to the local Clinical Commissioning Group (CCG), the NHS local area team and Healthwatch. The information they provided was used to inform the planning of the inspection. We were informed by the NHS local area team of concerns about the quality of care provided by the practice. We looked at a small selection of patient records, however our remit is not to investigate clinical decisions made by individual practitioners. We were reassured that the NHS local area team were undertaking further investigation.

We carried out an announced visit on 2 March 2014. We visited Oulton Medical Centre and the branch surgery, Marine Parade Surgery based at the Kirkley Mill Health Centre. During our visit we spoke with a range of staff, including the two GP partners, a health care assistant, reception and administration staff and the practice manager.

We spoke with two members of the patient participation group (PPG). PPGs are a way for patients and GP surgeries to work together to improve services, promote health and improve quality of care. We also spoke with nine patients who used the practice. We reviewed eight comments cards where patients had shared their views and experiences of the practice. We reviewed the treatment records of patients in order to effectively judge whether the care and treatment that patients received was safe and effective.

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 are provided for specific groups of people and what good care looks 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 living in vulnerable circumstances
- People experiencing poor mental health (including people with dementia)

Inadequate

Are services safe?

Our findings

Safe track record

Systems and processes to identify risks and improve patient safety were not robust. Not all practice staff were aware of how to report safety incidents and near misses that occurred. We found there was a culture of staff not being encouraged to report significant events. Three members of staff told us that they were discouraged from reporting significant events. Safety alerts were not passed onto staff in a systematic manner. There was no evidence of shared learning internally or externally.

We saw evidence of five significant events which had been recorded from August 2014 to December 2014. We found that three of these significant events had been completed following external prompting through the contract monitoring process. The two GPs we spoke with demonstrated a limited understanding of significant events and their definition was limited, as it included only clinical significant events with a focus on complaints based issues. The significant events we viewed were documented on an appropriate template and had been discussed by the GPs and nurse. One of these related to prescribing a medicine without following the correct monitoring protocol.

There were no records available to show how safety incidents had been managed at the practice over the long term.

Learning and improvement from safety incidents

One of the significant events that we looked at related to prescribing a medicine without following the correct monitoring protocol. Once this had been highlighted, patients on these types of medicines were identified and alerts put on their record to ensure the correct monitoring protocols were followed. We checked a sample of patient records and found that the correct monitoring protocols were being followed.

We saw evidence that the GPs responded to patient safety alerts although the system for disseminating safety information among staff and ensuring any action required was undertaken, was not robust. Patient safety alerts are issued when potentially harmful situations are identified and need to be acted on. Safety alerts were printed off but there was no process for checking that these had been seen and actioned appropriately.

Information that was made available to us did not demonstrate that systems were in place for staff to formally raise issues for consideration and learning. Systems for reporting, recording and monitoring significant events, incidents and accidents were not sufficiently robust to ensure shared learning by all staff.

There was no robust process to formally review actions from past significant events, safety alerts and complaints. There was limited evidence that the practice staff had learned from these as findings and learning was not shared with staff. We were told by the GPs that clinical meetings were held, however we only saw one record of a clinical meeting, in June 2014 and two records of a clinical governance meeting in October 2014 and February 2015. These did not show clear evidence of effective dissemination of safety issues or shared learning amongst the staff team.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We asked to see safeguarding training certificates during the inspection, but these were not provided to us. We asked members of staff about their most recent training. Some staff told us they had completed safeguarding training on line. Staff we spoke with knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also 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. Contact details were easily accessible.

The practice had an appointed GP lead in safeguarding vulnerable adults and children. We were told that they had been trained to level 3 in safeguarding children, which is the required level. We asked to be sent their certificate after the inspection, as this was not provided on the day. This was not sent to us. We were then told that although the training had been booked, the GP had not attended the training. The GPs we spoke with could demonstrate they had the knowledge to enable them to fulfil this role. Not all the staff we spoke with were aware who the lead GP was but all staff told us they would speak to one of the GPs in the practice if they had a safeguarding concern.

There was a chaperone policy, and notices informing patients of this service were displayed in the practice. (A

chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). We were told by the practice manager that reception/administration staff would not act as a chaperone. The reception/administration staff we spoke with did not confirm this. We spoke with three members of non-clinical staff who said they had undertaken chaperoning duties, had not been trained by the practice and were not clear of their responsibilities when chaperoning. For example, where to stand to be able to observe the examination. There was no evidence of chaperoning training in the seven staff files we looked at, or on the training monitoring tool that had recently been set up.

Medicines management

The NHS local area team are currently investigating some areas of concern regarding the prescribing of the GPs. Since the inspection visit, the NHS England local area team has commissioned an investigation conducted by several GPs which has identified several areas of significant concern relating to the care and treatment of patients. During our own inspection we did sample a small number of patient records and did not find any concerns. The NHS England investigation continues. However the seriousness of the early findings demonstrates a risk to patients.

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 policy for ensuring that medicines were kept at the required temperatures. Staff we spoke with were aware of the action to take in the event of a temperatures being outside of the accepted range. 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.

Cleanliness and infection control

We observed the premises to be clean and tidy. Patients we spoke with and comments we received highlighted that patients found the practice clean and had no concerns about cleanliness or infection control.

We were told by the practice manager that there were cleaning schedules in place and cleaning records were kept, but these were kept by the external cleaning company and were not on the premises. The practice manager told us that they completed a check of the general cleanliness of the building although this was not documented. There was no system in place to monitor and record the quality of the cleaning being undertaken.

The practice did not have an identified lead for infection control, as the nurse who was the lead for this had left the practice in November 2014. We asked to see the certificates for staff training for infection control on the day of the inspection but these were not provided. Staff we spoke with had a general knowledge around cleanliness and infection control.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, personal protective equipment including disposable gloves 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. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms.

We saw that an infection control audit had been undertaken by an infection prevention and control nurse, from the local CCG in May 2014 and the practice had achieved 83%. We noted that some of the areas for improvement from this audit had been completed. For example, notices about hand hygiene techniques were displayed in staff and patient toilets. There was no formal process in place where the areas for improvement had been identified and progress towards completion monitored.

We asked if any infection control audits had been undertaken by the practice and we were told that these had not been undertaken since the nurse lead for infection control had left.

The practice had a policy for the management, testing and investigation of legionella (a bacterium that can grow in contaminated water and can be potentially fatal). However there was no evidence to confirm the practice was carrying out regular checks in line with this policy to reduce the risk of infection to staff and patients.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly. The practice manager told us

that equipment was calibrated and tested for electrical safety and displayed stickers which confirmed that dates this had been undertaken. They confirmed that the calibration had taken place very recently and they were awaiting the certificate for this. We saw a certificate which confirmed that electrical safety testing had been undertaken and was next due on 25 October 2015. We saw that stickers had been put on equipment to show that they had been calibrated and tested for electrical safety.

Staffing and recruitment

Records we looked at did not contain evidence that there was a robust system in place to ensure appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, eligibility to work in the United Kingdom, references, qualifications, registration with the appropriate professional body and criminal records checks through the Disclosure and Barring Service.

We looked at the recruitment records for seven members of staff. The records contained some evidence of appropriate recruitment checks but this was limited to references and some staff had evidence of having a criminal record check through the Disclosure and Barring Service (DBS). The practice manager told us that historically they did not ask for photographic proof of identity or for confirmation of people's right to work in the UK. However, the management support that had recently been sourced for the practice were reviewing the recruitment arrangements.

Criminal records checks through the Disclosure and Barring Service (DBS) had not been completed for five staff members, which included two clinical staff. We were told by the practice manager that these were being requested. The practice had not undertaken any risk assessment in relation to the level of DBS checks required of the reception/administrative staff who undertook chaperoning duties. The level of DBS checks undertaken is dependent on the type of work and an enhanced DBS provides additional checks to help identify whether people are suitable to work with children and vulnerable adults. The practice manager told us they were in the process of arranging DBS checks for all staff.

We asked to see the practice recruitment policy during the inspection and this was not provided to us.

We found that the systems for checking the recruitment of locum staff were not robust. We were told that the practice were not responsible for checking the recruitment of locum staff as this was undertaken by another organisation. The practice was not able to provide assurance that appropriate recruitment checks had been undertaken. They did confirm that the locum GP was on the General Medical Council register and on the Performers List.

There was no evidence of robust assessment and monitoring of the practice's capacity to adequately meet patient need at all times. There were two GPs and a GP locum who worked half a day per week for 5300 patients on a split site practice. There was no practice nurse and a health care assistant worked from 9.00am until 1.00pm four days per week. A locum emergency care practitioner had very recently started and worked 8.00am to 4.00pm two days a week, under the supervision of the GP who was working that day. The practice also provided extended hours appointments from 6.30pm until 8.00pm every Tuesday, alternating between the two sites. There was some clear evidence of intermittent risk as the practice were not able to adequately provide GP cover to both sites. This was exacerbated during times of annual leave.

Some of the staff we spoke with told us there were not enough staff to maintain the smooth running of the practice and to keep patients safe. Due to the difficulties the practice had with GP recruitment, there were times when the practice was open and there were no clinical staff present. Some non-clinical staff told us that they were often called to come into work at late notice to provide cover.

Monitoring safety and responding to risk

The practice did not have systems in place to manage and monitor risks to patients, staff and visitors to the practice. There was no evidence that health and safety, fire or lone worker risk assessments were undertaken. Some of the staff we spoke with reported they felt vulnerable when working on their own at reception, when the GP was the only other member of staff in the building and would be undertaking consultations.

There was no evidence that risks to patients, staff and visitor were identified and there was no process in place for escalating these risks, if they were identified, in order for effective action to be taken.

Inadequate

Are services safe?

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. We were told that staff had attended training in basic life support at a shutdown afternoon event. We did not see the certificates for this training, but noted that the practice's own records showed that the majority of 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). Emergency medicines were also available in a secure area of the practice. When we asked members of staff, they all knew the location of the emergency equipment and medicines. Processes were in place to check whether emergency equipment and medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use. Records confirmed that these were checked regularly. However there were gaps in the records and we noted that this was when the staff member who usually undertook the checks was not at work.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Risks identified included for example loss of the computer system, loss of essential supplies, incapacity of GPs and power failure. The document also contained relevant contact details for staff to refer to. For example, contact details of the phone company to contact if the phone lines were not working. Staff contact details were also available. A copy of this was kept off site by the practice manager and the GPs.

The practice had not carried out a fire risk assessment. There were some notices which detailed the action to take in the event of a fire, however there was no evidence of practice fire drills or documented testing of fire equipment. There were no records to show that staff were up to date with fire training. Staff we spoke with had a limited understanding of what to do in the event of a fire. One member of staff was identified as a fire marshal and they had completed training to undertake this role, but this was organised and paid for by themselves.

Inadequate

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The NHS local area team are currently investigating some areas of concern regarding the effective needs assessment. Since the inspection visit, the NHS England Area Team has commissioned an investigation conducted by several GPs which has identified several areas of significant concern relating to the care and treatment of patients. The NHSE investigation continues. However the seriousness of the early findings demonstrates a risk to patients.

We found that there was no process in place for disseminating new NICE guidelines and discussing the implications for the practice's performance. NICE is the organisation responsible for promoting clinical excellence and cost-effectiveness and producing and issuing clinical guidelines to ensure that every NHS patient gets fair access to quality treatment.

The GPs we spoke with told us they used national standards for the referral of patients with suspected cancers to be seen within two weeks. We looked at six randomly selected patient records, where patients had a two week wait referral covering a six month period. We did not find any concerns with the clinical decision making in relation to these referrals.

Discrimination was avoided when making care and treatment decisions. 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

GPs in the practice undertook minor surgical procedures in line with their registration under the Health and Social Care Act 2008 and National Institute for Health and Care Excellence (NICE) guidance. We found that GPs who undertook minor surgical procedures were appropriately trained and kept up to date with their knowledge. They also regularly carried out clinical audits on their results and used that in their learning.

The practice showed us three clinical audits that had been undertaken in the last year. These were all two cycle audits, where the practice was able to demonstrate the changes resulting since the initial audit. One of these audits related to minor surgery and found no significant issues in terms of complications. The practice used the findings to implement improved monitoring processes which further reduced post-surgery infection rates. A further clinical audit showed that the practice has reassured itself that no significant complications resulted from coil insertion. The practice had improved its monitoring and follow up of patients with atrial fibrillation. (Atrial fibrillation is a heart condition that causes an irregular and often abnormally fast heart rate.)

The practice also used the information they collected for the Quality and Outcomes Framework (QOF) and their performance against national screening programmes to monitor outcomes for patients. Quality and Outcomes Framework (QOF) is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions e.g. diabetes and implementing preventative measures. The results are published annually. The QOF data showed that the practice were below the CCG and England average for clinical results. They were above the CCG, but below the England average for public health results. In relation to quality and productivity and patient experience they were the same as the CCG average and above the England average.

This practice was below average when compared with the CCG for the percentage of patients with diabetes, on the register, who have a record of an albumin: creatinine ratio test in the preceding 12 months. This is a urine test which can identify the early stages of kidney disease. We spoke with the GPs about this and they explained that due to the lack of nursing provision, this had impacted negatively on certain outcomes for QOF. The practice was aware of this and had a process in place to follow up patients who did not attend more closely.

Effective staffing

We did not find evidence that staff had received a period of induction when they started at the practice. We looked at seven staff files and found a completed induction for one member of staff. The record of induction for another member of staff had been backdated. The majority of the staff we spoke with confirmed that they had not received an induction.

We asked to see the certificates of training for all the courses that staff had undertaken. We also looked at seven staff files. We found that there was little evidence to show that staff had completed training appropriate to their role. For example fire safety, safeguarding adults and

Inadequate

Are services effective?

(for example, treatment is effective)

safeguarding children, (including safeguarding children level 3 for GPs), health and safety, infection control, chaperoning, coding, referring correspondence to GPs, use of the computer system. We found that staff were not trained to undertake their role effectively.

We looked at seven staff files and spoke with staff and found that one member of staff had a completed appraisal. Appraisals had not been completed for the other members of staff. This was confirmed by the practice manager. Staff learning and development needs had not been identified, which meant that effective development of staff was not in place. Staff interviews confirmed that the practice was not proactive in providing training and funding for relevant courses.

All GPs were up to date with their yearly continuing professional development requirements and all either had 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).

Working with colleagues and other services

The GPs told us that they worked with other service providers to meet patients' needs and manage those of patients with complex needs. We saw that the practice 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. We saw that this information was scanned onto the patient's record, coded and then administration staff told us that they had been told by the GP to decide what patient correspondence the GP needed to be sent to review. There was therefore a risk that the GP did not see all of the patient correspondence that they needed to.

The practice had a palliative care register and had regular multidisciplinary meetings to discuss the care and support needs of patients and their families. The practice held monthly palliative care/multidisciplinary team meetings up until January 2015, when the practice had decided to move the meetings to quarterly. We saw evidence that the needs of complex patients, for example those with end of life care needs were discussed and reviewed by the multidisciplinary team. These meetings were attended by a community matron and a representative from the East of England Ambulance Service, Age UK, MacMillan nursing team and the community nursing team. Decisions about care planning were documented in a shared care record.

Information sharing

We were told by the GPs that they worked collaboratively with other agencies and community health professionals and regularly shared information to ensure timely communication of changes in care and treatment. We saw evidence of alerts on patients' records for those who were at the end of their life.

The practice had systems in place to provide staff with the information they needed. An electronic patient record, called SystmOne, was used by all staff to coordinate, document and manage patients' care. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference. Staff had not all received training on how to use the system. We spoke with one member of staff who had asked for training but this had not been forthcoming. There was a risk that patient correspondence would not be correctly allocated to GPs for review, correctly coded and that patients' notes had not been added accurately.

Non-clinical staff were expected to code patients' records without an effective system in place to do this. We looked at the summarising notes protocol for the practice and found that although it was recommended that coding was placed under the responsibility of a clinical staff member acting as mentor, this was not happening in practice. There was not a practice list of preferred codes agreed and maintained, supported by random spot checks, quality audits and regular discussion of the coding in meetings, which was stated in the policy. Correct coding of patient data is an integral part of good clinical governance and an essential part of clinical risk management. It must be accurate, informative and relevant. Incorrect coding will lead to incorrect data which has the potential to seriously compromise patient safety and important data sharing with other agencies, within the terms of the Data Protection Act .

The practice used electronic systems to communicate with other providers. For example, 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.

Inadequate

Are services effective?

(for example, treatment is effective)

Consent to care and treatment

The GPs we spoke with described the processes to ensure that written informed consent was obtained from patients whenever necessary, for example when patients needed minor surgery. We were told that verbal consent was recorded in patient notes where appropriate. Patients that we spoke with and received comments from confirmed that their consent was obtained before they received care and treatment.

The Mental Capacity Act is designed to protect people who cannot make decisions for themselves or lack the mental capacity to do so. The GPs were aware of the Mental Capacity Act 2005 and their duties in fulfilling it. They understood the key parts of the legislation and were able to describe how they implemented it in their practice. When interviewed, they gave examples of how a patient's best interests were taken into account if a patient did not have capacity.

The staff we spoke with were aware of patients who needed support from nominated carers, and clinicians ensured that carers' views were listened to as appropriate.

The GPs demonstrated an understanding of the legal requirements when treating children and confirmed consent was always obtained from parents prior to immunisations being given. They had a clear understanding of Gillick competencies. (These help clinicians to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment).

We saw that up to date electronic copies of relevant guidance and Acts in relation to consent were kept on an electronic shared folder.

Health promotion and prevention

The practice displayed a wide range of health promotion and prevention information. The information displayed contained a lot of useful contacts and information to signpost patients to other services. For example contact details for domestic abuse services, bereavement information and support, sexual health advice for younger people, support for patients with an alcohol dependency and advice for patients with a variety of long term conditions.

It was practice policy to offer a health check with the health care assistant to all new patients registering with the practice and NHS Health Checks to patients aged 40 to 75 years. These helped identify any new or existing conditions that needed to be addressed. The practice were not able to provide us with the current percentage of patients who had received this health check.

The practice had ways of identifying patients who needed additional support. They had registers of patients with a learning disability and patients with poor mental health who needed additional support. We saw evidence that annual health checks that had been undertaken for patients in these groups. We were provided with data from the practice which showed that in the previous year, 59% of patients with a learning disability had either received an annual health check or had had a follow up letter sent and 61% of people with dementia had received an annual physical health check. This meant that a significant number of patients still required a review in order to ensure that their needs were being met.

The practice offered a range of health prevention and screening services. This included for example, child immunisations, flu vaccinations, cervical and chlamydia screening. We looked at the most recent Quality and Outcomes Framework (QOF) data from 2013 to 2014. The outcomes when compared to the Clinical Commissioning Group (CCG) and England average varied. The practice had scored lower than the CCG and England average for cervical screening. They had scored higher than the CCG and England average for dementia. The practice had also identified the smoking status of 84% of patients over the age of 15 and 78% of these patients had been offered support or treatment within the previous 12 months. Overall, the practice were the same as the CCG average for the indicator 'smoking' and below the England average.

There was no comparison data available for immunisation data.

Requires improvement

Are services caring?

Our findings

Respect, dignity, compassion and empathy

During our inspection we overheard and observed good interactions between staff and patients. We observed that patients were treated with respect and dignity during their time at the practice. Most of the patients we spoke with and received comments from, during our inspection made positive comments about the practice and the service they provided. Patients reported that all the staff were friendly and helpful and they were happy with the care they received.

We saw that patient's confidentiality was respected when care was being delivered and during discussions that staff were having with patients. Curtains or privacy screens were provided for use in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

The reception desk was open and conversations could be overheard. There was a notice at reception informing patients that they could ask at reception if they wanted to discuss something in private. Reception staff told us that a room would be used if patients wanted to talk in private.

We looked at data from the National GP Patient Survey, which was published on 8 January 2015. The survey showed satisfaction rates for patients who thought they were treated with care and concern by the nursing staff (81%) and by their GP (71%). 87% of patients reported that the reception staff were helpful. In relation to whether staff listened to them 79% reported this being good for nurses and 74% for GPs. 70% of respondents described their overall experience of the practice as good and 50% of patients stated they would recommend the practice. These results were below average when compared with other practices in the CCG area.

Care planning and involvement in decisions about care and treatment

We looked at data from the national GP patient survey, published on 8 January 2015, which related to patients involvement in planning and making decisions about their care and treatment. The data showed that 66% of practice respondents said the GP involved them in care decisions, 74% felt the GP was good at explaining tests and treatments and 72% said the GP was good at giving them time. In relation to nurses, 79% said they involved them in care decisions, 77% felt they were good at explaining tests and treatments and 80% said they were good at giving them enough time. These results were below average when compared with other practices in the CCG area.

Patients we spoke with on the day of our inspection told us that health issues were discussed with them and 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 they wished to receive. Patient feedback on the comment cards we received was also positive and aligned with these views.

Patient/carer support to cope emotionally with care and treatment

When a new patient registered at the practice they were asked if they were a carer and offered appropriate support. The practice identified patients who were also carers on the computer system. Staff and clinicians were automatically alerted to patients who were also carers. This ensured that GPs and clinical staff were aware of the wider context of the patients' health needs. Notices in the waiting room and practice website signposted patients to a number of support groups and organisations for carers.

Staff told us families who had suffered bereavement were identified, however this information was not systematically shared with all staff at the practice. We saw one complaint which highlighted that the system in place was not effective and had led to distress for a patient. The practice had recently set up a way of informing staff formally when a patient had died so that this information was shared effectively. Staff told us that recently bereaved families were contacted by the GP who signposted relatives and carers to suitable alternative services. We were told that bereaved families were sent a card from the GP. However, we noted that a further complaint had been received from a family member regarding poor end of life care for their relative. Furthermore, the practice had yet to respond to the complainant.

Inadequate

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

Although the practice was aware of the needs of its local population, it did not have the capacity or plans to secure improvements. We found the practice's approach to meeting patients' needs was generally opportunistic. The practice told us that they engaged with NHS England Area Team and Clinical Commissioning Group (CCG) although there were no minutes available from these meetings as to what was discussed.

We were told by the practice manager that the patient participation group (PPG) had recently been re- established and the first meeting had taken place. PPGs are a way in which patients and GP surgeries can work together to improve the quality of the service. We spoke with two representatives from the PPG but they were not able to provide any recent examples of how the practice had responded to their suggestions. The practice had implemented some suggestions for improvements and made changes to the way it delivered services in response to feedback from the most recent patient survey, undertaken in 2013. For example there was a privacy notice in reception advising patients they could speak in a private room and pre-booked appointments were available at Oulton Medical Centre.

We asked the practice how they were responding to the difficulties they were have with the telephone system. The practice manager advised that they had received a quote for work to improve the telephone system and had put in a bid for funding. The practice manager also told us that following some complaints from patients about the need for additional disabled car parking spaces at Oulton Medical Centre, they were in the process of obtaining a quote for four additional car parking spaces and had submitted a bid for funding for this.

Tackling inequity and promoting equality

We spoke with staff about how they supported different groups in the community to access care and treatment and reduce potential barriers. The practice held a register for patients with learning disabilities and poor mental health and we saw evidence that annual health reviews had been undertaken. Home visits were also undertaken for patients who were unable to attend the practice in person due to their health needs.

Both practice sites were accessible to people with mobility needs. This included disabled parking and toilet facilities. Oulton Medical Centre was a ground floor building and Marine Parade Surgery was located on the first floor and lifts were available for patients to use. The main doors into the practice were automatic. The waiting areas were large enough to accommodate patients with wheelchairs and prams. Baby changing facilities were available.

Staff told us that translation services were available for patients who did not have English as a first language. We saw notices informing patients this service was available.

Access to the service

Information was available to patients about appointments on the practice website and in the practice leaflet. 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, they were automatically redirected to the 111 service.

The practice was open from 8.00am to 6.30pm Monday to Friday. Appointments could be booked on line and both urgent and pre-bookable appointments were available at Oulton Medical Practice. Pre-bookable appointments were not available at Marine Parade Surgery. Extended hours appointments were available on a Tuesday evening until 8pm, alternating between the sites. The practice manager told us that all patients were able to pre book these appointments at both sites. This was particularly useful to patients with work commitments. Longer appointments were available for patients who needed them. Home visits were also undertaken to those patients who were unable to attend the surgery due to their health needs.

The practice had recently started using a locum emergency care practitioner, who ran a triage service. They received telephone calls at Oulton Medical Centre and depending on the patient's need, would either do a home visit, resolve their issue by telephone, book the patient to see a GP or book the patient to be seen by them. We were told that the emergency care practitioner arranged the appointments at whichever site was most suitable for the majority of patients.

Patients at Oulton Medical Centre were generally satisfied with the appointments system. However some patients reported difficulty in getting through to the practice by

Inadequate

Are services responsive to people's needs?

(for example, to feedback?)

telephone to make an appointment. We noted that there was no queuing system and no voicemail system in place. The inspection team tested out ease of access to the practice on two dates following the inspection and noted that they were cut off twice on both dates before their call was answered.

We looked at the National GP patient survey data, from January 2015. 335 surveys had been sent out, with 106 surveys returned, which was a 32% completion rate. The results showed that the practice scored higher than the CCG average, with 81% of patients who found it easy to get through to the practice by phone. The practice had informed patients that they were experiencing difficulties with the phone lines. We were told by the practice manager that they had submitted a request for funding to update the telephone system.

Patients confirmed that they could see a doctor on the same day if they needed to. Two patients we spoke with at Marine Parade Surgery were dissatisfied with not being able to book appointments in advance. One patient reported that they had attended for an appointment and were informed that this was at the other practice, despite having received a text confirming their appointment. This meant that they had to rebook their appointment. Three patients we spoke with told us that they had to wait a long time to see the GP once they had arrived for their appointment and one patient felt that an apology would be appropriate.

Listening and learning from concerns and complaints

The practice did not have a system in place to govern the effective management of complaints. The practice had a complaints handling procedure and the practice manager was the designated staff member who managed the complaints. However, information was held in different places and there was no audit trail to ensure which complaints still required action. We saw that 11 complaints had been recorded by the practice since June 2014. Ten complainants had received a response from the practice, although there had been a significant delay in responding to the majority of these. NHS England has been instrumental in ensuring that a response was provided to three complainants. We noted that one complainant had written to the practice in October 2014 and had still not received a response from the practice. The practice stated that they would be contacting the complainant by 06 March 2015.

There was no system in place to analyse and learn from complaints received in the practice. There were no formal meetings attended by clinical and non-clinical staff to discuss the complaints, ensure they were handled appropriately, analysed and lessons learned.

Are services well-led?

Inadequate

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

Our findings

Vision and strategy

The practice did not have a clear vision and strategy in place. The two GP partners worked hard to maintain the service for patients but limited clinical and managerial support was in place to develop a clear vision and strategy for the practice. There were no clear goals identified for staff to ensure that high quality care was prioritised and a continuous improvement process was in place. Some staff we spoke with told us that their daily aim was to provide a good service for patients, whilst others described a chaotic environment in which reactive and last minute decisions were made. We were told that opportunities for developing staff and expanding partnership working had been lost.

Governance arrangements

The responsibility for clinical leadership was carried by the two GP partners who had been unable to recruit permanent GPs to support the service. The practice used locum GPs at times. The practice had not held regular practice meetings which meant that clinical support staff, locum GPs and administrative staff had had limited opportunity to contribute to, or benefit from, quality improvement decisions. Practice meeting minutes we saw were very brief and did not reflect an adequate approach for monitoring service delivery and securing improvement.

The practice currently has one healthcare assistant, but no qualified nursing staff. There was no system used to check the competence and skills of the clinical support team. There was no evidence to show that regular supervision had taken place or that annual appraisals had been completed. The practice had some written policies in place, but we found that the policies and procedures used to support staff were inadequate. Job descriptions were not always in place and those that were, were generic and not based on expected level of competence. Administrative and clinical support staff had not benefitted from an appraisal or supervision process. The practice could not assure themselves that staff were supported to perform or develop within their role.

Risk management processes had not been established to support safe and effective practice.

We saw eleven complaints that had been sent to the practice in recent months. However, we did not see a process of analysis and learning from complaints to address the underlying issues.

Leadership, openness and transparency

The majority of staff we spoke with did not feel that there was effective leadership at the practice. The practice had recently sourced external management support for the practice and we saw that an electronic management tool had been set up to record and monitor for example, significant events, complaints and staff training. However, some staff told us that they were given conflicting information from the management team at the practice.

There was no evidence of regular staff meetings and staff reported that they had not been in place for many months. Staff told us that there was not an open culture within the practice and staff were discouraged from reporting concerns.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, which were in place to support staff, including: chaperoning, complaints, safeguarding adults and safeguarding children, carers and cold chain process. These were available on the shared drive and staff we spoke with knew where to find these policies if required. The practice manager advised that they were in the process of reviewing the policies and procedures to ensure they were up to date.

Seeking and acting on feedback from patients, public and staff

The practice had recently re-established their patient participation group (PPG). PPGs are a way for patients and GP surgeries to work together to improve services, promote health and improve quality of care. We saw that there was a PPG notice board in the waiting area, which provided patients with information about the PPG and how they could join. We reviewed the most recent patient survey action plan which was dated 2013. The areas for improvement included offering appointments with the GP of choice even if this was at the other practice, advance appointments being available at Oulton Medical Centre, improving waiting times with reception staff informing patients of any delays and a privacy notice being displayed in reception. We saw evidence that some of the actions had been undertaken and improvements made. The results and actions from this survey were available on the practice website.

Are services well-led?

Inadequate

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

There were no processes in place to obtain feedback from staff. There was no process in place for staff supervision or appraisal where feedback could be obtained from staff in order to improve the practice. We were told by staff that they did not have regular staff meetings. We asked for the minutes of staff meetings and were given two sets of minutes dated in January 2014 and February 2015. The majority of the staff we spoke with told us they did not feel involved and engaged in the practice to improve outcomes for both staff and patients. We were told that the staff team had been out together at Christmas and that a team building event was being planned.

The practice had a whistleblowing policy which was available to all staff electronically on the shared drive. The majority of staff that we spoke with were not aware of this policy and did not feel they would be supported if they raised concerns internally. Not all the staff we spoke with were clear on who they should go to outside the practice if they felt they could not raise concerns internally. Whistleblowing is the process by which staff can raise concerns they may have about the practice and the conduct of other members of staff. This enables concerns raised to be investigated and acted on to help safeguard patients from potentially unsafe or inappropriate care.

Management lead through learning and improvement

We did not see evidence that the practice supported staff to maintain their clinical professional development through training and mentoring. We found that only one member of staff had received an appraisal. Staff told us that the practice was not supportive of learning and training and we heard examples of when staff had asked for training to undertake their role effectively and this had not been provided. We were told by staff that on previous shutdown afternoons, where protected time should be provided for learning, that this time was used by staff to work through a backlog of patient correspondence.

There was little evidence to show that the practice routinely identified and reviewed significant events and other incidents that occurred. The practice was not proactive in the use of information available to drive improved outcomes for patients.

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 17 HSCA (RA) Regulations 2014 Good governance Effective systems were not in place for the management of risks to patients and others against inappropriate or unsafe care. This included arrangements for managing significant events, safety alerts, health and safety, fire safety and staff safety. The provider needs to ensure that there are robust processes in place for sharing the learning from significant events and complaints. Inadequate information governance processes were in place to ensure that all patient correspondence was reviewed by a GP and actioned in a timely way and that clinical coding of patients was accurate. Records relating to undertaking regulated activity, which included training records, clinical meetings and infection control audits could not be located promptly when required. This was in breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17 (1) and (2)(a) to (f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment There was no lead for infection control and there was no evidence of staff training in this area. Although cleaning schedules were in place, there were no checks of the cleaning completed. No internal infection control audits had been completed and although an audit had been completed by the Clinical Commissioning Group, there

Requirement notices

was no action plan or monitoring of the areas for improvement which had been identified. Actions from the legionella risk assessment must also be implemented.

This was in breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12 (1) and (2)(h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed Effective recruitment procedures were not in place. The practice could not assure itself that staff they had employed were of good character and had the skills and qualifications necessary for the work to be performed. This was in breach of regulation 21 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 19 (2) and (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Sufficient numbers of suitably qualified, competent, skilled and experienced persons were not in place. There was a risk to staff and patients where a surgery was open for patients to attend and no clinical cover was provided. We found that staff were making decisions which were outside of their area of responsibility. This was in relation to non-clinical staff reviewing patient correspondence and deciding if it needed to be reviewed by a GP. Persons employed did not receive appropriate support, training, professional development, supervision and appraisal to enable them to carry out the duties they were employed to perform. The majority of staff had not received an induction or training appropriate to their

This section is primarily information for the provider

Requirement notices

role. Only one member of staff had received an appraisal. There was a lack of support for training and development of staff. The majority of staff who we spoke with did not feel supported to undertake their role safely and effectively.

Regulation 18 (1) (2) (a)

This was in breach of regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 18 (1) and (2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.