Priory Avenue Surgery

Quality Report

2 Priory Avenue
Caversham
Reading
RG4 7SF
Tel: 01189472431
Website: www.prioryavesurgery.co.uk

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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 carried out an announced comprehensive inspection on Thursday 26 January 2017 at Priory Avenue Surgery. We undertook this inspection following urgent action taken as a result of our unannounced inspection on 1 December 2016 to identify whether improvements had been made and review all aspects of the service. We have rated the service as inadequate and taken further urgent enforcement action (subject to appeal) as a result of our findings.

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

- Risks to patients were not assessed or well managed.
- The practice had the necessary equipment and procedures for dealing with emergencies. However, regular checks of emergency medicines and equipment were not undertaken appropriately.
- Staffing levels were not appropriate to ensure the practice was staffed to a safe level and to ensure appropriate care was given to address patient's health needs.
- Effective systems to assess, monitor and improve the quality and safety of the services provided had also not been implemented. We found examples of poor care resulting from a lack of appropriate systems to monitor and address the backlog of clinical and administrative tasks.
- There was a significant backlog of patient correspondence not yet reviewed or filed onto the record system. This included records of discharge summaries, Out of Hours, walk-in centre reports and A&E discharges. There was a backlog of patient referrals dating back to November 2016 and new patient summarising back to October 2016.
- Staff did not always have the skills, knowledge and experience to deliver effective care and treatment.
- Data from the friends and family test had shown a steady decline in patient satisfaction since September 2016.
- Patients said there was a lack of continuity of care due to the use of locums and there were sometimes problems accessing an appropriate appointment.

Summary of findings

- Patients were referred to other services, such as accident and emergency or the local walk in centre, when the practice could not meet the patient's needs due a lack of appropriate staffing.
- There was a lack of strategy and supporting business plans to reflect and implement the provider's vision and values.
- The governance framework did not support the delivery of safe, effective and responsive care. We found significant risks were not assessed appropriately to determine the high level of impact to patient safety.
- There was no clear and embedded leadership structure at the practice.
- Staff told us there was not an open culture within the practice and although they had the opportunity to raise any issues they did not feel confident and supported in doing so.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.
- Since the inspection in January 2017, North and West Reading Clinical Commissioning Group have provided significant support to Priory Avenue Surgery to ensure the highest levels of risk and concern have been addressed urgently.

The areas where the provider must make improvements are:

- Ensure effective and sustainable clinical governance systems and process are implemented to assess, monitor and improve the quality and safety of the services provided. Including; the implementation of a sustainable system to ensure outstanding and future medication reviews are undertaken; Docman correspondence is reviewed; paper medical records requiring summarisation are actioned without delay; and significant events are shared with staff at all levels and is used make improvements within the practice.
- Assess the risks to the health and safety of service users of receiving the care or treatment in respect of the proper and safe management of medicines. This includes improving the monitoring of emergency medicines and equipment to ensure it is fit for purpose and suitable to be used in an emergency; and patient group directions are used appropriately.
- Ensure sufficient numbers of suitably qualified, competent, skilled and experienced persons are deployed to deliver a safe service.
- Ensure a system is implemented to effectively identify, receive, record, handle and respond to complaints made by service users.

The areas where the provider should make improvements are:

- Ensure patient and staff feedback is collated and used to influence and encourage positive change within the practice.

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

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

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

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Inadequate

The practice is rated as inadequate for providing safe services.

- Risks to patients were not assessed or well managed.
- There was an ineffective system in place for reporting and recording significant events to ensure that learning was shared and changes made as a result.
- The practice had the necessary equipment and procedures for dealing with emergencies. However, regular checks of emergency medicines and equipment were not undertaken appropriately.
- The practice had not followed the cold chain and vaccine storage policy. Checks were not undertaken as often as they should be to ensure vaccines were stored appropriately and were safe to use.
- Repeat prescriptions were not always processed within the advertised timescale.
- Staffing levels were not appropriate to ensure the practice was staffed to a safe level and to ensure appropriate care was given to address patient's health needs.
- Blank printer prescription stationery was stored securely within the practice and was tracked to individual practitioners, in line with current national guidance.
- The practice had embedded systems, processes and practices in place to keep patients safe and safeguarded from abuse.
- Recruitment checks were conducted in line with current legislation.

Are services effective?

Inadequate

The practice is rated as inadequate for providing effective services.

- There was a significant backlog of patient correspondence not yet reviewed or filed onto the record system. This included records of discharge summaries, Out of Hours, walk-in centre reports and A&E discharges
- Patients were at risk due to the unnecessary delays in providing the patients with timely care and treatment or referring for additional tests, investigations and assessment.
- There was a backlog of patient referrals dating back to November 2016 and new patient summarising back to October 2016.
- Unvalidated data from the Quality and Outcomes Framework (QOF) showed patient outcomes varied.

Summary of findings

- Clinical audits demonstrated limited quality improvement. Audits undertaken since September 2016 were requested by the local clinical commissioning group (CCG) and did not demonstrate quality improvements.
- Staff did not always have the skills, knowledge and experience to deliver effective care and treatment.
- Staffing levels were not appropriate to ensure patients were given effective care.
- There was a system to identify when staff had training and when it would need to be updated. Staff were given protected time to complete training. However, there were gaps where training for staff was overdue.
- All staff had received appraisals with the previous provider in the last 12 months.
- Staff worked with other health care professionals to understand and meet the range and complexity of patients' needs.
- Performance for diabetes related indicators was above the expected achievement.
- Staff assessed needs and delivered care in line with current evidence based guidance.

Are services caring?

Requires improvement 

The practice is rated as requires improvement for providing caring services.

- Data from the friends and family test had shown a steady decline in patient satisfaction since September 2016. Feedback on NHS Choices also demonstrated patient dissatisfaction with the practice since December 2016.
- National patient survery data was not available for the practice as there had been a change in provider in the previous four months.
- Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. However, patients said that there was a lack of continuity of care due to the use of locums and that there was sometimes problems accessing an appropriate appointment.
- Information for patients about the services available was easy to understand and accessible. Including leaflets in easy to read formats and other languages.
- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.

Are services responsive to people's needs?

Inadequate 

The practice is rated as inadequate for providing responsive services

Summary of findings

- Practice staff reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group to secure improvements to services where these were identified.
- Patients said they did not find it easy to make an appointment with a named GP and there was not always continuity of care. There had been no changes implemented to address this since the previous inspection.
- Urgent appointments were available the same day; however, there were occasions where patients were referred to other services due to a lack of clinical capacity.
- Regular visits to the local nursing home had been cancelled due to a lack of capacity. However, the provider confirmed these were to be re-established as an increase in home visits had occurred as result of this change.
- Patients were sometimes referred to other services, such as accident and emergency or the walk in centre, when the practice could not meet the patient's needs due to a lack of appropriate staffing.
- Information about how to complain was available and easy to understand. Patients did not always receive an appropriate or full response to their complaint. There was no learning or changes implemented when the practice received complaints from patients.
- The practice had good facilities and was well equipped to treat patients and meet their needs.

Are services well-led?

Inadequate

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

- Leaders did not have the necessary experience, knowledge, capacity or capability to lead effectively. Despite a local senior operations manager being on site and clinical lead being appointed there was a lack of clarity and authority to make decisions about mitigating risks or to make quality improvements.
- The provider's vision to deliver high quality care and promote good outcomes for patients was not supported by an effective leadership and governance. At the time of inspection the level of care and quality outcomes for patients was poor.
- There was a lack of strategy and supporting business plans to reflect the vision and values of the practice.
- The governance framework was not effective and did not support the delivery of safe, effective and responsive care. We

found significant risks were not assessed appropriately to determine the high level of impact to patient safety. The governance and processes had not dealt with the inherent risks associated with the backlog of patient correspondence, lack of appropriately trained staff and medical record summarising.

- Effective systems to assess, monitor and improve the quality and safety of the services provided had also not been implemented. We found examples of poor care resulting from a lack of appropriate systems to monitor and address the backlog of clinical and administrative tasks.
- There was no clear and embedded leadership structure at the practice. We found that the leadership team and processes that were in place did not enable development to manage and implement the changes required to address the regulatory breaches identified.
- There are low levels of staff satisfaction, high levels of stress and work overload for clinicians. Staff told us there was not an open culture within the practice and although they had the opportunity to raise any issues they did not feel confident and supported in doing so.

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. The concerns which led to these ratings apply to everyone using the practice, including this population group.

- There was no system to prioritise older patients for appointments. This risk was exacerbated by insufficient staffing leading to a shortage of appointments.
- The practice offered home visits and urgent appointments for those with enhanced needs. However, the practice did not always have the capacity to meet these needs.
- We saw hospital admissions, letters from specialists and paramedic correspondence was not acted on promptly and we saw examples where this led to risks for patients. This was a particularly significant risk for this population group.
- The practice identified older patients and coordinated the multi-disciplinary team (MDT) for the planning and delivery of palliative care for patients approaching the end of life.
- We saw unplanned hospital admissions and re-admissions for the over 75's were regularly reviewed and improvements made.
- Unvalidated data showed that outcomes for patients for conditions commonly found in older people were within the target range. For example, 75% of patients aged 50 or over (and who have not attained the age of 75) with a fragility fracture and confirmed diagnosis of osteoporosis, were currently treated with an appropriate bone-sparing agent. This is higher than the expected achievement of 60%. (The provider could not provide us with details of exception reporting for this data).

People with long term conditions

Inadequate

The provider was rated as inadequate. The concerns which led to these ratings apply to everyone using the practice, including this population group.

- Patient correspondence from external providers, such as hospital and paramedics, was often not being dealt with in a timely way. We saw several examples where patients with chronic conditions were placed at risk of significant harm as a result of the poor system for acting on this correspondence.
- Patients reported long delays in issuing repeat prescriptions, leaving patients at risk if they were unable to access their medicines.

Summary of findings

- The practice employed a pharmacist to assist with the health and medicines reviews of patients with long term conditions. For patients on less than four medicines 56% had an up to date medication review. For patients on four or more medicines 75% had an up to date medicine review.
- Unvalidated data for diabetes related indicators showed achievement of 84% with an expected achievement of 93%. (The provider could not provide us with details of exception reporting for this data)
- Longer appointments and home visits were available when needed.
- For those patients with the most complex needs, the practice worked with relevant health and care professionals to deliver a multidisciplinary package of care. However, patients felt that there was a lack of continuity of care which impacted on the management of their health needs.
- Unvalidated data for chronic obstructive pulmonary disease (COPD, a collection of lung diseases including chronic bronchitis and emphysema) indicators showed the practice had achieved 64% of annual reviews, with an expected achievement of 90%. (The provider could not provide us with details of exception reporting for this data).

Families, children and young people

Inadequate

The provider was rated as inadequate. The concerns which led to these ratings apply to everyone using the practice, including this population group.

- There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. However, the backlog of patient correspondence waiting to be viewed meant that the practice may not be aware of these risks from as far back as November 2016.
- We saw an example where a child did not receive care in a timely manner and had to be referred to the local A&E due to clinical capacity.
- Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals.
- The practice's unvalidated uptake for the cervical screening programme was 89%, which was above the expected achievement of 80%.
- Appointments were available outside of school hours and the premises were suitable for children and babies.

Summary of findings

- We saw positive examples of joint working with midwives, health visitors and school nurses.

Working age people (including those recently retired and students)

Inadequate

The provider was rated as inadequate. The concerns which led to these ratings apply to everyone using the practice, including this population group.

- The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care.
- The surgery offered extended late appointments every Tuesday and Wednesday until 7pm and on Saturday mornings.
- The practice was proactive in offering online services for repeat prescriptions as well as a range of health promotion and screening that reflects the needs for this age group. However, wait times for repeat prescriptions were unpredictable and some patients had to attend the practice to chase their requests for completion.

People whose circumstances may make them vulnerable

Inadequate

The provider was rated as inadequate. The concerns which led to these ratings apply to everyone using the practice, including this population group.

- The practice offered longer appointments for patients with a learning disability. The number of health checks undertaken for patients with a learning disability was 22 out of 37 patients (59%).
- Practice staff were trained to recognise signs of abuse within their vulnerable patients.
- GPs worked within a multi-disciplinary team to ensure the best outcomes for vulnerable patients. The practice worked with other health care professionals in the case management of vulnerable patients.
- 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.

Summary of findings

People experiencing poor mental health (including people with dementia)

Inadequate

The provider was rated as inadequate. The concerns which led to these ratings apply to everyone using the practice, including this population group.

- Unvalidated data showed 75% of patients diagnosed with a severe mental health issue had a comprehensive, agreed care plan documented in the last 12 months, with an expected achievement of 90%. (The provider could not provide us with details of exception reporting for this data).
- Unvalidated data showed 82% of patients diagnosed with dementia had a comprehensive, agreed care plan documented in the last 12 months, with an expected achievement of 70%. (The provider could not provide us with details of exception reporting for this data).
- Poor access to appointments placed patients with mental health problems at particular risk they became unwell or needed support.
- The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those with dementia.
- The practice carried out advance care planning for patients with dementia.
- The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations.
- The practice had a system in place to follow up patients who had attended accident and emergency where they may have been experiencing poor mental health.
- Staff had a good understanding of how to support patients with mental health needs and dementia.

Summary of findings

What people who use the service say

During this inspection we received 14 patient CQC comment cards. Of these, five were positive about the service experienced, with seven having some negative comments regarding waiting times for appointments, continuity of care and delays with repeat prescriptions.

Patients we spoke to on the day said they felt the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect. However, patients also told us that they had recently had long waits for repeat prescriptions (up to one week) and that they did not always receive the appropriate care due to a lack of continuity.

Results from the national GP patient survey are not available for this provider. One Medicare Ltd took over the contact in September 2016 and annual results for this practice will be available in July 2017.

Friends and family test results showed that patient satisfaction had steadily decreased since September 2016:

- In September 2016, 72% of patients were either likely or extremely likely to recommend Priory Avenue Surgery to their friends and family. 19% were unlikely or extremely unlikely to recommend the practice to their friends and family.
- In October 2016, 63% of patients were either likely or extremely likely to recommend Priory Avenue Surgery to their friends and family. 22% were unlikely or extremely unlikely to recommend the practice to their friends and family.
- In November 2016, 63% of patients were either likely or extremely likely to recommend Priory Avenue Surgery to their friends and family. 25% were unlikely or extremely unlikely to recommend the practice to their friends and family.
- In December 2016, 60% of patients were either likely or extremely likely to recommend Priory Avenue Surgery to their friends and family. 27% were unlikely or extremely unlikely to recommend the practice to their friends and family.

Priory Avenue Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector**.** The team also included an inspection manager, two further CQC inspectors, a GP specialist adviser and an assistant inspector.

Background to Priory Avenue Surgery

Priory Avenue Surgery provides primary medical services to the Caversham area of Reading from a two-storey converted dwelling, which has undergone several extensions over the last 10 years. The practice serves a population of around 8,000 patients in an area of mainly average deprivation but with some pockets of low deprivation. The population is predominantly white British dispersed with eastern European. The practice has a larger proportion of patients of working age compared to both local and national averages.

The consultation and treatment rooms are on both the ground and first floors with three waiting areas. The first floor can only be reached by a staircase, with no lift facility currently in place. Patients who could not use the stairs were seen on the ground floor.

All services are provided from: 2 Priory Avenue, Caversham, Reading, Berkshire, RG4 7SF

The practice has been through a challenging four years with three changes in provider and a number of GPs and managers leaving, which has caused instability in the practice. One Medicare Ltd took the contract from the local clinical commissioning group (CCG) in September 2016.

The service is staffed by: one employed GP and locum GPs, a GP clinical lead and a pharmacist (both shared with another practice), four practice nurses, locum advanced nurse practitioners, a health care assistant, a deputy practice manager and a reception and administration team. The practice manager had left the practice in December 2016.

The practice is open between 8am and 6.30pm Monday to Friday. Extended hours appointments are available until 7pm Tuesday and Wednesday and on Saturday mornings. The practice operate under an alternative provider medical services contract.

When the practice is closed, out-of-hours (OOH) GP cover is provided by Westcall via the NHS 111 service. Notices on the entrance door, in the patient leaflet and on the practice website clearly inform patients of how to contact the OOH service.

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. We undertook this inspection following urgent action taken as a result of our unannounced inspection on 1 December 2016 to identify whether improvements had been made and review all aspects of the service. 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.

Detailed findings

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 26 January 2017.

During our visit we:

- Spoke with a range of staff (GPs, practice nurses, reception staff, administration staff and members of the senior leadership team) and spoke with patients who used the service.
- Observed how patients were being cared for and talked with carers and/or family members
- Reviewed an anonymised sample of the personal care or treatment records of patients.
- Reviewed comment cards where patients and members of the public shared their views and experiences of the service.

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

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

We also looked at how well services were provided for specific groups of people and what good care looked like for them. The population groups are:

- Older people
- People with long-term conditions
- Families, children and young people
- Working age people (including those recently retired and students)
- People whose circumstances may make them vulnerable
- People experiencing poor mental health (including people with dementia).

Please note that when referring to information throughout this report, for example any reference to the Quality and Outcomes Framework data, this relates to the most recent information available to the CQC at that time.

Inadequate

Are services safe?

Our findings

During our inspection in December 2016, we identified concerns in relation to the safe domain. This included concerns regarding the investigation process and resulting actions from significant events. Learning was not taking place when incidents occurred and staff did not feel their feedback was being acted on. In December 2016, we found that staffing levels were insufficient to ensure patients' health, safety and welfare were being protected.

At the inspection in January 2017, we found limited improvements had been made with many issues still unaddressed.

Safe track record and learning

- Safety was not afforded sufficient priority. There were unacceptable levels of serious incidents or significant events, which were not fully reviewed investigated or actions taken to mitigate risk. We looked the significant event log and found there had been eight significant events recorded on a log since our previous inspection in December 2016. These events related to the insufficient staffing levels at the practice, a backlog of administrative and clinical tasks, lack of appointments (resulting in patients being referred to the walk in clinic) and locum staff not attending for their shift.
- On the day of inspection we were given a further three significant event forms detailing further incidents with a lack of clinical capacity to ensure safe care for patients.
- The practice did not carry out a thorough analysis of the significant events to identify learning and implement changes to reduce the risk of the same events occurring again.
- We saw from the records of significant events that the learning and actions taken were limited. The minutes of meetings where significant events were discussed were minimal and no changes, learning or actions taken were recorded.

Overview of safety systems and processes

- Arrangements were in place to safeguard children and vulnerable adults from abuse. There was a lead GP for safeguarding and they had level three child safeguarding training. However, the practice did not have all the records to demonstrate all GPs had received safeguarding training. We saw nursing and support staff had received training to the correct level, but some were overdue for refresher training and this was booked before the 31 March 2017. There were safeguarding policies and these were accessible to all staff. There were contact details for further guidance if staff had concerns about a patient's welfare. We saw evidence that GPs attended multidisciplinary team meetings to discuss vulnerable patients and also provided information to case conferences where required. There was no training provided on female genital mutilation (FGM) to ensure staff understood the risks and their responsibilities in reporting suspected cases and supporting victims of FGM. There was an alert on the patient record system to alert staff to any children deemed at risk of abuse or harm.
- A notice in the waiting room advised patients that chaperones were available if required. In accordance with the provider's policy, all staff who acted as chaperones were trained and had Disclosure and Barring Service (DBS) checks. (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 that the practice was clean and tidy. There was an audit tool used to identify any improvements in infection control and we saw the last audit was undertaken in January 2017. Cleaning checks were undertaken in clinical treatment rooms. Staff had access to training on infection control, but we saw that several staff were due their refresher training. Reception staff received guidance from the infection control lead on handling specimens handed in by patients at reception. There was an infection control protocol in place. This included a sharps injury protocol (needle stick injury) which was available to staff. Clinical waste was stored appropriately. Appropriate sharps containers were used and removed before becoming overfull. Privacy curtains were used and replaced when required.
- The arrangements for managing medicines, including emergency medicines and vaccines, in the practice did not always keep patients safe (including obtaining, prescribing, recording, handling, storing, security and disposal). We found that all emergency medicines (contained within two grab boxes) were in date. However, regular checks were not completed to ensure the medicines were in date and appropriate for use.

- Vaccines were stored appropriately and in accordance with the practice policy. However, we found there were gaps in the recording of fridge temperatures. The practice policy stated they should be checked every day (when the practice was open). The practice also had data logger thermometers inside the fridge. However, the staff we spoke with on inspection were unware of how often these were checked and how this was recorded.
- Patient group directions (PGD) were not appropriately signed by the current clinical lead within the practice. (**A PGD is a written instruction for the supply and/or administration of a named licensed medicine for a defined clinical condition.** Their use allows a registered health care professional to administer a prescription only medicine to a group of patients who fit the criteria without them necessarily seeing a prescriber.) This was corrected on the day of inspection.
- Processes were in place for handling repeat prescriptions which included the review of high risk medicines. However, we found that medicine reviews were not taking place as appropriate.
- During the inspection in December 2016, we found that there was a delay for processing repeat prescriptions of up to eight working days. At this inspection we found there were no outstanding prescriptions awaiting processing. Staff told us this was the first time since December that the practice had been up to date. Patients told us that during the previous week they had waited five working days for repeat prescriptions.
- The practice had carried out one medicines audit since September 2016 to ensure prescribing was in line with best practice guidelines for safe prescribing. This audit was to assess the compliance with appropriate antibiotic prescribing. Results of the audit showed 44% of a particular type of antibiotic prescribed (in October 2016) did not follow the recommended antibiotic guidelines. This had improved by 52% since April 2016. The audit highlighted action points for the practice to follow to enable further improvements.
- Blank prescription forms and pads were securely stored and there were systems in place to monitor their use.
- We reviewed five personnel files to look at staff recruitment processes and background checks. We found appropriate recruitment checks had been undertaken in most cases. All clinical staff had checks through the Disclosure and Barring Service.

Monitoring risks to patients

Procedures in place were not appropriate for monitoring and managing risks to patient and staff safety. Staff at all levels told us that staffing levels were unsafe and did not ensure appropriate clinical cover for appointments or to complete clinical and administrative tasks to ensure patient safety. Patient feedback to CQC and from other sources indicated patients could not always access the care they needed.

- There was a health and safety policy available with a poster in the reception office which identified local health and safety representatives. The practice had up to date fire risk assessments and carried out regular fire drills. There were three actions from a fire risk assessment that was due to be completed by 7 January 2017. Two had not been actioned.
- All electrical equipment was checked to ensure the equipment was safe to use.
- Calibration of medical equipment was due by 19 January 2017 and we saw records that this was booked to take place in February 2017. We found a set of weighing scales that had not been calibrated since 6 February 2015.
- 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 for planning and monitoring the number of staff and mix of staff needed to meet patients' needs was insufficient. There were reported significant events and a backlog of clinical and administrative tasks to evidence this.

- The levels of staffing were not adequate to meet the needs of the patient population and evidence sent to us regarding the staffing levels at Priory Avenue Surgery was inconsistent. For example, we were told by the provider there had been 193 GP appointments for week commencing 23 January 2017. However, the screenshots of appointments we collected on the day of inspection shows that there were 84 GP appointments provided during the week commencing 23 January 2017. We were told that there were currently 3.8 whole time equivalent (WTE) GPs and 1.2 advanced nurse practitioners (ANP) providing clinical sessions at Priory

Avenue Surgery. However, we saw evidence from the rota provided to us during the inspection that there was an average of 1.4 GP WTE and 0.8 ANP WTE the week prior to the inspection.

- Not all staff deployed at the practice had the skills and experience to meet patients' needs. We noted from staffing rotas that there was frequent use of locum GPs and ANPs between October 2016 and January 2017. Staff reported that the ANPs were often unable to prescribe or treat the range of conditions that a fully trained ANP would be able to do. This regularly increased the number of patients that the GPs were left to see. This posed a difficulty for patients who needed ongoing care for a specific health need and sometimes created further unnecessary delays in waiting to see a second clinician.
- Staff told us that locum ANPs and GPs regularly did not turn up for their shift. We saw examples of this recorded on the significant event log. GPs failing to turn up for their shift meant that the remaining GP on shift was given a second list of patients to see or call and undertake home visits as required. The GPs we spoke with told us about the impact of staff shortages, which resulted in delayed contact with patients. They explained that they were under so much pressure that they were concerned about a mistake being made. They also reported not being able to review and process documentation to ensure patients received timely care and treatment or referrals to other services. The GPs we spoke with told us that they regularly worked additional unpaid hours in order to try and complete care tasks such as reviewing and issuing prescriptions.
- Patients reported that they were not always able to access appointments with the nursing team. Significant events raised show that patients were regularly being referred to the walk in centre due to a lack of capacity with the nursing staff at the practice.
- During the inspection we found evidence that demonstrated the extent of patient correspondence not yet reviewed or filed onto the record system. There were records of discharge summaries, Out of Hours, walk-in centre reports and A&E discharges on the EMIS system, dating back to 4 November 2016, and on the Docman system, back to 20 November 2016. The practice was unable to confirm that all of these documents had been reviewed to ensure the correct level of care and treatment had been received or further assessment had been requested.
- Since December 2016 the provider had employed a new clinical lead GP to support with clinical governance and leadership. They were employed as a 0.5 WTE for Priory Avenue Surgery according to discussions with members of the One Medicare Ltd leadership team. We saw from rotas they were given designated time to provide clinical governance support to GPs and other staff.

Arrangements to deal with emergencies and major incidents

The practice had adequate 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, staff were overdue update training, which was booked within the coming weeks, 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.
- 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. However, we found out of date emergency equipment and regular checks on emergency medicines were not completed.
- The practice had a comprehensive business continuity plan in place for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff.

Inadequate

Are services effective?

(for example, treatment is effective)

Our findings

During our inspection in December 2016, we identified concerns in relation to the effective domain. This included concerns regarding the backlog of administration and clinical tasks such as reviewing patient correspondence which may require action, patient summarising and referrals were not being dealt with in a timely way, leading to significant backlogs and delays in patient care. There was not an adequate system to prioritise patients who had urgent action waiting to be taken regarding communication from external care providers. At the inspection in January 2017, we found limited improvements had been made.

Effective needs assessment

The practice had systems for assessing the needs of its patients in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines. However, due to the limited access to appointments and lack of time for staff to complete clinical and administration tasks, the needs of patients were not always being met.

We saw examples where patients had required assessments such as blood tests and action had not been taken, despite significant health risks being identified. For example:

- We identified evidence of one patient who had an abnormally raised potassium level from results sent to practice on 12 December 2016. This was not reviewed by a GP until 9 January 2017. A further blood test was requested and results were received on 16 January 2017 identifying that the potassium was still abnormally raised. This had not been actioned until 26 January 2017. The delay in assessing the path results resulted in an unnecessary risk to a patient who needed an urgent review, care and treatment.
- We saw patient correspondence from the local hospital on 24 November 2016 requesting further blood tests for a patient, with a suspected borderline iron deficiency, which had not been actioned on the 26 January 2017.
- We saw patient correspondence, from a consultant cardiologist, requesting a change in medication to treat a patient for secondary prevention of progressing heart disease on 23 November 2016. This had still not been actioned on the 26 January 2017.
- We reviewed the referrals and identified there were 11 referral requests outstanding. As of 26 January 2017, the referral log indicated that the oldest request was dated 14 January 2017. However, upon review of the Docman system we identified further referrals which had not been actioned since 29 November 2016.
- We saw the backlog of patient summarising dated back to October 2016. There had been no action taken regarding the summarising since the previous inspection on 1 December 2016.
- From information provided before the inspection, we saw that patient medicine reviews were not taking place in a timely way. For patients on less than four medicines 56% had an up to date medication review and for patients on four or more medicines 75% had an up to date medicine review. This posed a risk of harm to patients as they may be taking medicines for longer periods than necessary.
- The practice had systems in place to keep all clinical staff up to date. Staff had access to guidelines from NICE and used this information to deliver care and treatment that met patients' needs.

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent unvalidated data from 2016/17 showed variation in performance within the current QOF year (ending in March 2017). For example:

- In 2016/17 performance for diabetes was as follows: Blood pressure indicators showed 84% of patients were within desirable blood pressure ranges compared to the expected achievement of 93%, 87% of patients had a foot examination within the last 12 months compared to the expected achievement of 93%.
- Performance for chronic obstructive pulmonary disease related (COPD) indicators in 2016/17 showed that 95% of patients had received up to date spirometry tests while 64% had an annual review within the current year.
- Performance for mental health related indicators in 2016/17 showed 75% of patients had an agreed care

Inadequate

Are services effective?

(for example, treatment is effective)

plan in place compared to the expected achievement of 90%. Blood pressure indicators showed that 98% of patients were in the desirable range compared to the expected achievement of 90%.
- Seventy two percent of patients had up to date asthma reviews compared to the expected achievement of 70%.

The practice was not yet able to provide an exception rate for their QOF data. (Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects).

Staff told us the high use of locum staff did not ensure that all nurses could deliver the assessments patients always required to meet the needs of patients with long term conditions and complex needs. However, we unable to measure the impact lack of assessments and monitoring from the current QOF results. The provider had taken over the contract of Priory Avenue Surgery in September 2016 and a full years QOF data was not available.

There was limited evidence of quality improvement including clinical audit.

- We looked at clinical audits undertaken since the provider took over in September 2016. The single cycle audits were prescribing incentive scheme audits, with templates and searches provided by the CCG for the practice to undertake. They had not been repeated to identify or make quality improvements.

Effective staffing

Staff deployed onsite did not always have 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.
- Staff could access role-specific training and updates when required, but records we reviewed demonstrated that training for several topics such as fire safety, safeguarding and health and safety was overdue.
- Staff told us that locum advanced nurse practitioners did not always have the necessary skills to prescribe and provide specific care to patients. Some locum GPs did not have the experience, knowledge or tools to undertake all tasks relevant to their role, such as referrals.

Coordinating patient care and information sharing

The information needed to plan and deliver care and treatment was available to relevant staff. However, they were unable to review and process this in a timely and accessible way through the practice's patient record system and their intranet system, due to the reduced staff capacity.

- This included delays to updating care and risk assessments, reviewing care plans, updating medical records and reviewing investigation and test results.
- The practice shared relevant information with other services in a timely way, for example when referring patients to other services.
- Meetings took place with other health care professionals on a monthly basis when care plans were routinely reviewed for patients with complex needs.

Staff worked together and with other health and social care professionals to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. This included when patients moved between services, including when they were referred, or after they were discharged from hospital.

Consent to care and treatment

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

- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005.
- 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 some patients who may be in need of extra support and provided some screening programmes. For example:

Inadequate

Are services effective?

(for example, treatment is effective)

- Patients receiving end of life care, carers, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation. Patients were signposted to the relevant service.
- The practice's unvalidated uptake for the cervical screening programme was 89%, which was above the expected achievement of 80%.
- The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening.
- There were 35 patients on the dementia register and one eligible patient had been offered screening for dementia since the new provider took over the contract in September 2016.
- The practice offered annual health checks to patients with a learning disability. There were 37 patients on the register and 22 had health checks since September 2016.
- The practice had referred and seen 12 patients at a smoking cessation clinic.

The latest available childhood immunisation rates for the vaccinations given to children registered with Priory Avenue were comparable to CCG averages. For example in 2015/16, childhood immunisation rates for the vaccinations given to under two year olds ranged from 85% to 96% (CCG averages 58%-96%) and five year olds from 77% to 92% (CCG averages 91%-97%).

Requires improvement

Are services caring?

Our findings

There were times when patients did not feel well supported or well cared for. Evidence from patients we spoke with on the day, comments cards, feedback from external individuals and stakeholders described poor levels of service and care received by patients since September 2016.

Kindness, dignity, respect and compassion.

We observed that members of staff were courteous and very helpful to patients and treated them with dignity and respect.

- Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- We noted that consultation and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.
- Reception staff knew when patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.

During this inspection we received 14 patient CQC comment cards. Of these, five were positive about the service experienced, with seven having some negative comments regarding waiting times for appointments, continuity of care and delays with repeat prescriptions. This showed some progress but further improvements were needed to meet patient's needs.

Patients we spoke to on the day of inspection said they felt the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect. However, patients also told us that they had recently had long waits for repeat prescriptions (up to one week) and that they did not always receive the appropriate care due to a lack of continuity. One patient raised a complaint about the care and treatment they had received, we shared this with the practice so they could review the patients concerns.

We also spoke with three members of the patient participation group. They told us that they had raised concerns to the provider on the poor level and quality of services being offered to patients. Members of the PPG confirmed they were working with the practice to try and identify different ways of working so improvements were made to patient care and access to appointments.

Results from the national GP patient survey are not available for this provider. One Medicare Ltd took over the contact in September 2016 and annual results for this practice will be available in July 2017.

Friends and family test results showed that patient satisfaction had steadily decreased since September 2016:

- In September 2016, 72% of patients were either likely or extremely likely to recommend Priory Avenue Surgery to their friends and family. 19% were unlikely or extremely unlikely to recommend the practice to their friends and family.
- In October 2016, 63% of patients were either likely or extremely likely to recommend Priory Avenue Surgery to their friends and family. 22% were unlikely or extremely unlikely to recommend the practice to their friends and family.
- In November 2016, 63% of patients were either likely or extremely likely to recommend Priory Avenue Surgery to their friends and family. 25% were unlikely or extremely unlikely to recommend the practice to their friends and family.
- In December 2016, 60% of patients were either likely or extremely likely to recommend Priory Avenue Surgery to their friends and family. 27% were unlikely or extremely unlikely to recommend the practice to their friends and family.

Feedback on the NHS Choices website showed the practice had scored 2 out of five stars on the overall score for the practice. Three patients had left feedback about the practice since December 2016, which related to poor services and the lack of access to appointments.

One Medicare had recognised patient feedback was poor and was working to improve the services to patients. We saw from evidence on the day of inspection that future staffing plans included increased numbers of clinical staff to ensure access was improved. However, we were unable to test or evidence the impact of these improvements at this inspection.

Care planning and involvement in decisions about care and treatment

Requires improvement

Are services caring?

Patients 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. However, the difficulty in making appointments affected their continuity of care.

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.
- Information leaflets were available in easy read format.

Patient and carer support to cope emotionally with care and treatment

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

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 93 patients as carers (Approximately 1.3% of the practice list). Written information was available to direct carers to the various avenues of support available to them. Carers were flagged on the record system to identify them to staff.

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

Inadequate

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

During our inspection in December 2016, we identified concerns in relation to the responsive domain. This included concerns regarding access to appointments, continuity of care and a lack of planning to meet the needs of the practice population.

At the inspection in January 2017, we found limited improvements had been made.

Responding to and meeting people's needs

The practice had a limited review of the needs of its local population. However, they had engaged with the Clinical Commissioning Group (CCG) to secure additional funding to ensure limited improvements to services. The current staffing model and shortages of staff had impacted on the practice's ability to respond to patient's needs. For example, the change in GP staffing levels had meant the principle of 'personal list' had ceased. Patients over 75 years old were no longer supported in having a named GP due to the low numbers of GPs in the practice. This resulted in a lack of continuity of care and patients reported this as a concern on the day of inspection.

- The practice offered appointments until 6.30pm every weekday and extended hours on a Tuesday and Wednesday evening until 7pm. The practice also offered Saturday morning appointments.
- Appointments could be booked in person, over the phone or electronically.
- There was an online repeat prescription service for patients. This enabled patients who worked full time to access and order their prescriptions. Patients could also drop in repeat prescription forms to the surgery to get their medications. Some patients we spoke with told us that the repeat prescription service had delays of up to one week. However, we found the back log of repeat prescription requests had been resolved on the day of inspection.
- Patients were able to receive travel vaccinations available on the NHS.
- There were disabled facilities, a hearing loop and translation services available.
- The facilities were based on two floors, with patients who could use the stairs seen on the ground floor.

Access to the service

The practice was open between 8am and 6.30pm Monday to Friday. Appointments were from 8.30am to 6.30pm every weekday. Extended hours appointments were offered between 6.30pm and 7pm on Tuesdays and Wednesdays. The practice also offered Saturday morning appointments.

The patient feedback on access was mixed. Some patients we spoke with reported difficulty in accessing a named GP which led to a poor continuity of care. Patients said access to a preferred GP was poor and at times had to wait for a routine appointment with a preferred GP for over four weeks. Other patients said they were happy to see any GP and were able to make an appointment fairly easily and did not have wait too long to be seen.

The practice had a system in place to assess:

- whether a home visit was clinically necessary; and
- the urgency of the need for medical attention.

This was done by telephoning the patient or carer in advance to gather information to allow for an informed decision to be made on prioritisation according to clinical need. In cases where the urgency of need was so great that it would be inappropriate for the patient to wait for a GP home visit, alternative emergency care arrangements were made. Clinical and non-clinical staff were aware of their responsibilities when managing requests for home visits.

- Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice. One of the GPs had previously undertaken a weekly visit to the local care home but this had been stopped due to capacity issues. The practice advised us on the day of inspection that the care home visit was to be reinstated as this had created an increase in home visit requests.
- Same day appointments were available for children and those patients with medical problems that require same day consultation. However, patients reported not being able to access appointments for their child. On the day of inspection, we identified a parent of a child had contacted the practice requesting an urgent appointment at 8am in the morning. Staff asked the GP to give the parent a call back but they did not take place until after 6pm the same evening. The evening call resulted in the child being taken to accident and

Inadequate

Are services responsive to people's needs?

(for example, to feedback?)

emergency for care and treatment as the GP was unable to offer the family an appointment that evening. The patient was placed at risk due to the delayed call and untimely advice about care and treatment.
- Staff reported that they were often unable to offer appointments to patients on the same day and they were redirected to other local services, such as the walk in centre.

Listening and learning from concerns and complaints

The practice had an ineffective system in place for handling complaints and concerns.

- The provider's complaints policy was in line with recognised guidance and contractual obligations for GPs in England.
- We saw that information was available to help patients understand the complaints system including posters and leaflets in the waiting areas and reception. Details of how to make a complaint was also on the practice website.
- We looked at ten complaints received since the previous inspection in December 2016. All of these related to long delays with repeat prescriptions. However, there was limited action taken and recorded to demonstrate the improvement to the quality of care or services. All complainants were sent an acknowledgement letter but no final apology letter was sent outlining the findings of any investigations or actions taken to make improvements. The practice was failing to act in accordance with the complaints policy.
- Investigation and records of complaints were not comprehensive or discussed with relevant practice staff to ensure the sharing of lessons learnt. We reviewed the minutes of meetings held between September and November 2016, these included no details about complaints discussions. The practice confirmed that no further meetings had taken place after November 2016 and therefore complaints were not considered collectively to identify the trends.

Are services well-led?

Inadequate

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

Our findings

During our inspection in December 2016, we identified concerns in relation to the well-led domain. This included concerns regarding a lack of governance systems in place to assess, monitor and mitigate risks to the health and welfare of patients. Effective systems to assess, monitor and improve the quality and safety of the services provided had also not been implemented.

At the inspection in January 2017, we found limited improvements had been made.

Vision and strategy

The provider's vision to deliver high quality care and promote good outcomes for patients was not supported by an effective leadership and governance. At the time of inspection, evidence confirmed that the level of care and quality outcomes for patients was poor and patients had reported in the previous six weeks that improvements were limited.

The practice had a mission statement. However, there was a lack of strategy and supporting business plans to reflect the vision and values and these were not regularly monitored and updated.

Governance arrangements

The practice had a governance framework but this was not effective and did not support the delivery of safe, effective and responsive care. We found significant risks were not assessed appropriately to determine the high level of impact to patient safety. The actions to mitigate the risks were ineffective and had not made sufficient improvements to the levels and quality of services provided to patients.

- The governance and processes had not dealt with the inherent risks associated with the backlog of patient correspondence, lack of appropriately trained staff and medical record summarising that was identified at the previous inspection in December 2016. In January 2017, we found the provider had not taken appropriate action based on a priority of risk and patient need.
- There was a limited system for identifying, capturing and managing issues and risks. Significant issues that threatened the delivery of safe and effective care to patients were not adequately managed or acted on with sufficient urgency. The provider did not have a plan in place to mitigate the risks associated with the lack of consistent and appropriately trained GPs and Advance Nurse Practitioners. The provider told us they were supporting the practice with remote clinical advice and a new clinical lead had been employed since the previous inspection. However, there was no contingency plans to ensure sustainable levels of suitably trained, skilled and experienced clinical staff were maintained during the recruitment of new GPs and ANPs or in the longer term as the provider plans included a high use of locum staff.
- Staff who worked at the practice told us they repeatedly reported concerns to the provider about staffing levels and the backlog of patient correspondence and prescription requests. During the January 2017 inspection, we found that the provider had still not responded appropriately to reduce the high level of risk or taken corrective action to reduce the backlog of administration tasks. We found examples of poor care resulting from a lack of appropriate systems to monitor and address the backlog.
- The information that was used to monitor performance or to make decisions was inaccurate and unreliable. The action plan information provided to the Care Quality Commission and North and West Clinical Commissioning Group following the December inspection was inaccurate. We noted many of the actions were confirmed as completed on the action log, however on the day of inspection in January 2017 we identified continued concerns which evidenced most actions had not been completed as described. Furthermore, the evidence submitted from the provider to demonstrate the number of nurses and GPs was inconsistent and we were unable to ascertain the actual level of staffing at the practice.

Leadership and culture

Leaders did not have the necessary experience, knowledge, capacity or capability to lead effectively. Despite a local senior operations manager being on site and clinical lead being appointed there was a lack of clarity and authority to make decisions about mitigating risks or to make quality improvements. Some of the staff we spoke with on the day of inspection and individuals who contacted prior to the inspection, reported that quality and safety were not the top priority for the provider leadership team and meeting financial targets was seen as more important.

Are services well-led?

Inadequate

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

Staff were not clear about their own roles and responsibilities, and this had been affected by the constant changes in staffing. The practice had gone through significant periods of change in the last few years. We found the leadership team and processes that were in place did not enable effective change management processes. There had been failures in communication between the provider, the leadership team and staff. For example, significant events learning was not shared with staff and practice meetings had been cancelled from November 2016. Practice staff reported feeling demotivated, demoralised and disillusioned with the reported lack of management support. The departure of on-site practice management and other staff in the recent months further de-stabilised the practice team.

The practice had recently employed a clinical lead to support governance systems and process and to drive improvement. The provider did have a recruitment drive in place to try and recruit a lead nurse, a practice manager and regular advanced nurse practitioners.

Staff told us that they felt the provider did not encourage a culture of openness and honesty. This was evidenced by staff reporting significant events and them not being responded too, investigated thoroughly and appropriate action taken. Other staff also reported being pressurised by senior leaders of One Medicare Ltd to just get on with the work and not report any concerns to the Care Quality Commission.

The practice did not have systems in place to ensure that when things went wrong with care and treatment:

- The practice did not give affected people reasonable support, truthful information and a verbal and written apology
- The practice kept written records of verbal interactions as well as written correspondence, but information within the records was limited.

There was a leadership structure in place, however staff told us that this was not a supportive relationship.

- Staff told us the practice had their team meetings cancelled since December 2016.
- Staff told us there was not an open culture within the practice and although they had the opportunity to raise any issues they did not feel confident and supported in doing so.

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

The practice had not acted on feedback provided from patients, the public and staff. There was limited action to improve the concerns patients raised about the delivery of service.

- Staff told us that regular team meetings were cancelled due to the pressures of providing the service to patients and the lack of all levels of staff.
- Staff told us they had the opportunity to raise any issues but did not feel confident and supported in doing so or that action would be taken.
- There are low levels of staff satisfaction, high levels of stress and work overload for clinicians. Staff did not always feel respected, valued, supported and appreciated, particularly by the management team or provider leadership team. We reported this to the provider's senior leader who told us that all staff were involved in discussions about how to run and develop the practice, and the management team encouraged all members of staff to identify opportunities to improve the service delivered by the practice. The practice had gathered further feedback from patients through the patient participation group (PPG), but members of the PPG reported minimal improvements had been made and there was a lack of engagement from the provider leadership team. The practice had not collected feedback through surveys and did not respond appropriately or take action from complaints received. However, improvements to the same day appointment system had been discussed but had not been implemented on the day of inspection.

- Staff commented the onsite leadership team had changed and reduced to an extent that they did not know who would appropriately deal with any concerns raised.

Continuous improvement

- The provider had failed to respond and implement changes identified at the previous inspection to a safe level. This includes the failure to meet requirements of the urgent enforcement action taken by the Care Quality Commission to ensure patients health, safety and welfare was protected.
- Due to the current difficulties in the practice there was little opportunity for innovation or service development.

Are services well-led?

Inadequate

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

There was also minimal evidence of learning and reflective practice. However, the provider did share their vision to implement a new service model which focuses more on support and advice for patients and the prevention of illness.

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 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints Insert the relevant regulation and justification of how it was not being met. Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.: Receiving and Acting on Complaints **How the regulation was not being met:** The registered person did not establish and operate effectively and accessible system for identifying, receiving, recording, handling and responding to complaints by service users. This was in breach of regulation 16 (1) (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 **How the regulation was not being met:** The provider did not assess the risks to the health and safety of service users in regards to receiving the care or treatment and not doing all that is reasonably practicable to mitigate any such risks. The provider did not ensure that where responsibility for the care and treatment of service users was shared with, or transferred to, other persons, working with such other persons, service users and other appropriate persons to ensure that timely care planning took place to ensure the health, safety and welfare of the service users. Specifically risks associated with repeat prescription requests, referrals, medication reviews, patient correspondence and paper medical records. This was in breach of Regulation 12 Safe care and treatment (1) (The action taken is subject to appeal)

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 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. **How the regulation was not being met:**

This section is primarily information for the provider

Enforcement actions

The system of clinical governance did not ensure that the provider assessed and monitored the quality and safety of the services provided in the carrying on of the regulated activity. They did not implement quality improvement where this was required and where specific risks were reported to the provider by CQC in December 2016. They did not evaluate and improve their practice in respect of the processing of information regarding the performance of the service. Specifically in regards to concerns reported by patients and staff and the inherent risks identified by a backlog of patient correspondence and other care related processes.

This was in breach of Regulation 17 Good governance (1)

(The action taken is subject to appeal)

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 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. **How the regulation was not being met:** There was not sufficient numbers of suitably qualified, competent, skilled and experienced persons in order to meet the requirements of this regulation. There was not sufficient staff to provide the care and appointments that the patient population required in a timely way. This posed a risk to the health and wellbeing of patients. Regulation 18(1) (The action taken is subject to appeal)