

# Dr Paul Moss (also known as North Shoebury Surgery

## Quality Report

Frobisher Way, Shoeburyness, Southend On Sea  
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Date of inspection visit: 20 March 2018

Website: <http://www.northshoeburysurgery.nhs.uk/> Date of publication: 14/05/2018

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

## Ratings

### Overall rating for this service

Requires improvement



Are services safe?

Requires improvement



Are services effective?

Good



Are services caring?

Requires improvement



Are services responsive to people's needs?

Good



Are services well-led?

Good



# Summary of findings

## Contents

### Summary of this inspection

|   |   |
|---|---|
| Overall summary                             | 2 |
| The six population groups and what we found | 4 |

### Detailed findings from this inspection

|  |    |
|--|----|
| Our inspection team  | 5  |
| Background to Dr Paul Moss (also known as North Shoebury Surgery | 5  |
| Detailed findings  | 6  |
| Action we have told the provider to take                         | 17 |

## Overall summary

### Letter from the Chief Inspector of General Practice

**This practice is rated as Requires improvement overall.** (Previous inspection September 2015 – Good)

The key questions are rated as:

Are services safe? – Requires improvement

Are services effective? – Good

Are services caring? – Requires improvement

Are services responsive? – Good

Are services well-led? – Good

As part of our inspection process, we also look at the quality of care for specific population groups. The population groups are rated as:

Older People – Requires improvement

People with long-term conditions – Requires improvement

Families, children and young people – Requires improvement

Working age people (including those recently retired and students) – Requires improvement

People whose circumstances may make them vulnerable – Requires improvement

People experiencing poor mental health (including people with dementia) – Requires improvement

We carried out an announced comprehensive inspection at Dr Paul Moss on 20 March 2018 as part of our inspection programme.

At this inspection we found:

- The practice had clear systems to manage risk so that safety incidents were less likely to happen. When incidents did happen, the practice investigated appropriately and discussed them within meetings however, there was a lack of evidence on what actions were taken to reduce the risk of reoccurrence.
- Prescription stationery was not stored securely.
- There were no risk assessments in place for hazardous chemicals used onsite.
- Although recruitment checks were in place, some checks, required by legislation, were not completed.
- The practice ensured that care and treatment was delivered according to evidence-based guidelines.
- CQC comment cards and patients with spoke with on the day mostly told us that staff involved and treated them with dignity and respect. Data from the GP survey shows that patients were less satisfied in these areas.
- Patients' views on the appointments system were mixed.

# Summary of findings

- The practice monitored performance however, for some performance areas, such as patient satisfaction data, there were no plans to address this.
- The lead GP was key in many of the practice processes and there was no firm contingency plan for unexpected absence.
- There was a focus on continuous learning and improvement at all levels of the organisation.

The areas where the provider **must** make improvements are:

- Ensure care and treatment is provided in a safe way to patients.

The areas where the provider **should** make improvements are:

- Continue to monitor and review practice performance and complete action plans for areas of lower performance.
- Consider a contingency plan for unexpected absence of the lead GP.
- Review patients satisfaction data to identify where improvements could be made.

**Professor Steve Field (CBE FRCP FFPH FRCGP)**

Chief Inspector of General Practice

# Summary of findings

## The six population groups and what we found

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

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

# Dr Paul Moss (also known as North Shoebury Surgery)

## Detailed findings

### Our inspection team

#### **Our inspection team was led by:**

A CQC lead inspector and included a GP specialist adviser.

<http://www.northshoeburysurgery.nhs.uk/>

Dr Paul Moss has a patient list size of around 3,237. The level of income deprivation affecting children within the practice patient population is slightly higher levels of deprivation than the Clinical Commissioning Group (CCG) and England average.

## Background to Dr Paul Moss (also known as North Shoebury Surgery)

The provider for this service is Dr Paul Moss. The practice is based in Southend-on-Sea, and provides general medical services to the local population. The practice website is:

# Are services safe?

## Our findings

**We rated the practice, and all of the population groups, as requires improvement for providing safe services.**

The practice was rated as requires improvement for providing safe services because:

- Systems relating to the security of prescription stationery required strengthening.
- Procedures around recruitment checks required review.
- Although incidents were reported and investigated, there was a lack of information on actions that the practice had taken to reduce the risk of a reoccurrence.
- There was no risk assessment regarding the hazardous chemicals used within the practice.

### Safety systems and processes

The practice had systems to keep patients safe and safeguarded from abuse, by some of these required strengthening.

- The practice had a suite of safety policies including adult and child safeguarding policies which were regularly reviewed and communicated to staff. Staff received safety information for the practice as part of their induction and refresher training. Policies were regularly reviewed and were accessible to all staff, including locums.
- There was a system to highlight vulnerable patients on records and a risk register of vulnerable patients.
- The practice worked with other agencies to support patients and protect them from neglect and abuse. Staff took steps to protect patients from abuse, neglect, harassment, discrimination and breaches of their dignity and respect.
- All staff received up-to-date safeguarding and safety training appropriate to their role. They knew how to identify and report concerns. Reports and learning from safeguarding incidents were available to staff. Staff who acted as chaperones were trained for the role and had received a DBS check.
- The practice carried out staff checks, including checks of professional registration where relevant, on recruitment and on an ongoing basis. Disclosure and Barring Service (DBS) checks were undertaken where required. (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). We found that the practice did not ask for and keep proof of address for employees. On recruitment the practice only checked the hepatitis B status of staff and did not complete other expected immunity checks.

- There was an effective system to manage infection prevention and control.
- There were systems for safely managing healthcare waste.
- The practice ensured that facilities and equipment were safe and that equipment was maintained according to manufacturers' instructions.
- The practice had not completed any risk assessments for the use of chemicals kept onsite, such as, ant killer.

### Risks to patients

There were adequate systems to assess, monitor and manage risks to patient safety.

- There were arrangements for planning and monitoring the number and mix of staff needed. There was an effective approach to managing staff absences and for responding to epidemics, sickness, holidays and busy periods.
- There was an effective induction system for temporary staff tailored to their role.
- The practice was equipped to deal with medical emergencies and staff were suitably trained in emergency procedures.
- Staff understood their responsibilities to manage emergencies on the premises and to recognise those in need of urgent medical attention. Clinicians knew how to identify and manage patients with severe infections including sepsis.

### Information to deliver safe care and treatment

Staff had the information they needed to deliver safe care and treatment to patients.

- Individual care records were written and managed in a way that kept patients safe. The care records we saw showed that information needed to deliver safe care and treatment was available to relevant staff in an accessible way.
- The practice had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment. The practice had an approach for the management of test results.

# Are services safe?

- Referral letters included all of the necessary information.

## Safe and appropriate use of medicines

The majority of the practices systems for appropriate and safe handling of medicines were reliable, however some required strengthening.

- The systems for managing and storing medicines, including vaccines, medical gases, and emergency medicines and equipment minimised risks.
- The procedures relating to prescription stationery security required review and improvement, in relation to security and storage.
- Staff prescribed, administered or supplied medicines to patients and gave advice on medicines in line with legal requirements and current national guidance.
- Patients' health was monitored to ensure medicines were being used safely and followed up on appropriately. The practice involved patients in regular reviews of their medicines.

## Track record on safety

The practice had a good safety record.

- There were comprehensive risk assessments in relation to safety issues.
- The practice monitored and reviewed activity. This helped it to understand risks and gave a clear, accurate and current picture that led to safety improvements.

## Lessons learned and improvements made

The practice learned and made improvements when things went wrong, however this process could be further improved.

- There was a system and policy for recording and acting on significant events and incidents. Staff understood their duty to raise concerns and report incidents and near misses. Leaders and managers supported them when they did so.
- There were adequate systems for reviewing and investigating when things went wrong. We saw that although events and incidents were discussed within clinical and other meetings it was not always clear what changes or improvements had been made to minimise the risks of it occurring again.
- There was a system for receiving and acting on safety alerts.

# Are services effective?

(for example, treatment is effective)

## Our findings

**We rated the practice and all of the population groups as good for providing effective services overall.**

### Effective needs assessment, care and treatment

The practice had systems to keep clinicians up to date with current evidence-based practice. We saw that clinicians assessed needs and delivered care and treatment in line with current legislation, standards and guidance supported by clear clinical pathways and protocols.

- Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.
- Prescribing data was in line with the Clinical Commissioning Group (CCG) and national average. The data was slightly higher than Public Health England (PHE) targets for GP practices.
- We saw no evidence of discrimination when making care and treatment decisions.
- Staff used appropriate tools to assess the level of pain in patients.
- Staff advised patients what to do if their condition got worse and where to seek further help and support.

#### Older people:

- Older patients who are frail or may be vulnerable received a full assessment of their physical, mental and social needs. The practice used an appropriate tool to identify patients aged 65 and over who were living with moderate or severe frailty. Those identified as being frail received a review by the local complex care team.
- Patients aged over 75 were invited for a health check. If necessary they were referred to other services such as voluntary services and supported by an appropriate care plan.
- The practice followed up on older patients discharged from hospital. It ensured that their care plans and prescriptions were updated to reflect any extra or changed needs.
- Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs.

#### People with long-term conditions:

- Patients with long-term conditions had a structured annual review to check their health and medicines

needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.

- Staff who were responsible for reviews of patients with long-term conditions had received specific training.
- Data from 2016-2017 regarding the practice performance for patients with long-term conditions was comparable to the Clinical Commissioning Group (CCG) and national averages.

#### Families, children and young people:

- Childhood immunisations were carried out in line with the national childhood vaccination programme. Uptake rates for the vaccines given were above the target percentage of 90%.
- The practice had arrangements to identify and review the treatment of newly pregnant women on long-term medicines. These patients were provided with advice and post-natal support in accordance with best practice guidance.
- The practice had arrangements for following up failed attendance of children's appointments following an appointment in secondary care or for immunisation.

#### Working age people (including those recently retired and students):

- The practice's uptake for cervical screening was 75%. This was in line with the CCG and national average but lower than the 80% coverage target for the national screening programme.
- The practices' uptake for breast and bowel cancer screening was in line the national average.
- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40-74. There was appropriate follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.

#### People whose circumstances make them vulnerable:

- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.



# Are services effective?

## (for example, treatment is effective)

- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability.

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

- 94% of patients diagnosed with dementia had their care reviewed in a face-to-face meeting in the previous 12 months. This is comparable to the CCG and national average.
- 94% of patients diagnosed with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive, agreed care plan documented in the previous 12 months. This is above the national average.
- The practice specifically considered the physical health needs of patients with poor mental health and those living with dementia. For example, 97% of patients experiencing poor mental health had received discussion and advice about alcohol consumption. This is comparable to the national average.

### Monitoring care and treatment

The practice had a programme of quality improvement activity. For example, they completed an audit relating to osteoporosis which resulted in improved outcomes for patients with this condition.

The most recent published QOF results for the year 2016-2017 was 97% of the total number of points available compared with the clinical commissioning group (CCG) average of 93% and national average of 97%. The overall exception reporting rate was 9% compared with the CCG average of 9% and the national average of 10%. (Exception reporting is the removal of patients from QOF calculations where, for example, the patients decline or do not respond to invitations to attend a review of their condition or when a medicine is not appropriate.)

- The practice used information about care and treatment to make improvements. For example, they used information to guide medicines management and staff learning needs.
- The practice was actively involved in some quality improvement activity, such as audit.
- Where appropriate, clinicians took part in local improvement initiatives, such as locality meetings which reviewed patient care.

### Effective staffing

Staff had the skills, knowledge and experience to carry out their roles. For example, staff whose role included immunisation and taking samples for the cervical screening programme had received specific training and could demonstrate how they stayed up to date.

- The practice understood the learning needs of staff and provided protected time and training to meet them. Up to date records of skills, qualifications and training were maintained. Staff were encouraged and given opportunities to develop.
- The practice provided staff with ongoing support. This included an induction process, appraisals, clinical supervision and support.

### Coordinating care and treatment

Staff worked together and with other health and social care professionals to deliver effective care and treatment.

- We saw records that showed that all appropriate staff, including those in different teams, services and organisations, were involved in assessing, planning and delivering care and treatment.
- Patients received coordinated and person-centred care. This included when they moved between services, when they were referred, or after they were discharged from hospital. The practice worked with patients to develop personal care plans that were shared with relevant agencies.
- The practice ensured that end of life care was delivered in a coordinated way which took into account the needs of different patients, including those who may be vulnerable because of their circumstances.

### Helping patients to live healthier lives

Staff were consistent and proactive in helping patients to live healthier lives.

- The practice identified patients who may be in need of extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.
- Staff encouraged and supported patients to be involved in monitoring and managing their health.
- Staff discussed changes to care or treatment with patients and their carers as necessary.

# Are services effective?

(for example, treatment is effective)

- The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns, tackling obesity.
- Clinicians understood the requirements of legislation and guidance when considering consent and decision-making.
- Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.

## Consent to care and treatment

The practice obtained consent to care and treatment in line with legislation and guidance.

# Are services caring?

## Our findings

**We rated the practice, and all of the population groups, as requires improvement for caring.**

The practice was rated as requires improvement for providing caring services because:

- Data from the GP survey published in July 2017 showed patients were less satisfied with many aspects of patient care.

### Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- Staff understood patients' personal, cultural, social and religious needs.
- The practice gave patients timely support and information.
- Reception staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.
- Four of the five patient Care Quality Commission comment cards we received were positive about the service experienced. The fifth comment card did not relate to this area.
- This is in line with the majority of results of the NHS Friends and Family Test and other feedback received by the practice.

Results from the July 2017 annual national GP patient survey showed patients felt they were treated with compassion, dignity and respect. 288 surveys were sent out and 101 were returned. This represented a 35% response rate. The practice was below average for some of its satisfaction scores on consultations with GPs and nurses. For example:

- 76% of patients who responded said the GP was good at listening to them compared with the clinical commissioning group (CCG) average of 87% and the national average of 89%.
- 90% of patients who responded said they had confidence and trust in the last GP they saw compared with the CCG average of 94% and the national average of 96%.

- 75% of patients who responded said the last GP they spoke to was good at treating them with care and concern compared with the CCG average of 83% and the national average of 86%.
- 72% of patients who responded said the nurse was good at listening to them compared with the CCG average of 93% and the national average of 92%.
- 75% of patients who responded said the last nurse they spoke to was good at treating them with care and concern compared with the CCG average of 92% and the national average of 91%.

The practice had completed a satisfaction survey and had an action plan to address issues. The action plan did not show what action would be taken to improve the outcome for those patients who had responded less positively beyond discussing this in the next practice meeting.

### Involvement in decisions about care and treatment

Staff offered some support to enable patients be involved in decisions about their care.

- Staff were aware of the Accessible Information Standard (a requirement to make sure that patients and their carers can access and understand the information they are given). Support offered to patients included translation of documents, use of text messaging, and a hearing loop. Depending on the specific patient need, the clinicians have a computer alert so that they ensure they take into account the patient's communication needs during the consultation or treatment session. Following inspection, we found that the healthcare assistant at the practice had received an update and now asked all new patients if they had any communication needs and how they would like information to be communicated.
- Interpretation services were available for patients who did not have English as a first language.
- Staff helped patients and their carers find further information and access community and advocacy services.

The practice proactively identified patients who were carers through consultations and via the new patient forms. The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 53 patients as carers (1.6% of the practice list).

- Carers were offered annual reviews and flu vaccinations.

## Are services caring?

- Staff told us that if families of patients with complex needs had experienced bereavement, their usual GP contacted them or sent them a sympathy card. This call may either be followed by a patient consultation and/or by giving them advice on how to find a support service.

Results from the national GP patient survey showed patients were less satisfied about their involvement in planning and making decisions about their care and treatment. Results were lower than local and national averages:

- 73% of patients who responded said the last GP they saw was good at explaining tests and treatments compared with the clinical commissioning group (CCG) average of 84% and the national average of 86%.
- 66% of patients who responded said the last GP they saw was good at involving them in decisions about their care compared with the CCG average of 78% and the national average of 82%.
- 72% of patients who responded said the last nurse they saw was good at explaining tests and treatments compared with the CCG average of 92% and the national average of 90%.
- 67% of patients who responded said the nurse was good at involving them in decisions about their care compared with the CCG average of 87% and the national average of 85%.

The patient satisfaction survey completed by the practice mentioned earlier also related to patients satisfaction with their level of involvement in their care.

### Privacy and dignity

The practice respected patients' privacy and dignity.

- Staff recognised the importance of patients' dignity and respect.
- The waiting room was in the same area as the reception however there were windows in place with minimised the amount of detail that could be overheard.

# Are services responsive to people's needs?

(for example, to feedback?)

## Our findings

**We rated the practice, and all of the population groups, as good for providing responsive services.**

### Responding to and meeting people's needs

The practice organised and delivered services to meet patients' needs. It took account of patient needs and preferences.

- The practice had a basic understanding of the needs of its population. They were restricted in the services that they could offer due to their current staffing structure. They offered online services such as repeat prescription requests, advanced booking of appointments. They also offered a phlebotomy service for those who were unable to access external services, where this was required urgently, or for those who were vulnerable.
- The facilities and premises were appropriate for the services delivered.
- The practice made reasonable adjustments when patients found it hard to access services. For example, where patients found it difficult to sit in the waiting area, the practice arranged the appointment either at the beginning or end of the clinic, or arranged for the patient to wait in an empty room.
- Care and treatment for patients with multiple long-term conditions and patients approaching the end of life was coordinated with other services.

#### Older people:

- All patients had a named GP who supported them in whatever setting they lived, whether it was at home or in a care home or supported living scheme.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs.
- If patients were unable to attend the practice then we could have a phlebotomy appointment in their own home.
- Older patients had access to fifteen-minute appointment slots.

#### People with long-term conditions:

- Patients with a long-term condition received an annual review to check their health and medicines needs were being appropriately met.

- The practice held regular meetings with the local district nursing team to discuss and manage the needs of patients with complex medical issues.
- The practice was working on identifying patients with Diabetes Mellitus who were at increased cardiovascular risk.

#### Families, children and young people:

- We found there were systems 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 accident and emergency (A&E) attendances. Records we looked at confirmed this.
- The practice kept a list of patients who have been unable to obtain a same day appointment and these are triaged, so that those with urgent need either are seen or receive a telephone consultation.

#### Working age people (including those recently retired and students):

- The needs of this population group had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care.
- Students studying away from home were able to access appointments.
- Telephone consultations were available which supported patients who were unable to attend the practice during normal working hours.

#### People whose circumstances make them vulnerable:

- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability.

#### People experiencing poor mental health (including people with dementia):

- Staff interviewed had a good understanding of how to support patients with mental health needs and those patients living with dementia.
- People experiencing poor mental health had access to fifteen-minute appointment slots.
- The practice was involved in a pilot to improve the physical health of those experiencing poor mental health. They told us that they continued to follow the principles of this pilot when reviewing patients from this group.

# Are services responsive to people's needs?

## (for example, to feedback?)

- A counsellor from a local therapy service was based at the practice weekly as part of a national initiative.

### Timely access to care and treatment

Patients had mixed views on whether they were able to access care and treatment from the practice within an acceptable timescale for their needs.

- Most patients had timely access to initial assessment, test results, diagnosis and treatment.
- Waiting times, delays and cancellations were minimal and managed appropriately.
- Patients with the most urgent needs had their care and treatment prioritised.
- Most patients reported that the appointment system was easy to use.
- We spoke with four patients; three told us that they were unable to easily make an appointment when they needed one.

Results from the July 2017 annual national GP patient survey showed that patients' satisfaction with how they could access care and treatment was comparable to local and national averages for four indicators and lower for two.

- 64% of patients who responded were satisfied with the practice's opening hours compared with the clinical commissioning group (CCG) average of 79% and the national average of 80%.
- 62% of patients who responded said they could get through easily to the practice by phone compared with the CCG average of 62% and the national average of 71%.
- 56% of patients who responded said that the last time they wanted to speak to a GP or nurse they were able to get an appointment compared with the CCG average of 71% and the national average of 75%.

- 64% of patients who responded said their last appointment was convenient compared with the CCG average of 64% and the national average of 73%.
- 64% of patients who responded described their experience of making an appointment as good compared with the CCG average of 70% and the national average of 73%.
- 53% of patients who responded said they don't normally have to wait too long to be seen compared with the CCG average of 53% and the national average of 58%.

The practice told us that their premises were used for a pilot weekend pre bookable GP service available to patients both within the practice and in the local area. They told us that they now had recruited more nurses. The practice told us that had struggled to recruit permanent GP staff.

### Listening and learning from concerns and complaints

The practice took complaints and concerns seriously and responded to them appropriately to improve the quality of care.

- Information about how to make a complaint or raise concerns was available. Staff treated patients who made complaints compassionately.
- The complaint policy and procedures were in line with recognised guidance. Four complaints were received in the last year. We reviewed three complaints in detail and found that they were satisfactorily handled in a timely way.
- The practice learned lessons from individual concerns and complaints and changed its procedures where necessary to improve the quality of care.



# Are services well-led?

Good 

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

## Our findings

**We rated the practice and all of the population groups as good for providing a well-led service.**

### Leadership capacity and capability

The sole partner had the skills to deliver high quality, sustainable care, however many of the systems in place were reliant on them which reduced their capacity.

- Leaders had the experience, capability and integrity to deliver the practice strategy and address risks to it.
- They were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges and were trying to address them.
- Leaders were visible and approachable.
- The practice had considered the future leadership of the practice, however was experiencing difficulties in recruiting a permanent clinical team.
- The lead GP had a period of protracted absence the previous year and during that time we found evidence that the governance and leadership required strengthening.

### Vision and strategy

The practice had a clear vision to deliver high quality, sustainable care. There was a clear set of values. They wanted to stabilise their clinical team. The practice had some strategies to achieve their priorities however these were reliant on the recruitment of permanent clinical staff.

### Culture

The practice had a culture of high-quality sustainable care.

- Staff stated they felt supported.
- The practice focused on the needs of patients.
- Leaders and managers acted on behaviour and performance inconsistent with the vision and values.
- Openness, honesty and transparency were demonstrated when responding to incidents and complaints. The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour.
- Staff we spoke with told us they were able to raise concerns and were encouraged to do so. They had confidence that these would be addressed.

- There were processes for providing all staff with the development they need. This included appraisal and career development conversations. Most staff had received regular annual appraisals in the last year. The practice manager had not received an appraisal in the last two years.
- Nurses were considered valued members of the practice team. They were given protected time for professional development.
- The practice actively promoted equality and diversity. Staff had received equality and diversity training.
- There were positive relationships between staff and teams.

### Governance arrangements

There were clear responsibilities, roles and systems of accountability to support good governance and management.

- Structures, processes and systems to support good governance and management were clearly set out, understood and effective.
- Staff were clear on their roles and accountabilities including in respect of safeguarding and infection prevention and control
- Practice leaders had established proper policies, procedures and activities to ensure safety and assured themselves that they were operating as intended.

### Managing risks, issues and performance

There were clear processes for managing risks, issues and performance.

- There were processes to identify, understand, monitor and address current and future risks including risks to patient safety.
- The practice had processes to manage current and future performance. Practice leaders had oversight of national and local safety alerts, incidents, and complaints.
- Clinical audit had a positive impact on quality of care and outcomes for patients. There was some evidence of action to change practice to improve quality.
- The practice had plans in place and had trained staff for major incidents.

### Appropriate and accurate information

The practice acted on some of their performance information.

# Are services well-led?

Good 

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

- Quality was discussed in relevant meetings where staff had sufficient access to information.
- Some information was used to monitor performance, however in other areas there was no formal action plan to address poor data. For example, the practice had no action plan to address the areas of the GP survey where they had not performed as well as other practices.
- The practice used information technology systems to monitor and improve the quality of care.
- The practice submitted data or notifications to external organisations as required.
- There were arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.
- Following our inspection, the practice provided us with an action plan showing the actions they had taken and were going to take to rectify the issues we identified.

## **Engagement with patients, the public, staff and external partners**

The practice involved patients, the public, staff and external partners to support services.

- A range of patients' staff were encouraged, heard and acted on to shape services and culture.
- There was an active patient participation group.
- The service was transparent, collaborative and open with stakeholders about performance.

## **Continuous improvement and innovation**

There were systems and processes for learning and continuous improvement.

- There was a focus on continuous learning and improvement at all levels within the practice.
- Staff knew about improvement methods and had the skills to use them.
- The practice made use of internal reviews of incidents and complaints, although learning from these could be improved. Learning was shared and used to make improvements.



## Requirement notices

### Action we have told the provider to take

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

| Regulated activity   | Regulation  |
|--|---|
| Diagnostic and screening procedures<br>Family planning services<br>Maternity and midwifery services<br>Surgical procedures<br>Treatment of disease, disorder or injury | <p>Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment</p> <p><b>Regulation 12(1): Safe care and treatment</b></p> <p>Care and treatment must be provided in a safe way for service users</p> <p><b>How the regulation was not being met:</b></p> <p>The registered persons had not done all that was reasonably practicable to mitigate risks to the health and safety of service users receiving care and treatment. In particular: Prescription stationery was not kept securely; there was a lack of information on action taken following investigation of significant events to reduce the risk of reoccurrence; there were no risk assessments completed for hazardous chemical kept onsite; recruitment checks did not consistently contain proof of address checks and the practice only checked staff for hepatitis B immunity.</p> <p>This was in breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.</p> |