Croston Medical Centre

Quality Report

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

Ratings

Overall rating for this service	Good
Are services safe?	Good
Are services effective?	Good
Are services well-led?	Requires improvement

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced focused inspection at Croston Medical Practice on 15 November 2016. The overall rating for the practice was requires improvement with the key questions of safe, effective and well-led rated as requires improvement. The full comprehensive report on the November 2016 inspection can be found on our website at http://www.cqc.org.uk/location/1-551021659.

This inspection was an announced focused inspection carried out on 28 June 2017 to confirm that the practice had carried out their plan to meet the legal requirements in relation to the breaches in regulations that we identified in our previous inspection on 15 November 2016. This report covers our findings in relation to those requirements and also additional improvements made since our last inspection.

Overall the practice is now rated as good.

Our key findings were as follows:

- In our inspection in November 2016, we saw that reviews and investigations of incidents were not thorough enough and there was confusion as to what constituted a significant incident. At this inspection, we saw that there was an open and transparent approach to safety and a system in place for reporting and recording significant events. Staff were clear about what constituted a significant event. Actions taken as a result of significant events were reviewed in a timely way and learning from events was shared.
- At our previous inspection we identified that recruitment procedures were not consistently undertaken, particularly for those undertaking chaperone duties. This inspection showed that the practice had a comprehensive recruitment policy that reflected current guidance. We saw that this policy was followed for all new staff recruited by the practice except for one locum practice nurse who had been previously permanently employed by the practice. We also saw that appropriate checks had been carried out for all staff acting as chaperones.
- During our previous inspection we found that staff had not received appraisals since 2014 and professional

Summary of findings

development was not identified. At this inspection visit we saw that all staff had received an appraisal within the last 12 months where any training needs were recognised.

- At our previous inspection, we found that there was no system for receiving national clinical guidance and guidelines and patient safety alerts into the practice. We saw evidence at this inspection that this situation had been addressed and that systems were now in place. However, there was no evidence of shared learning from these notifications, no formal clinical meetings or documentation of discussion.
- At our inspection in November 2016 we saw that clinical audits and quality improvement initiatives were limited. At this inspection, we saw evidence of further clinical audit and quality improvement that had been used to improve clinical practice. We also saw evidence of the implementation of an audit summary and a folder that had been created on the practice shared drive to share learning.
- During our previous inspection, we found that the registered person had not assessed the capacity to ensure sufficient numbers of clinical and non-clinical staff were employed to meet the requirements of the service. We found at this inspection that this capacity had still not been sufficiently addressed.
- At our previous inspection, we found that medicine expiry dates and the oxygen cylinder for use in emergencies were not effectively checked and recorded. At this inspection, we found that systems for checking medicine expiry dates and the emergency oxygen supply had been put in place, however, management overview of these systems and of logging daily vaccine fridge temperatures was lacking.
- During our inspection in November 2016, items of clinical stock and medicines were found to be out of date and the required pads for adult and paediatric use with the defibrillator were not in place. We saw at this inspection that this had been rectified and all items of stock were in date and pads in place.
- At our previous inspection, we saw that there was no evidence to show learning from complaints and that verbal complaints had not been recorded. We found that this had been addressed and saw evidence of learning and documentation of verbal complaints.
- At our inspection in November 2016, we found that office facilities for the practice manager were inappropriate and that medical records were not held securely. We saw at this inspection that this had been rectified; the practice manager's office was fit for purpose and medical records were securely stored.
- During our previous inspection, we asked that the practice confirm with the medical indemnity insurers that appropriate cover was in place for the number of sessions undertaken by the GP. This had now been confirmed appropriately.
- In our inspection in November 2016, we suggested that the practice make improvements to accurately identify the number of patients registered who also acted as carers and provide appropriate support. At this inspection, the practice showed us how they had interrogated their list of carers to ensure that they were appropriately coded and had made a small increase to the number of carers identified from 25 to 31 (0.8% of the practice list).

The areas where the provider must make improvements are:

- Ensure sufficient numbers of suitably qualified, competent, skilled and experienced persons are deployed to meet the fundamental standards of care and treatment.

In addition the provider should:

- Follow practice recruitment procedures for those staff who have been re-employed by the practice following an interval of more than three years.
- Develop clinical meeting structures and processes to allow formal clinical meetings to take place in order to evidence learning.
- Improve the oversight of staff monitoring of stocks and expiry dates of medicines and for the recording of vaccine fridge temperatures.
- Continue to identify and support patients who are also carers.

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?

Good

The practice is rated as good for providing safe services.

- From the sample of documented examples we reviewed, we found there was an effective system for reporting and recording significant events; lessons were shared to make sure action was taken to improve safety in the practice and these actions were reviewed in a timely manner. When things went wrong patients were informed as soon as practicable, received reasonable support, truthful information, and a written apology. They were told about any actions to improve processes to prevent the same thing happening again.
- We saw evidence that patient safety alerts were being received by the practice and were acted on. There was a file of alerts held by the principal GP and notes that these had been discussed and actions had been taken although recorded details of these actions were insufficient to ensure that learning was shared with all staff in the clinical team.
- Staff working as chaperones in the practice had been suitably trained and all staff had received a disclosure and barring service (DBS) check. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).
- There was a new system in place to check the stock levels and expiry dates of drugs in the practice, although there were some gaps in the recording of these. New temperature recorders for vaccine fridge temperatures had been purchased by the practice to better record temperatures, although we identified some gaps in the written records of daily temperature recordings.
- The practice had adequate arrangements to respond to emergencies and major incidents.
- The practice had a comprehensive recruitment policy and we saw that this had been followed for all staff except for one locum practice nurse who had previously been employed by the practice and had left in 2013. Appropriate recruitment checks were recorded in the file for the original employment.
- The practice had had a problem with recruitment and retention of staff. We saw that suitable numbers of reception staff would be in place following our inspection. However, an assessment of practice management and clinical hours had yet to be completed.

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Are services effective?

Good

The practice is rated as good for providing effective services.

- The practice received and acted on national guidelines and guidance such as NICE guidelines.
- We saw evidence of practice audit activity to demonstrate quality improvement.
- All staff had had an appraisal where learning needs were identified. Staff training was comprehensive and well supported by the practice.
- Newly-appointed staff had received a comprehensive induction into the practice including topics such as fire safety, information governance and confidentiality.

Are services well-led?

Requires improvement

The practice is rated as requires improvement for providing well-led services.

- The practice had started legal proceedings to develop future plans for the practice.
- There were comprehensive risk assessments in place to govern practice activity and all areas of risk had been actioned or mitigated save in the area of insufficient staffing.
- Clinical meetings were held between the two GPs to discuss areas of patient safety and clinical quality improvement, however these meetings were not minuted and were held on an ad hoc basis. We saw evidence of these occurring but no details of discussion to evidence and share learning. The practice assured us that they would address this in the future.
- There was no management overview of the system of checking the stock level and expiry dates of medicines in the practice or of recording daily vaccine fridge temperatures. New systems were in place but we saw some gaps in the monitoring of these.
- Patient medical records were held securely and the practice manager's office was fit for purpose and provided good facilities.
- We saw that the medical indemnity cover for the principal GP was sufficient.
- Staff told us that the authority of the practice manager was undermined by the principal GP and that they continued to work under unnecessary scrutiny. Staff felt that opportunities to rely on staff expertise were being missed and that current staffing levels meant that staff were working under pressure.
- We saw that there would be sufficient reception staff working following our inspection, however, the breach identified at our previous inspection in relation to management and clinical staffing capacity had not been addressed. The practice

Summary of findings

manager reported insufficient hours for the role and practice nursing hours had been decreased. At the time of our inspection, locum practice nurses were only providing nine hours a week, compared to the original 25 hours which were deemed insufficient at our last inspection.

- The practice had reinstated the patient participation group (PPG) with whom they shared information and received feedback. Staff feedback was sought at meetings and at appraisal and was acted on.
- The practice had a comprehensive complaints policy and learning from complaints was shared with staff at regular team meetings.

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
The provider had resolved the concerns for safety and effectiveness identified at our inspection on 15 November 2016 which applied to everyone using this practice, including this population group, although some concerns regarding providing well-led services remain. The population group ratings have been updated to reflect this. The specific findings relating to this population group can be found at http://www.cqc.org.uk/location/1-551021659

Good

People with long term conditions
The provider had resolved the concerns for safety and effectiveness identified at our inspection on 15 November 2016 which applied to everyone using this practice, including this population group, although some concerns regarding providing well-led services remain. The population group ratings have been updated to reflect this. The specific findings relating to this population group can be found at http://www.cqc.org.uk/location/1-551021659

Good

Families, children and young people
The provider had resolved the concerns for safety and effectiveness identified at our inspection on 15 November 2016 which applied to everyone using this practice, including this population group, although some concerns regarding providing well-led services remain. The population group ratings have been updated to reflect this. The specific findings relating to this population group can be found at http://www.cqc.org.uk/location/1-551021659

Good

Working age people (including those recently retired and students)
The provider had resolved the concerns for safety and effectiveness identified at our inspection on 15 November 2016 which applied to everyone using this practice, including this population group, although some concerns regarding providing well-led services remain. The population group ratings have been updated to reflect this. The specific findings relating to this population group can be found at http://www.cqc.org.uk/location/1-551021659

Good

People whose circumstances may make them vulnerable
The provider had resolved the concerns for safety and effectiveness identified at our inspection on 15 November 2016 which applied to everyone using this practice, including this population group,

Good

Summary of findings

although some concerns regarding providing well-led services remain. The population group ratings have been updated to reflect this. The specific findings relating to this population group can be found at http://www.cqc.org.uk/location/1-551021659	
People experiencing poor mental health (including people with dementia) The provider had resolved the concerns for safety and effectiveness identified at our inspection on 15 November 2016 which applied to everyone using this practice, including this population group, although some concerns regarding providing well-led services remain. The population group ratings have been updated to reflect this. The specific findings relating to this population group can be found at http://www.cqc.org.uk/location/1-551021659	Good 

Summary of findings

Areas for improvement

Action the service MUST take to improve

- Ensure sufficient numbers of suitably qualified, competent, skilled and experienced persons are deployed to meet the fundamental standards of care and treatment.

Action the service SHOULD take to improve

- Follow practice recruitment procedures for those staff who have been re-employed by the practice following an interval of more than three years.
- Develop clinical meeting structures and processes to allow formal clinical meetings to take place in order to evidence learning.
- Improve the oversight of staff monitoring of stocks and expiry dates of medicines and for the recording of vaccine fridge temperatures.
- Continue to identify and support patients who are also carers.

Croston Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

A CQC lead inspector and a second CQC inspector visited the practice and carried out a focused inspection.

Background to Croston Medical Centre

Croston Medical Centre, 30 Brookfield, Croston, PR26 9HY, is situated within a purpose built health centre in a residential area of Croston, Leyland in Lancashire. The practice also has a

branch surgery in Eccleston Health Centre at Doctors Lane, Eccleston approximately three miles away from the main surgery. Patients can attend either surgery.

The practice delivers primary medical services under a General Medical Services (GMS) contract with NHS England. It is part of the NHS Chorley and South Ribble Clinical Commissioning Group (CCG).

At the time of inspection, the practice confirmed the number of registered patients as 3,975.

Information published by Public Health England rates the level of deprivation within the practice population group as nine on a scale of one to ten. Level one represents the highest levels of deprivation and level ten the lowest. There are considerably more patients aged over 45 years of age on the practice register, 53%, than the national average of 43% and a higher percentage of patients with a long-standing health condition, 55%, than the national average of 53%.

The practice has one lead female GP and one male salaried, sessional GP. They are assisted by a practice manager and five administration and reception staff, with a sixth staff member recruited to commence in the week following our inspection. The practice is looking to recruit to a vacant practice nurse position and is employing two part-time locum practice nurses.

Croston Medical Centre is open from 8.30am until 7.30pm each Monday, 8.30 until 6.30 Tuesday to Friday and 9am until 12 noon on alternate Saturdays. The branch site at Eccleston Health Centre is open on Tuesday and Friday afternoons from 3pm to 5pm.

Appointments are available at Croston between 8.30am and 10.30am Monday to Friday and 3.30pm to 7.30pm on Monday, 3.30pm to 6pm Wednesday and 4pm to 6pm on Thursday. Patients can also attend an “open access surgery” each day, when no appointment is required and patients wait to be seen. Appointments and walk in access are also available at the Eccleston branch site from 3.30pm to 5pm Tuesday and Friday, when the Croston surgery is closed. Evening surgeries are by appointment only. On alternate Saturdays, pre-bookable appointments are available at Croston between 9am and 11.30am.

Patients can book appointments in person, via the telephone or online. The practice provides telephone consultations, pre-bookable consultations, urgent consultations and home visits.

When the surgery is closed patients are directed to the local out of hours service (GotoDoc) and NHS 111.

Information regarding out of hours services is displayed on the website and in the practice information leaflet.

Detailed findings

Why we carried out this inspection

We undertook a comprehensive inspection of the Croston Medical Centre on 15 November 2016 under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The practice was rated as requires improvement and requirement notices were issued in relation to safe care and treatment, good governance and staffing. The full comprehensive report following the inspection in November 2016 can be found on our website at http://www.cqc.org.uk/location/1-551021659

We undertook a follow up focused inspection of the Croston Medical Centre on 28 June 2017. This inspection was carried out to review in detail the actions taken by the practice to improve the quality of care and to confirm that the practice was now meeting legal requirements.

How we carried out this inspection

During our visit we:

- Spoke with a range of staff including the principal GP, the locum GP, the practice manager, a locum practice nurse and two members of the practice administration team.
- Observed how patients were being cared for in the reception area.
- Reviewed a range of practice documentation.

We did not visit the practice branch site at Eccleston which was closed at the time of our inspection.

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.

Good

Are services safe?

Our findings

At our previous inspection on 15 November 2016, we rated the practice as requires improvement for providing safe services as risks to patients had not been effectively assessed in the areas of medicines and emergency equipment monitoring. Reviews and investigations of incidents were not thorough enough and there was confusion as to what constituted a significant incident. In addition, there was no system for receiving medical and safety alerts into the practice and recruitment procedures were not consistently undertaken, particularly for those undertaking

chaperone duties. In addition, we noted that staffing levels were insufficient to ensure the delivery of safe care and treatment. We found that office facilities for the practice manager were unsuitable and that medical records were not held securely. There was also a lack of evidence to show that the medical indemnity cover for the principal GP was sufficient.

These arrangements had improved when we undertook a follow up inspection on 28 June 2017. The practice is now rated as good for providing safe services.

Safe track record and learning

At this inspection, we saw that a comprehensive system of reporting and recording significant events had been introduced.

- Staff told us they would inform the practice manager of any incidents and there was a recording form available on the practice's computer system and in a folder in the practice manager's office. The incident recording form supported the recording of notifiable incidents under the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment). Staff were clear about what constituted a significant event and had received training in significant events.
- From the sample of two documented examples we reviewed we found that when things went wrong with care and treatment, patients were informed of the incident as soon as reasonably practicable, received reasonable support, truthful information, a verbal or written apology and were told about any actions to improve processes to prevent the same thing happening again. Patients were invited into the surgery for a face-to-face discussion of events where appropriate.
- We reviewed safety records, incident reports and minutes of meetings where significant events were discussed. The practice carried out a thorough analysis of the significant events and all actions taken as a result of significant events were reviewed to ensure that they were effective.
- We saw evidence that lessons were shared and action was taken to improve safety in the practice. For example, clinical staff were reminded of the need to be more vigilant when assessing patients presenting with a deterioration in lung conditions, and were prompted to provide suitable treatment options.

We saw evidence that patient safety alerts were being received by the practice and were acted on. There was a file of alerts held by the principal GP and notes that alerts had been discussed and actions had been taken. However, recorded details of these actions were insufficient to ensure that learning was shared with all staff in the clinical team.

Overview of safety systems and process

At our last inspection, we found that staff acting as chaperones had been trained, but checks with the disclosure and barring service (DBS) or risk assessment for the role had not been done consistently. (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). At this inspection, we saw evidence that all staff working in the practice had had a DBS check.

A system for monitoring the expiry dates of medicines and quantities held in the practice had been introduced. This system was comprehensive and allowed for staff to make regular checks, however, we saw that there had been a gap in recording stocks and expiry dates between 16 January 2017 and 24 April 2017. We saw that there were no expired medicines in the practice at the time of our inspection and that stocks of medicines held were sufficient for practice needs.

We also saw that although the system for monitoring vaccine fridge temperatures was in place, there were missing daily entries for recording these temperatures. Since the departure of the regular practice nurse,

administration staff had been responsible for documenting fridge temperatures. The practice had purchased new data loggers since our last inspection in November and the practice manager told us that staff would be reminded of the necessity of recording temperatures each day and that the data loggers would be interrogated to ensure that temperatures had not been outside recommended levels on those days where records were missing.

At our inspection in November 2016 we saw that appropriate recruitment checks had not been carried out for all staff employed by the practice. At this inspection, we saw that the practice had introduced a rigorous recruitment policy and procedure. We reviewed three staff files, including files for the two locum practice nurses. We found that appropriate checks had been carried out for all staff, save for one locum practice nurse for whom there were insufficient checks on file, for example, references, proof of identity and interview notes. When we asked to practice about this, they explained that the nurse had previously been employed by the practice and had left in 2013. The practice held a previous file for the nurse that contained all relevant documents although these had not been checked on her re-employment as a locum nurse.

Monitoring risks to patients

At our previous inspection, we saw that there was a three week wait for an appointment with the practice nurse who was employed for 25 hours a week. Since our inspection, this nurse had left the practice and the practice was employing two locum nurses for a total of nine hours a week and the wait for patients to be seen was between two and three weeks. The practice told us that they knew that this was insufficient and that they had advertised for another practice nurse. They told us that they were interviewing for the position in the week following our inspection. We were told that this position was also to be for 25 hours a week and that they would monitor appointment provision to ensure that these hours were sufficient.

We also saw at this inspection that there was inadequate staffing to cover reception and administration duties, both at the main surgery in Croston on some mornings and also on Friday afternoons at the Eccleston branch surgery. This meant that on Friday afternoons, there was no member of staff at the branch site to perform chaperone duties if needed. The practice showed us evidence that they had recruited a further staff member to cover the mornings in Croston who was starting employment in the week following our inspection. They were also interviewing for the vacancy on Friday afternoons at the Eccleston practice. Following our inspection, the practice manager told us that they had successfully recruited for this vacancy and were waiting for a second satisfactory reference in order to appoint.

Arrangements to deal with emergencies and major incidents

The practice had introduced a system to check the expiry dates and stock levels of emergency medications. We noted a gap in the records for the monitoring of stock levels and expiry dates between 16 January 2017 and 24 April 2017. However, we saw that all medicines were in date and that there were sufficient medicines in stock. Since our last inspection, the practice had purchased new defibrillator pads for both adult and children use. There was also a record of checks made for the oxygen supply to ensure that this was adequate and safe to use.

Good

Are services effective?

(for example, treatment is effective)

Our findings

At our previous inspection on 15 November 2016, we rated the practice as requires improvement for providing effective services as the system for receiving and acting on national clinical guidance and guidelines, clinical audits and staff appraisal needed improving.

These arrangements had improved when we undertook a follow up inspection on 28 June 2017. The practice is now rated as good for providing effective services.

Effective needs assessment

There was evidence at this inspection that the practice had used information from guidelines from the National Institute for Health and Care Excellence (NICE) to deliver care and treatment that met patients' needs and had monitored that these guidelines were followed through audits. We saw evidence of the application of guidance to inform patient care, for example in the management of patients taking certain blood thinning medications. We saw that these patients had been clearly identified on the practice clinical record system so that their treatment could be optimised.

Management, monitoring and improving outcomes for people

We saw evidence of practice audit activity since our last inspection in relation to patients who were immunosuppressed (immunosuppression is a reduction of the activation or efficacy of the immune system). In November 2016, the practice had identified those patients who were coded as immunosuppressed and had ensured that the register of patients was accurate. They removed eight coded patients from the list and added an additional six. This audit was repeated in June 2017 and two further patients removed from the list and four were added. This ensured that the correct patients were able to be offered the flu vaccination and also ensured that those patients were not invited for vaccination against shingles. Although individual audits were not formally written up, the practice had introduced an audit summary that detailed those audits undertaken with dates of re-audit and actions taken. This summary was held in an audit file for practice reference purposes and an audit folder had been created on the practice shared drive for sharing learning with other clinicians.

The practice manager was the medicines co-ordinator for the practice who worked with the local clinical commissioning group (CCG) to ensure that practice prescribing was in line with best practice. We saw evidence of this work that included audits of practice prescribing.

Effective staffing

At our last inspection, the new practice manager had been in post for five months and we saw that there had been no appraisals carried out for staff. At this inspection, all staff had received an appraisal where staff learning needs had been assessed. Staff training was well-supported and the practice had received funding through the practice resilience fund to provide training for the practice manager.

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. We saw evidence that a very comprehensive induction programme had been employed with newly recruited staff.

Are services well-led?

Requires improvement

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

Our findings

At our previous inspection on 15 November 2016, we rated the practice as requires improvement for providing well-led services as there was a lack of effective systems and processes to ensure good governance in accordance with the fundamental standards of care.

We issued a requirement notice in respect of these issues and found that although arrangements had improved when we undertook a follow up inspection of the service on 28 June 2017, the practice was still rated as requires improvement for being well-led.

Vision and strategy

At our previous inspection, we found that the practice did not have a clear vision and a strategy. The principal GP spoke about a succession plan for the future although there was no business plan in place. At this inspection we were shown a legal document, a draft letter of intent, that detailed future plans for the practice and we were told that legal proceedings had started to make these plans contractually binding.

Governance arrangements

The practice had supplemented the risk assessments that had previously been in place in November 2016 to include all aspects of practice working and the environment. These included those risks that had been identified by our inspection in November 2016. Identified risks had been indicated as actioned or mitigated in most cases save in the area of staff resources.

There was a comprehensive system in place to manage significant events and patient complaints and to share learning. Incidents and complaints were a standing agenda item at monthly practice team meetings. Although we were told that clinical issues such as patient safety alerts, medicine alerts, audits and clinical quality improvement work were discussed at clinical meetings, these meetings were not formally minuted and were held on an ad hoc basis. We saw handwritten records of issues discussed, who they were discussed with and when, but there was no detail of results of these discussions to evidence and share learning. The practice assured us that they would hold formal, minuted clinical meetings on a regular basis in the future.

Management overview of systems for checking the stock and expiry dates of medicines in the practice and also for logging vaccine fridge temperatures was lacking. New monitoring systems had been had been put in place, however there were some gaps in the recording of these checks and we also found gaps in the daily recording of vaccine fridge temperatures.

Facilities for the storage of medical records were much improved. The practice had purchased lockable medical record cabinets and these were securely stored in a separate locked room in the practice. The practice manager's office had been cleared of records and excess shelving, a door had been added for confidentiality and document storage facilities had been provided.

At our previous inspection, there had been some discussion with the GP about the level of indemnity cover for the number of sessions worked in total, and the GP was asked to check this with the medical indemnity insurers as soon as possible. At this inspection, we were shown that this had been checked and that cover was sufficient.

Leadership and culture

At our inspection in November 2016, we observed evidence of care and compassion for patients. However, we also saw a distinct difference between patient care, and leadership and human resource management within the practice**.** Since our last inspection, the practice manager had implemented many changes to the practice policies and procedures and had developed and clarified staff roles in the practice. However, staff told us that the authority of the practice manager was undermined by the principal GP and that they continued to work under unnecessary scrutiny. Staff felt that opportunities to rely on staff expertise were being missed and that current staffing levels meant that staff were working under pressure.

Our last inspection had identified insufficiencies in the amount of administration and clinical hours available to ensure the safe running of the service. Since then, the practice had experienced changes in staffing. The practice nurse had left and administration staff had reduced their hours. The practice had advertised for additional staff and had struggled to recruit and retain staff. This meant that staff resources were fewer than when we last inspected. The practice showed us evidence that a new staff member had been recruited to work in reception and administration to cover busy mornings at Croston from the week following

Are services well-led?

Requires improvement

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

our inspection. They also showed us that a further potential employee was to be interviewed to cover Friday afternoons at the branch site. Following our inspection, we were told that the Friday afternoon vacancy had been filled subject to receipt of one further reference. In addition, the practice had purchased a new patient check-in and calling system to free up time for reception staff. Two locum practice nurses had been recruited to cover nine of the vacant 25 practice nursing hours but the practice told us that they could find no further cover. They confirmed to us that one of the locum nurses had expressed an interest in working permanently for the practice and that they were interviewing her for the position during the week following our inspection. However, this role was to be for 25 hours, the same as when we inspected in November 2016. Following our inspection, the practice confirmed that they had appointed the nurse to work for 14 hours a week with an additional 6 hours a week supplied by one of the locum practice nurses until 16 August 2017 when this would cease. The practice had planned to recruit a healthcare assistant following our last inspection, however this had not happened.

The practice manager was unable to fulfil her role in her contracted hours. We were told that although training was fully supported by payments from the practice resilience fund and extra hours completed on site were funded, hours spent on practice management duties on the two days when the practice manager was not on site were not claimed. Following our inspection, we were told that these management hours had been acknowledged by the practice. The principal GP told us that she felt that the contracted hours were sufficient and that extra time was only needed for the role because the practice manager was relatively new and was still learning.

The practice manager had reinstated regular team meetings in the practice and staff said that they felt supported by the practice manager. Clinical meetings were held on an ad hoc basis and were not formally recorded. Without a permanent practice nurse in place, meetings were only between the two GPs.

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

Since our last inspection, the practice had re-instated the patient participation group (PPG) and had used the meetings to share information and gather feedback.

All staff in the practice had received appraisal where feedback had been sought and acted on. Staff feedback had also been sought at practice team meetings. For example, staff requested that they had an electronic file on the practice shared drive of useful telephone contact numbers. We saw that this had been initiated and was regularly updated.

The practice had an effective system in place for handling complaints and concerns. We saw evidence that learning from complaints was shared with staff and that the practice recorded both written and verbal complaints.

Continuous improvement

At our previous inspection in November 2016, we found that there had not been a culture of empowerment of staff to utilise expertise to improve patient care, or to develop staff, encourage improvement or improve care through clinical audit. This had improved to some extent in that staff had been involved in planning for future improvements in the service through appraisals and team meetings. We saw however, that full, formal clinical meetings had yet to be established to embed learning into practice and plan future clinical quality improvement. Also, a full assessment of staffing requirements had not yet taken place to allow improvements to be maintained.

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 Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **The practice must comply with Regulation 18(1).** **Sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed in order to meet the requirements of this Part.** **How the regulation was not being met:** **The registered person had failed to ensure that sufficient numbers of suitably qualified, competent, skilled and experienced persons were deployed in order to meet the requirements of fundamental standards in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. In particular:** • The registered person had not assessed the capacity to ensure there were sufficient hours of clinical and non-clinical staff time available to meet the requirements of the service. **This was in breach of regulation 18(1 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**