The Meadows Surgery

Quality Report

Meadow Lane, Thrapston, Kettering,
Northamptonshire. NN14 4GD.
Tel: 01832 734444
Website: www.themeadowsthrapston.nhs.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?	Good
Are services responsive to people's needs?	Requires improvement
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 inspection of The Meadows Surgery on 25 November 2015. This was a comprehensive inspection under Section 60 of the Health and Social Care Act (2008) as part of our regulatory functions. The practice achieved an overall rating of inadequate. Specifically, we found the practice to be inadequate for providing safe, effective and well-led services. We found it to be good for providing caring services and requires improvement for providing responsive services. Consequently, it is rated inadequate for providing services for older people; people with long-term conditions; families, children and young people; working age people; people whose circumstances may make them vulnerable and people experiencing poor mental health.

Our key findings were as follows:

- The processes for recording action and learning points from reported incidents and events and reviewing the effectiveness of any action taken were insufficient.
- Staff were not receiving safety alerts relevant to the area of care they were responsible for.
- Adequate procedures for completing the required background checks on staff were lacking.
- Some systems designed to assess the risk of and to prevent, detect and control the spread of infection were lacking or not fully implemented.
- Systems to ensure the appropriate management of medicines were lacking or not fully implemented.
- Systems designed to assess, monitor, mitigate risks to and improve the quality and safety of services for patients were insufficient. For example, there was no programme of repeated (full cycle) clinical audit.
- Available data showed the practice was performing below local and national standards for a range of chronic conditions management.
- A system to ensure patients were reviewed at required intervals to ensure their treatment

Summary of findings

remained effective was lacking. There was a risk patients would not receive the appropriate management, medication and review for their conditions.

- There was no clear leadership structure at the practice. There was no active leadership role for overseeing that any systems in place to monitor the quality of the service were consistently being used and were effective. There were limited formal governance arrangements.
- Some patient feedback was that access to appointments was poor and getting through to the practice by phone was difficult. The wait for some advance release pre-bookable appointments was long.
- We saw patients receiving respectful treatment from staff. Patients felt they were seen by friendly and helpful staff. Patients reported feeling satisfied with the care and treatment they received.

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

Importantly, the provider must:

- Not register any new patients without the prior written agreement of the Care Quality Commission.
- Ensure there is sufficient clinical capacity within the practice to allow for the appropriate clinical leadership and governance arrangements to be embedded and systems that govern activity to be fully implemented.
- Ensure there is sufficient management support for the practice to complete and sustain improvements to enable compliance with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
- Implement systems to record the completion of and any complications arising from minor surgery at the practice and to monitor and review the histology requests made.
- Ensure key performance indicators are met each month in respect of chronic conditions management and review.
- Ensure that safety alerts are received, distributed appropriately and have their recommendations implemented.
- Ensure the timely and accurate completion of records relating to patients' health, care and treatment.
- Ensure that the review and clinical oversight of hospital referrals is completed.
- Ensure an appropriate system is in place for the safe use and management of medicines and prescriptions, including medical consumables.
- Ensure that systems designed to assess the risk of and to prevent, detect and control the spread of infection are fully implemented.
- Ensure that all applicable staff receive a criminal records check and that the required information is available in respect of the relevant persons employed.
- Ensure that all staff employed are supported, receiving the appropriate supervision and completing the essential training relevant to their roles.
- Ensure that where responsibility for patients' care and treatment is shared with others it is organised and completed appropriately.
- Take steps to act on feedback from patients for the purpose of improving the service. This may include reducing the waiting time for routine pre-bookable appointments and improve patients' access to the practice by telephone.

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

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Inadequate

The practice is rated as inadequate for providing safe services. Patients were at risk from the lack of safety systems, processes and procedures in place. There were incident and significant event reporting procedures in place. However, the system in place for learning from safety incidents and significant events was lacking. When asked about reported incidents and events most staff could not recall any details, including their learning from them and any action points. Patients were at risk of previous incidents and events reoccurring. There was no system in place for the management of safety alerts. Staff were not receiving alerts relevant to the area of care they were responsible for.

Systems to ensure that medicines were checked, stored securely and managed appropriately were lacking. Vaccines were not stored securely and staff were unaware of the action to take in the event of the failure of the fridges or power supply. Some medical consumables were beyond their expiry dates. Blank prescription forms were not tracked or stored securely. The practice appeared clean and staff were adhering to infection control processes, but some staff had not recently completed infection control training. There was no infection control lead and the moderate risks identified from a Legionella risk assessment were not dealt with. There was no health and safety related training, policies and risk assessments. Systems to ensure that all the applicable staff employed at the practice received the relevant criminal records checks were lacking. Reception and administration staff acting as chaperones had not received the appropriate training. However, they demonstrated an understanding of their responsibilities when acting as chaperones.

The medical equipment at the practice was fit for purpose and received regular checks for accuracy. Arrangements were in place for the practice to respond to foreseeable emergencies.

Are services effective?

Inadequate

The practice is rated as inadequate for providing effective services. A system to ensure patients were reviewed at required intervals to ensure their treatment remained effective was lacking. There was a risk patients would not receive the appropriate management, medication and review for their conditions. Patients were not always receiving chronic condition reviews and records of reviews were not always completed appropriately. There were no formal or recorded

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multi-disciplinary team meetings to discuss the needs of complex patients. There was a risk that high level care patients would not receive a full and appropriate multi-disciplinary review of their care needs.

Processes to identify where improvements could be made were lacking. There was no programme of repeated (full cycle) clinical audit at the practice to monitor quality and systems and identify where action should be taken. There was no system in place to identify if histology requests made were received and the appropriate action was taken. No audits were completed or records maintained of the complications arising from minor surgery procedures at the practice.

The QOF data for this practice showed it was performing below local and national standards. QOF is a national data management tool generated from patients' records that provides performance information about primary medical services. During our inspection we found there was a lack of awareness among senior staff about the practice's current position in relation to QOF data.

However, clinical staff were aware of the process to obtain patient consent and were informed and knowledgeable on the requirements of the Mental Capacity Act (2005). A system to ensure all staff received an appraisal of their skills, abilities and development requirements was in place.

Are services caring?

Good

The practice is rated as good for providing caring services. On the day of our inspection we saw staff interacting with patients in reception and outside consulting rooms in a respectful and friendly manner. There were a number of arrangements in place to promote patients' involvement in their care. Accessible information was provided to help patients understand the care available to them. Patients told us they felt listened to and included in decisions about their care. They said they were treated with dignity and respect and were positive about staff behaviours.

Are services responsive to people's needs?

Requires improvement

The practice is rated as requires improvement for providing responsive services. The premises and services were adapted to meet the needs of people with disabilities including communication and mobility issues. Some additional access to services for those who found attending in normal working hours difficult was available. The practice used a number of methods to ensure patients had access to resources and information. Methods were available for patients to leave feedback about their experiences. The practice demonstrated it responded to patients' comments and complaints. At the time of our inspection there was a considerable

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wait for routine pre-bookable appointments, however those required in an emergency were available. The results of some patient feedback showed this and access to the practice by telephone was of concern to them.

Are services well-led?

Inadequate

The practice is rated as inadequate for being well-led. Governance arrangements at the practice were not fully embedded and the practice was not yet safe, effective and responsive. The practice's system of policies and procedures to govern activity was not sufficient. The absence of a clinically led vision for securing the future, monitoring the service and driving improvements in the quality of service meant that critical areas of risk to patient care were not being addressed. Staff were unable to contribute to improvements and implement necessary changes. The practice had failed to address concerns raised by patients about accessing the practice by phone and being able to make pre-bookable appointments.

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 practice is rated as inadequate for the care of older people because the processes and procedures at the practice were not safe, effective, responsive or well-led and this put all patients at risk. There were no formal or recorded multi-disciplinary team meetings to discuss the needs of complex patients including palliative patients. There was a risk that some older people with end of life care needs would not receive a full and appropriate multi-disciplinary review. However, older patients had access to a named GP, home visits when needed and targeted immunisations such as the flu vaccine.

People with long term conditions

Inadequate

The practice is rated as inadequate for the care of people with long-term conditions because the processes and procedures at the practice were not safe, effective, responsive or well-led and this put all patients at risk. Structured annual reviews were not always undertaken to check that patients' health and care needs were being met. Those reviews completed were not always appropriately recorded and coded. There was no clear clinical leadership structure at the practice which had named members of staff in lead roles for a range of long-term conditions. Available data for this practice showed it was performing below local and national standards for the care of patients with asthma, chronic obstructive pulmonary disease and diabetes among others. However, all newly diagnosed patients with diabetes were managed in line with an agreed pathway. Patients with long-term conditions had access to a named GP and targeted immunisations such as the flu vaccine.

Families, children and young people

Inadequate

The practice is rated as inadequate for the care of families, children and young people because the processes and procedures at the practice were not safe, effective, responsive or well-led and this put all patients at risk. However, there were six week post-natal checks for mothers and their children. Programmes of cervical screening for women over the age of 25 and childhood immunisations were available to respond to the needs of these patients. Available data for this practice showed it was performing slightly below local and national standards for cervical screening. Appointments were scheduled to be available outside of school hours. A range of contraceptive and family planning services were available. The premises was suitable for children and babies.

Summary of findings

Working age people (including those recently retired and students)

Inadequate

The practice is rated as inadequate for the care of working age people (including those recently retired and students) because the processes and procedures at the practice were not safe, effective, responsive or well-led and this put all patients at risk. There was a low uptake for the health checks available for all patients between 40 and 74 years old.

However, the practice offered online services such as appointment booking and repeat prescriptions. There was additional out of working hours access to meet the needs of working age patients. There were extended opening hours with early opening every Tuesday from 7.00am and late opening until 7.00pm every Monday.

People whose circumstances may make them vulnerable

Inadequate

The practice is rated as inadequate for the care of people whose circumstances may make them vulnerable because the processes and procedures at the practice were not safe, effective, responsive or well-led and this put all patients at risk. The practice's data showed that patients with a learning disability received an annual health review. However, those reviews completed were not always appropriately recorded and coded. There were no formal or recorded multi-disciplinary team meetings to discuss the needs of complex patients including those whose circumstances may make them vulnerable. There was a risk that some of those patients would not receive a full and appropriate multi-disciplinary review.

However, the practice maintained a register of patients who were identified as carers and additional information was available for those patients. Staff knew how to recognise signs of abuse in vulnerable people and were aware of their responsibilities in raising safeguarding concerns.

People experiencing poor mental health (including people with dementia)

Inadequate

The practice is rated as inadequate for the care of people experiencing poor mental health (including people with dementia) because the processes and procedures at the practice were not safe, effective, responsive or well-led and this put all patients at risk. Available data for this practice showed it was performing below local and national standards for such things as dementia care. The practice's data showed that none of its identified patients experiencing dementia had received a health review in the past 12 months. There were no formal or recorded multi-disciplinary team meetings to discuss the needs of complex patients including those

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experiencing poor mental health. There was a risk that some of those patients would not receive a full and appropriate multi-disciplinary review. There was no clinical lead for those patients.

However, mental health trust well-being workers were based at the practice twice each week. The practice employed its own counsellor for three sessions a week. Patients could access these to obtain psychological and emotional well-being counselling and advice through referral from the GPs. A drug and alcohol counsellor was available at the practice twice each week.

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What people who use the service say

During our inspection, we spoke with 11 patients, reviewed 13 comment cards left by them and spoke with two representatives of the patient participation group (PPG). The PPG is a group of patients who work with the practice to discuss and develop the services provided.

Patients told us that the care and treatment they received at the practice was good. Patients said they felt staff were kind, friendly and helpful and that their privacy and dignity was respected. The results of the national GP survey for 2015 showed that 91.3% of the 108 respondents found the receptionists helpful. This was above the national average of 86.8%.

They told us they felt listened to by the GPs and involved in their own care and treatment. The results of the national GP survey for 2015 showed that 88.8% of the 108 respondents felt the GPs at the practice displayed care and concern towards them. The national average was 85.1%. For the nurses, this figure reduced to 86.2%, slightly below the national average of 90.4%.

Results from the national GP patient survey in 2015 showed that 82.5% of the 108 respondents felt their experience of making an appointment was good. This was above average when compared to the rest of England (73.3%). When asked about getting through to the practice on the phone, 73.6% of respondents found this to be an easy experience. This was very slightly above average when compared to the rest of England (73.3%). This data was collected from July to September 2014 and January to March 2015.

However, the response from the patients we spoke with or who left comments for us on the appointments system and access to the practice did not reflect the positive responses from the national GP patient survey. Most patients said access to appointments, including the wait for pre-bookable appointments was poor and getting through to the practice by phone was difficult.

Areas for improvement

Action the service MUST take to improve

- Not register any new patients without the prior written agreement of the Care Quality Commission.
- Ensure there is sufficient clinical capacity within the practice to allow for the appropriate clinical leadership and governance arrangements to be embedded and systems that govern activity to be fully implemented.
- Ensure there is sufficient management support for the practice to complete and sustain improvements to enable compliance with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
- Implement systems to record the completion of and any complications arising from minor surgery at the practice and to monitor and review the histology requests made.
- Ensure key performance indicators are met each month in respect of chronic conditions management and review.
- Ensure that safety alerts are received, distributed appropriately and have their recommendations implemented.
- Ensure the timely and accurate completion of records relating to patients' health, care and treatment.
- Ensure that the review and clinical oversight of hospital referrals is completed.
- Ensure an appropriate system is in place for the safe use and management of medicines and prescriptions, including medical consumables.
- Ensure that systems designed to assess the risk of and to prevent, detect and control the spread of infection are fully implemented.

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- Ensure that all applicable staff receive a criminal records check and that the required information is available in respect of the relevant persons employed.
- Ensure that all staff employed are supported, receiving the appropriate supervision and completing the essential training relevant to their roles.
- Ensure that where responsibility for patients' care and treatment is shared with others it is organised and completed appropriately.
- Take steps to act on feedback from patients for the purpose of improving the service. This may include reducing the waiting time for routine pre-bookable appointments and improve patients' access to the practice by telephone.

The Meadows Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC lead inspector. The team included a second CQC inspector and a GP acting as a specialist adviser.

Background to The Meadows Surgery

The Meadows Surgery provides a range of primary medical services from its premises at Meadow Lane, Thrapston, Kettering, Northamptonshire, NN14 4GD.

The practice serves a population of approximately 5,439. The area served is less deprived compared to England as a whole. The practice population is predominantly white British. The practice serves an above average population of those aged from 5 to 19 and 40 to 69. There is a considerably lower than average population of those aged between 20 and 34 and a lower than average population of those aged 70 and above.

The clinical team includes one male and one female GP partner, one long term female locum GP and two female practice nurses. The team is supported by a counsellor, a practice manager, an assistant manager and seven other administration, reception and secretarial staff. The GP partners work 10 sessions each and the locum GP works three sessions weekly. The practice is on a GMS contract.

The practice is staffed with phones lines open from 8.00am to 6.30pm Monday to Friday with the doors open from 8.30am to 6.00pm. Appointments are from 9.00am to midday and 4.00pm to 6.00pm daily. In addition to this, there is early opening every Tuesday from 7.00am and late opening until 7.00pm every Monday. An out of hours service for when the practice is closed is provided by Nenedoc Limited.

Why we carried out this inspection

We inspected this practice as part of our new comprehensive inspection programme.

We carried out a comprehensive inspection of this practice under Section 60 of the Health and Social Care Act (2008) as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act (2008). Also, to look at the overall quality of the service and to provide a rating for the practice under the Care Act (2014).

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

How we carried out this inspection

Before our inspection, we reviewed a range of information we held about the practice and asked other organisations to share what they knew about the practice. We carried out an announced inspection on 25 November 2015. During our inspection we spoke with a range of staff including two GP partners, two nurses, the practice manager and members of the reception and administration team. We spoke with 11 patients and two representatives of the patient participation group (the PPG is a group of patients

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who work with the practice to discuss and develop the services provided). We observed how staff interacted with patients. We reviewed 13 CQC comment cards left for us by patients to share their views and experiences of the practice with us.

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 are provided for specific groups of people and what good care looks like for them. The population groups are:

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

Inadequate

Are services safe?

Our findings

Safe track record

The staff we spoke with demonstrated an understanding of their roles in reporting incidents and significant events and were clear on the reporting process used at the practice.

We looked at examples of how the procedure was used to report incidents and significant events relating to clinical practice and other issues. From our conversations with clinical staff we found that serious incidents and events were discussed informally between the doctors. The discussions sometimes, but not always included the nurses. No minutes or records of these discussions were maintained. We saw that through keeping each significant event report, the practice maintained a log of all reported incidents and events. The reports we looked at detailed the nature of the incidents. They contained some detail on the action taken to deal directly with the reported incidents. This was normally resolved by the individual most directly involved.

Learning and improvement from safety incidents

The system in place for learning from safety incidents and significant events was lacking. Patients were at risk of previous incidents and events reoccurring. Significant event analysis is used by practices to reflect on individual cases and where necessary, make changes to improve the quality and safety of care. From our review of reported incidents and events we found there was no record of the discussions had or actions and learning points set for staff to reduce the risk of the incidents reoccurring.

Most staff said that anything they needed to know about the learning from incidents and events would be communicated to them in the monthly practice meeting. This was the only formal staff meeting held. Minutes of this meeting were taken for the first time in November 2015. Before that they were not recorded. When asked about reported incidents and events most staff could not recall any details, including their learning from them and any action points.

There was no system in place for the management of safety alerts. Senior staff we spoke with told us safety alerts were reviewed by and distributed to the relevant staff by the practice manager. However, we found that the practice manager, doctors and nurses had not received or reviewed any safety alerts in the last four months. When asked about safety alerts that had been distributed locally in that time the staff we spoke with had no awareness of them. They were unable to give examples of recent alerts relevant to the care they were responsible for. There was a risk that patients taking some medicines had not received an urgent review deemed necessary by the relevant safety alerts.

Reliable safety systems and processes including safeguarding

One of the GP partners was the nominated lead for safeguarding issues. When we asked to see the practice's policies or protocols on safeguarding these were not available. However, the staff we spoke with demonstrated a knowledge and understanding of their own responsibilities and the role of the lead in raising and progressing any concerns about patients. From our conversations with them and our review of training documentation, we saw that most staff had received safeguarding and child protection training at the level specific to their roles. This excluded staff who were not employed at the practice in February 2015 when the last training session was held.

When we asked staff about any recent safeguarding concerns raised at the practice, they said there were none. We asked staff how they would know if any patients were considered to be at risk. Some said identifying symbols were used on the patients' notes to inform staff they were considered to be at risk. Others were unaware of this system.

From our conversations with them we found that reception and administration staff would act as a chaperone if nursing staff were not available (a chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). A generic policy was in place to guide them in that role, but this was not specific to the practice. From our conversations with them and our review of training documentation we found that none of those staff had received the relevant training. However, they demonstrated an understanding of their responsibilities when acting as chaperones.

We looked at which staff had received criminal records checks. A recent and recorded check for one of the GP partners was available. The other partner said a check was completed many years ago, but a record of this was not available. For one nurse a recorded check by a previous

employer five years ago was available. There were no records of a check for the other nurse employed in 2015. From our conversations with them and our review of documentation we found none of the non-clinical staff, including those completing chaperone duties had received a check. Senior staff confirmed that risk assessments on why those staff did not require a criminal records check despite acting as chaperones had not been completed. We also found that at the time of our inspection, applications for criminal records checks on two new nursing staff with start dates of 7 and 8 December 2015 had not been completed.

Medicines management

We checked medicines and medical consumables stored in the treatment rooms and medicine refrigerators. All the medicines including those in the refrigerators were within their expiry dates. However, we found five medical consumables that were beyond their expiry dates. The vaccines in the fridges were not stored securely as all the fridge doors and the doors to the treatment rooms were unlocked when unattended.

There was a system in place to record the amount and type of medicines kept at the practice. However, this excluded vaccines. The nurses told us they completed undocumented visual checks on those.

Records showed some fridge temperature checks were carried out to ensure medication was stored at the appropriate temperature. However, there were considerable gaps in the recording of these checks on the fridge in the room used for minor surgery. The clinical staff we spoke with were unaware of a process and policy which described the action for staff to take in the event of a potential failure of the fridges or power supply. They said they would not know what to do with the refrigerated vaccines in such circumstances.

No controlled drugs were kept at the practice. All prescriptions were reviewed and signed by a GP before they were given to the patient. However, on the day of our inspection a concern was raised involving the incorrect address on a prescription form for a patient under a protection order. This was not identified by practice staff before being sent to the patient's pharmacy.

Blank forms used for hand written and computer generated prescriptions were not tracked. Also, they were left unsecured in printers and consultation rooms when those areas were unattended. None of the consultation or treatment rooms were locked when unattended. There was no process in place that would identify if a prescription form was missing or used inappropriately.

The system for discussing and learning from all types of incidents and errors, including those relating to medicines was lacking. There was a risk that appropriate actions to minimise the chance of similar errors occurring again were not taken.

Cleanliness and infection control

We saw that the practice appeared clean. We saw there were cleaning schedules in place and the cleaning records we looked at demonstrated these were adhered to. Hand wash facilities, including hand sanitiser were available throughout the practice. There were appropriate processes in place for the management of sharps (needles) and clinical waste.

A generic policy on infection control issues partially adapted to the requirements of the practice was available. Most staff we spoke with were unaware of the policy. There was no nominated lead and designated responsible individual for infection control. From our conversations with staff and our review of documentation we found that no staff had completed infection control training in the past year. However, records showed that one nurse and seven non-clinical staff had completed the training in June 2014. Senior staff confirmed that a risk assessment on why all staff did not require training had not been completed.

Despite this, all the staff we spoke with were knowledgeable about infection control processes at the practice and we found these were adhered to.

The staff we spoke with said an audit of cleanliness and infection control issues at the practice was completed by an external contractor the week before our inspection. Documentation relating to the audit was not yet available but staff demonstrated an awareness of the issues raised and we saw that some action had been taken in response to this.

A Legionella risk assessment (Legionella is a term for particular bacteria which can contaminate water systems in buildings) completed at the practice in July 2014 identified some moderate risks and made specific recommendations. These included taking action on the lack of structure for the management of Legionella risk at

the practice, water temperatures being outside the acceptable range and concerns about infrequently used outlets. We found that there was no plan in place to resolve the issues raised and no action had been taken by the practice.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. We saw documentary evidence of the annual calibration of medical equipment to ensure the accuracy of measurements and readings taken. All of the equipment we saw during our inspection appeared fit for purpose. All portable electrical equipment was routinely tested and the relevant report was available to demonstrate this.

Staffing and recruitment

The staff we spoke with understood what they were qualified to do and this was reflected in how the practice had arranged its services. There was an awareness amongst the staff we spoke with that the practice was understaffed. Nursing staff in particular said they were struggling with their workloads and providing a full level of service. This was reflected in the responses we received from patients when discussing staffing levels at the practice. A programme of recruitment was underway and a new nurse practitioner and a healthcare assistant were due to start on 7 and 8 December 2015. Senior staff told us this would allow for the redistribution of roles and workload in the nursing team and would facilitate relieving the doctors of completing some minor illness work.

We looked at six staff records. Each staff file lacked one or more pieces of documentation to complete appropriate recruitment checks such as satisfactory evidence of conduct in previous employment or photographic identification. However, most of the missing checks were for staff who had been employed for a long time. The available checks and documentation for a staff member employed during 2015 were more in line with the requirements of the practice's own recruitment policy.

The process for completing criminal records checks on staff was lacking. A documented check relating to the practice was available for one GP partner. A documented check from a previous employer was available for one nurse. For all other staff no documented checks were available and from our conversations with them it was confirmed that non-clinical staff had not received criminal records checks. Senior staff confirmed that risk assessments on why those staff did not require a criminal records check despite acting as chaperones had not been completed.

Monitoring safety and responding to risk

Systems, policies and processes to manage and monitor risks to patients, staff and visitors to the practice were lacking. These included infection control, medicines management and the health and safety (including fire safety) of the environment, staff and patients.

The staff we spoke with were unaware of the existence of policies covering most areas of risk at the practice. We asked to see policies and risk assessments in relation to health and safety including fire safety and these were not available. Where policies were available, these were often overdue review and contained out-of-date or generic information. From our conversations with staff and our review of documentation we found there was no formal induction programme including basic training for staff. Also, the completion of essential training in the past 12 months was poor due to a period the practice was without an e-learning facility. Staff told us they had not completed any health and safety training. The practice's records confirmed this. However, one nurse and seven clerical staff had completed fire safety training in June 2014. Any staff employed since then had not completed the training.

However, we saw that in the past three months contractors had completed an inspection of fire equipment at the practice. Also, fire alarm and emergency lighting tests were up-to-date and a fire safety logbook that was poorly completed after April 2015 contained entries for November 2015. We were told by the practice manager that a process was underway to have a fire risk assessment completed by an external contractor although this was not confirmed at the time of our inspection.

Informal and undocumented discussions were used for senior staff to take action on all reported risks, incidents and events. However, the process was lacking and there was a risk staff were not made aware of all the decisions made and changes in practice required as a result of discussions around reported incidents and events.

Arrangements to deal with emergencies and major incidents

Inadequate

Are services safe?

The practice had procedures in place to respond to emergencies and reduce the risk to patients' safety from such incidents. We saw that the practice had a business continuity and recovery plan in place. This covered the emergency measures the practice would take to respond to any loss of premises, records and utilities among other things. However, the plan was overdue a review and some of the staff details and contacts were out-of-date. The relevant staff we spoke with understood their roles in relation to the contingency plan.

There was documentary evidence to demonstrate all staff except four members of the administration team had completed basic life support including cardio-pulmonary resuscitation training on 11 November 2015. The same provider was booked to complete anaphylaxis training for all staff on 20 January 2016.

The practice provided emergency medical equipment that was easily accessible to staff. We looked at the emergency medical equipment and drugs available at the practice including oxygen and a defibrillator. All of the equipment and emergency drugs were within their expiry dates. Documented checks on the equipment were available and completed regularly.

Inadequate

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

A system was in place for National Institute for Health and Care Excellence (NICE) guidelines to be distributed and reviewed by clinical staff.

A system to ensure care was planned to meet identified needs and patients were reviewed at required intervals to ensure their treatment remained effective was lacking. There was a risk patients would not receive the appropriate management, medication and review for their conditions. The staff we spoke with told us they were not always calling patients in for their chronic condition reviews due to a lack of staff capacity. Those patients experiencing chronic conditions that we spoke with said they arranged their own annual reviews to ensure they received one. We reviewed the records of five patients with chronic conditions. The quality of information recorded varied considerably. Some records lacked basic data on the patients' lifestyles and health management and the appropriate coding. We looked at the records of three patients with learning disabilities who'd been offered and received a review. In one case, the review template was not completed.

The GPs and nurses we spoke with told us there were no clinical lead roles in place with the exception of diabetes. A recently recruited nurse held the lead role for patients with diabetes. From our conversation with her we found this was a developmental role in which she was not yet fully confident. However, two new members of nursing staff were due to start in December 2015 and senior staff we spoke with said this would allow for the introduction of more lead roles.

Management, monitoring and improving outcomes for people

We found systems around quality improvement were lacking. The clinical staff we spoke with told us there was no programme of repeated (full cycle) clinical audit at the practice. No documented clinical audit of any kind was available and staff confirmed these had not been completed for more than two years. Clinical audit is a way of identifying if healthcare is provided in line with recommended standards, if it is effective and where improvements could be made. The clinical staff we spoke with said they reflected on the outcomes being achieved for patients and where areas could be improved through informal and undocumented discussion.

All minor surgery at the practice was completed by one of the GP partners. From our conversations with staff we found that no record was kept of the minor surgery completed or the histology requests made. There was no system in place to identify if the histology requests made were received and the appropriate action was taken. No audits were completed or records maintained of the complications arising from minor surgery procedures.

The practice participated in recognised clinical quality and effectiveness schemes such as the national Quality and Outcomes Framework (QOF). QOF is a national data management tool generated from patients' records that provides performance information about primary medical services. However, there was no QOF lead at the practice. When asked, the doctors were unable to access QOF data. The staff we spoke with were not able to demonstrate how the practice assured itself that patient outcomes were adequate. We found there was no suitable system in place for the practice to measure its performance in this area.

We saw the practice was an outlier for the number of antibacterial prescription items prescribed between January and December 2014. During our conversations with the GPs they confirmed the above average antibiotic prescribing had been brought to their attention by the local prescribing authority for the past three years. They told us they felt their prescribing was appropriate, but there was no evidence to suggest this was the case.

This practice achieved 97% of the total QOF target in the 2013/2014 year, which was above the national average of 94.2%. This reduced to 77.5% in the 2014/2015 year which was 19.2% below the clinical commissioning group (CCG) average and 16% below the national (England) average.

For asthma, the practice achieved 100% of the target in 2013/2014. This reduced to 80% in 2014/2015 which was 18.6% below CCG average and 17.4% below the national average. At the time of our inspection, with two thirds of the year complete the practice had achieved 41.6% of its target.

For chronic obstructive pulmonary disease (COPD), the practice achieved 99.8% of the target in 2013/2014. This

Inadequate

Are services effective?

(for example, treatment is effective)

reduced to 54.3% in 2014/2015 which was 43.5% below CCG average and 41.7% below the national average. At the time of our inspection, with two thirds of the year complete the practice had achieved 41.1% of its target.

For diabetes, the practice achieved 94.6% of the target in 2013/2014. This reduced to 53.5% in 2014/2015 which was 38.9% below CCG average and 35.7% below the national average. At the time of our inspection, with two thirds of the year complete the practice had achieved 40.7% of its target.

Effective staffing

From speaking with staff and our review of documentation we found that where applicable, the professional registrations of staff at the practice were up-to-date. All the GPs had been revalidated or had a date for revalidation and as part of this process, the relevant bodies check the fitness to practise of each individual.

From our conversations with staff and our review of documentation we found there was no formal induction programme in place. However, a system of mentoring with a member of staff in a similar role was used to assist new members of staff in learning about their roles. We saw that a system of essential training (training that each staff member is required to complete in accordance with the practice's own requirements) was lacking. Senior staff told us that due to not paying the renewal to the contracted e-learning supplier the service was withdrawn earlier in 2015. The new practice manager had reinstated the contract but staff were yet to complete the training available.

The practice nurses told us they had job descriptions outlining their roles and responsibilities and they provided evidence that they were adequately trained to fulfil these duties. For example, they were up-to-date with cervical cytology training. They told us their clinical supervision was informal and between themselves.

From our conversations with staff and our review of documentation we saw that most staff had received an appraisal of their performance and competencies in the past year. A programme was in place to complete the remaining appraisals. We looked at some examples and saw that there was an opportunity for staff to discuss any learning needs.

Working with colleagues and other services

We saw that a system was in place for such things as patient blood and radiology results and pathology reports to be received electronically. These processes allowed for patients requiring follow up to be identified and contacted. A system was in place to ensure that in any GP's absence, the results were still reviewed and processed. All the staff we spoke with understood how the system was used and we saw this was working.

From our conversations with staff we found there was no external peer review of hospital referrals made at the practice and no formal internal review. Both the GP partners said if letters were received from hospitals alerting them to inappropriate referrals they would discuss it amongst themselves. We found that without a formal system of review and clinical oversight patients were at risk that their referrals were not made with sufficient urgency, lacked the required clinical details and might go to the wrong department.

There were no formal or recorded multi-disciplinary team meetings to discuss the needs of complex patients. This included those with end of life care needs. The staff we spoke with said communication with other health care professionals such as district nurses and health visitors was done either by fax or through informal conversations on their ad-hoc visits to the practice. There was a risk that high level care patients would not receive a full and appropriate multi-disciplinary review of their care needs. Also, that any issues discussed and actions agreed between health care professionals were not properly recorded and implemented.

Information sharing

The practice used several processes and electronic systems to communicate with other providers. For example, there was a system in place with the local out of hours provider to enable patient data to be shared in a secure and timely manner. An electronic system was also in place for making referrals through the Choose and Book system. The Choose and Book system enables patients to choose which hospital they will be seen in and to book their own outpatient appointments in discussion with their chosen hospital.

The practice had systems in place to provide staff with the information they needed. An electronic patient record system was used by all staff to coordinate, document and

Inadequate

Are services effective?

(for example, treatment is effective)

manage patients' care. All staff were competent on the system. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

Consent to care and treatment

The clinical staff we spoke with demonstrated an understanding of the Mental Capacity Act (2005) and its implications for patients at the practice. From our conversations with them we found that patients' capacity to consent was assessed in line with the Mental Capacity Act (2005). Clinical staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity. However, during our discussion with one doctor we found that the consultation notes from a best interests meeting with a patient and their carer two days previous had not yet been written.

Clinical staff were also aware and demonstrated a good understanding of the Gillick competency test (a process to assess whether children under 16 years old are able to consent to their medical treatment, without the need for parental permission or knowledge).

There was a practice process for documenting consent for specific interventions. The clinical staff we spoke with were clear on the process and when documented consent was required. We saw examples of documented patient consent for recent patient procedures completed at the practice.

Health promotion and prevention

We saw that all new patients at the practice were offered a health check. This included a review of their weight, blood pressure, smoking and alcohol consumption. Routine health checks were also available for all patients between 40 and 74 years old. The practice had started its participation in this programme in April 2010. In the five year period from that date, 799 (31.5%) of the 2,531 eligible patients had received the check.

The practice maintained a register of all patients with learning disabilities. Of the 19 eligible patients on the register, all had received a health check review in the past 12 months. Of the 20 patients on the dementia register none had received their annual reviews in the same time period.

We found that the practice offered a number of services designed to promote patients' health and wellbeing and prevent the onset of illness. We saw various health related information was available for patients in the waiting area and throughout the practice.

The practice had participated in targeted vaccination programmes for older people and those with long term conditions. These included the shingles vaccine for those aged 70 to 79, and the flu vaccine for children, people with long term conditions and those over 65. The practice had 839 patients aged over 65. Of those, 529 (63%) had received the flu vaccine in the 2014/2015 year.

Both nurses at the practice were trained to provide and carry out cervical cytology. They had both completed their update training. A system of alerts and recalls was in place to provide cervical screening to women aged 25 years and older. At the time of our inspection, the current practice data showed there was a 78.5% take up rate for this programme over the past five years (1,044 out of 1,329 eligible patients). For the 2014/2015 year the practice achieved 95% of the total QOF target for cervical screening. This was 3.5% below the clinical commissioning group (CCG) average and 2.6% below the national (England) average.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

During our inspection we saw that staff behaviours were respectful and professional. We saw examples of reception staff being helpful and courteous to patients attending the practice. We saw the clinical staff interacting with patients in the waiting area and outside clinical and consulting rooms in a friendly and caring manner. All staff spoke quietly with patients to protect their confidentiality as much as possible in public areas. A separate interview room also used as a privacy booth was located next to the reception desk and could be accessed from both the patient and staff sides. The results of the national GP survey for 2015 showed that 91.3% of the 108 respondents found the receptionists helpful. This was above the national average of 86.8%.

We spoke with 11 patients on the day of our inspection, all of whom were very positive about staff behaviours and the good clinical care they felt they received. They said they felt treated with dignity and respect by staff at all times. A total of 13 patients completed CQC comment cards to provide us with feedback on the practice. All of the responses received about staff behaviours were positive. They said staff were kind, friendly and helpful and treated them with dignity and respect.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We found that doors were closed during consultations and that conversations taking place in those rooms could not be overheard.

Care planning and involvement in decisions about care and treatment

The practice had made suitable arrangements to ensure that patients were involved in, and able to participate in decisions about their care. The 11 patients we spoke with said they felt listened to and had a communicative relationship with the GPs and nurses. They said their questions were answered by the clinical staff and any concerns they had were discussed. We also read comments left for us by 13 patients. Of those who commented on how involved they felt in their care and the explanations they received about their care, all of the responses were very positive.

The results of the national GP survey for 2015 showed that 84.6% of the 108 respondents felt the GPs at the practice were good at involving them in decisions about their care. The national average was 81.4%. The GPs were considered to be good at listening by 93.8% of patients who responded. This was also above the national average of 88.6%.

Patient/carer support to cope emotionally with care and treatment

The results of the national GP survey for 2015 showed that 88.8% of the 108 respondents felt the GPs at the practice displayed care and concern towards them. The national average was 85.1%. For the nurses, this figure reduced to 86.2%, slightly below the national average of 90.4%. The feedback we received during our conversations with 11 patients and review of the comments left for us by 13 patients was that all staff at the practice were highly regarded. Patients told us they had no concerns at all about the caring nature of the staff.

We saw that the practice maintained a record of all recent patient deaths. From speaking with staff, we found that the GPs made contact with the families of deceased patients offering an invitation to approach the practice for support.

Mental health trust well-being workers were based at the practice on Monday and Thursday every week. The practice employed its own counsellor for three sessions a week. Patients could access these to obtain psychological and emotional well-being counselling and advice through referral from the GPs. The staff we spoke with knew of the availability of other local charitable counselling services (including bereavement counselling) and the practice directed patients requiring such support to them. A drug and alcohol counsellor was available at the practice twice each week on a Wednesday and Friday.

Patients in a carer role were identified where possible. The practice maintained a register of patients who identified as carers. This information was mainly sourced from patients upon registering with the practice or during their consultations with the GPs. Staff told us those patients on the register had access to the flu vaccination which could

Good

Are services caring?

be provided at home if required. We saw information aimed at carers provided on the practice's website and displayed in the waiting areas. This gave details of the local support available among other things.

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

Smoking cessation services including advice were provided at the practice by the nurses. At the time of our inspection, there were 1,238 known smokers in the practice patient population. Intervention was offered to 745 patients and of those 167 accepted, all of whom had received advice or referral from the practice at the time of our inspection.

All newly diagnosed patients with type two diabetes were referred for diabetic eye screening and to the DESMOND programme in adherence with National Institute for Health and Care Excellence (NICE) guidelines. DESMOND is an NHS training course that helps patients to identify their own health risks and set their own goals in the management of their condition.

There were six week post-natal checks for mothers and their children. A range of contraceptive and family planning services were available at the practice.

The practice had a patient participation group (PPG). The PPG is a group of patients who work with the practice to discuss and develop the services provided. From our conversations with PPG members and our review of PPG meeting minutes, it was clear the group was currently involved with the practice.

Tackling inequity and promoting equality

Our review of training documentation showed that seven non-clinical staff had completed equality and diversity training in March and April 2014. No other staff, including those employed at that time had completed the training. We saw the premises and services were adapted to meet the needs of people with disabilities. All the clinical services were provided at ground level and there was step free access to the main entrance. A working lift was available to the first floor used only by practice staff. A wheelchair was available at the practice for patient use. We found that the waiting area was open and accessible enough to comfortably accommodate patients with wheelchairs and prams and allowed for manageable access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients and these included a baby changing area.

An external translation service was available to the practice. However, due to the local patient population being predominantly from a white British background this was not frequently used by patients. A signing interpreter was also available. A portable hearing loop was provided in reception for those patients who may need it. There was a male and two female GPs in the practice and patients could choose to see a male or female doctor. We found the practice was aware of and catered for its patients with specific needs. These included home visits for those patients who were unable to attend the practice due to the nature of their conditions and those who required specific and individual methods of communication. From our conversations with reception staff we found they demonstrated a good awareness of their patient population.

Access to the service

On the day of our inspection we checked the appointments system and found the next advance release routine bookable appointment to see any of the three GPs we checked was at least 19 working days away and up to 22 working days away (this doctor was away for two weeks in December). However, on-the-day release appointments would be available for each doctor during that time. We saw that the appointments system was structured to ensure that the two GP partners were able to complete home visits every day. The system was designed to enable the practice to attempt to see all urgent cases on the same day and each GP was able to complete telephone consultations.

The practice was staffed with phones lines open from 8.00am to 6.30pm Monday to Friday with the doors open from 8.30am to 6.00pm. In addition to this, there was early opening every Tuesday from 7.00am and late opening until 7.00pm every Monday. The doors and phone lines remained open over the lunchtime period. The extended opening times provided some additional access to the practice for those who found attending in normal working hours difficult.

Information was available to patients about appointments on the practice website. This included how to book appointments through the website. Patients were able to make their repeat prescription requests at the practice or online through the practice's website. There were also arrangements in place to ensure patients received urgent medical assistance when the practice was closed. Information on how to access the out of hours (OOH) service was provided to patients.

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

We saw there was a standard process in place for the practice to receive notifications of patient contact and care from the out of hours provider. We saw evidence that the practice reviewed the notifications and took action to contact the patients concerned and provide further care where necessary.

Results from the national GP patient survey in 2015 showed that 69.1% of patients felt they did not have to wait too long to be seen at the practice. This was above average when compared to the rest of England (57.7%). Of the 108 respondents, 82.5% felt their experience of making an appointment was good. This was also above average when compared to the rest of England (73.3%). When asked about getting through to the practice on the phone, 73.6% of respondents found this to be an easy experience. This was very slightly above average when compared to the rest of England (73.3%). This data was collected from July to September 2014 and January to March 2015.

During our inspection, we spoke with 11 patients and read the comments left for us by 13 patients. Their feedback on the appointments system and access to the practice did not reflect the positive responses from the national GP patient survey. Most patients said access to appointments, including the wait for pre-bookable appointments was poor and getting through to the practice by phone was difficult. They told us the wait for pre-bookable appointments was long and they felt this was because the practice was understaffed. Some patients told us they queued outside the practice from 8.00am to get an on-the-day appointment as this was preferable to attempting to get through on the phone. Others said that if they needed an appointment urgently they would travel to the nearest walk-in centre in Corby in preference to attempting to get one at the practice. Three of the six complaints we looked at received by the practice between January and November 2015 related to the difficulty in accessing appointments. One was passed to the practice by the local MP.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. During our inspection we saw there was a complaints procedure available and there was a designated responsible person who handled all complaints in the practice. This was the practice manager. However, for all clinical complaints, the relevant clinicians were involved.

We saw that information was available to help patients understand the complaints system. Information on how to complain was contained in the practice leaflet available from reception. An overview of the practice's complaints procedure was available on the website.

We looked at the practice's records of complaints from January to November 2015. We saw examples of when the complainants were contacted to discuss the issues raised. We saw that where possible, actions were taken. Complainants were formally responded to in writing in accordance with the practice's own procedure. The practice manager told us that any action and learning points from the complaints received was communicated to staff verbally and informally. The staff we spoke with demonstrated an awareness of the themes and details of recent complaints received by the practice. There was no formal or documented review of complaints to identify the effectiveness of any actions taken.

Are services well-led?

Inadequate

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

Our findings

Vision and strategy

The practice had a vision contained in its statement of purpose and this was known to staff. However, it was clear from discussions with the staff that the absence of a clinical leadership structure and clarity of roles and responsibilities meant that there were significant areas that needed addressing. These included the development of lead roles for long term conditions, more robust clinical management structures and the need to recruit new GPs to replace those approaching retirement.

Governance arrangements

The lack of leadership and process was demonstrated by out-of-date or absent policies and ineffective communication systems that failed to ensure staff were involved in, or kept up-to-date with changes which affected them. This resulted in risks to patients and staff.

We found that the lack of leadership also meant that there were no systematic approaches to either monitoring or improving the quality of care. This was demonstrated by a lack of awareness by staff about the practice's poor position with respect to the Quality and Outcomes Framework (QOF). QOF is a national data management tool generated from patients' records that provides performance information about primary medical services. The practice performed below national and clinical commissioning group (CCG) averages for QOF. Additionally, the GPs told us there was no programme of clinical audit and we found there were no systems for tracking histology requests or quality assuring minor surgery.

There were no specific clinical leads for any areas (except a recently employed nurse who led for patients with diabetes, but was not yet comfortable in the role) and it appeared that this situation was severely impacting on the practice's ability to make progress.

Leadership, openness and transparency

The staff we spoke with told us they felt the partners were visible in the practice and approachable. The patients we spoke with said the same. Staff said the culture in the practice was mostly friendly. They told us they tried their best to support each other as much as possible in a busy environment. Some said the past year was unsettling and disruptive for them as there had been two changes of practice manager.

The staff we spoke with told us that without regular staff team meetings they did not always have the opportunity to discuss relevant issues that affected them as staff and also their patients. Staff said that the monthly protected learning session was the only opportunity for all staff discussion, but was more based around updates and practice procedures. The meeting was documented for the first time in November 2015. We looked at the minutes of the meeting from 11 November 2015 which detailed updates on the repeat prescription process, staff leave and the re-introduction of e-learning among other things.

Practice seeks and acts on feedback from its patients, the public and staff

The practice had some mechanisms in place to listen to the views of patients and those close to them. The practice had a patient participation group (PPG) of eight members. The PPG is a group of patients who work with the practice to discuss and develop the services provided. We spoke with senior staff and two members of the PPG who said the group had lacked structure and direction over the past year and that meetings were ad-hoc. They said that with the arrival of the new practice manager there was an effort to reinvigorate the group. Our review of the minutes of the meeting held on 13 October 2015 showed that the group's terms of reference and priorities were discussed and the meetings would be held every other month from that point. The next meeting was scheduled for 6 December 2015. The two members of the PPG we spoke with said they felt supported by the practice and were optimistic about the group's potential.

The senior staff we spoke with confirmed there had not been a recent patient survey completed at the practice. There was no patient suggestions box available on the day of our inspection. Staff we spoke with said this was usually available but had been temporarily withdrawn and replaced with the CQC comments box for the period of our inspection. We were told that no suggestions or comments had been made using the box or the online comments facility on the practice's website since the arrival of the current practice manager in July 2015.

Are services well-led?

Inadequate

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

During our inspection patients told us they were concerned about the long wait for pre-bookable appointments and poor access to the practice by telephone. Three of the six complaints we looked at received by the practice between January and November 2015 related to the difficulty in accessing appointments. We found the practice had not sufficiently sought and acted on patients' comments and complaints in those areas.

Management lead through learning and improvement

From our conversations with staff and our review of documentation we found that a programme of appraisals was in place and most staff had completed one in the past year. A schedule was in place to complete the remaining appraisals. The examples we looked at showed these were an opportunity for staff to discuss any learning needs and their professional development.

Most of the staff we spoke with said that opportunities for their professional development were limited due to the lack of staff and management changes at the practice in the past year. However, protected learning time was used to provide staff with some of the training and development they needed to carry out their roles effectively such as safeguarding and basic life support training.

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 Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **How the regulation was not being met:** We found that the registered person did not always provide care in a safe way and had not assessed the risks to the health and safety of people of receiving their care or treatment or done all that is reasonably practicable to mitigate such risks. The practice did not receive or implement the recommendations of safety alerts. There was a risk that patients taking some medicines had not received an urgent review deemed necessary by the relevant safety alerts. There was a risk patients would not receive the appropriate management, medication and review for their conditions. Also, some risks to their health and welfare might not be managed appropriately because they had not been documented correctly. Patients were not always invited for and receiving chronic condition reviews. The practice completed only 53.5% of reviews for patients with diabetes in 2014/2015. For patients with chronic obstructive pulmonary disease it was 54.3% in the same period. Of the 20 patients on the dementia register none had received their annual reviews in the past 12 months. Where patient reviews were completed, the documentation was not always fit for purpose. We reviewed the records of five patients with chronic conditions. The quality of information recorded varied considerably. Some records lacked basic data. We looked at the records of three patients with learning disabilities who had been offered and received a review. In one case, the review template was not completed.

This section is primarily information for the provider

Requirement notices

Patients' health and welfare was not always protected as there was a risk that their referrals were not made with sufficient urgency, lacked the required clinical details and might go to the wrong department. There was no formal review or clinical oversight of hospital referrals.

We found that the registered person had not protected people from the risks associated with the improper and unsafe use and management of medicines by means of the making of appropriate arrangements for the storing and recording of some medicines used for the purpose of the regulated activity.

There was no system in place to record the amount and type of vaccines kept. Vaccines were not stored securely. Policies and checks relating to medicines management, including vaccines were insufficient. Five medical consumables were beyond their expiry dates. There was no process in place that would identify if a blank form for hand written and computer generated prescriptions was missing or used inappropriately and they were not stored securely.

We found that the registered person had not protected people against the risk of infection because some systems designed to assess the risk of and to prevent, detect and control the spread of infection were lacking, or did not meet specification.

There was no staff lead for infection control issues. Not all staff were trained in infection control and there was no risk assessment as to why this was not necessary. No plan was in place to control and resolve the moderate risks identified from the Legionella risk assessment.

We found that where the responsibility for the care and treatment of people was shared with others, the registered person was not working with such others appropriately to ensure people's health, safety and welfare.

There were no formal or recorded multi-disciplinary team meetings to discuss the needs of complex patients. There was a risk that high level care patients would not receive a full and appropriate multi-disciplinary review of their care needs.

This was in breach of Regulation 12 (1) and (2) (a), (b), (g), (h) and (i) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Surgical procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **How the regulation was not being met:** We found that the registered person had not protected people from the risks of unsafe or inappropriate care and treatment by ensuring all persons employed received the appropriate support, training and supervision as is necessary to enable them to carry out the duties they are employed to perform. Most staff were overdue most essential training. Some essential training was not completed. The clinical supervision of the nurses was informal and ad-hoc. This was in breach of Regulation 18 (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Surgical procedures Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed **How the regulation was not being met:** We found that the registered person had not protected people from the risks of unsafe or inappropriate care and treatment by ensuring all the required information in respect of each person employed was available and up-to-date. There was no available criminal records check for one nurse. The available criminal records check for another nurse was from a previous employer. We looked at six staff records. Each staff file lacked one or more pieces of documentation to complete appropriate recruitment checks such as satisfactory evidence of conduct in previous employment or photographic identification. This was in breach of Regulation 19 (3) (a) and (b) and Schedule 3 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 Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **How the regulation was not being met:** We found that the registered person had not protected people against the risk of inappropriate or unsafe care and treatment because systems designed to assess, monitor, mitigate risks to and improve the quality and safety of services for patients were lacking. An accurate, complete and contemporaneous record of each patient, including a record of their care and treatment was not always maintained. The processes for recording action and learning points from reported incidents and events and reviewing the effectiveness of any action taken were insufficient. There was no formal or documented review of complaints received to identify areas for improvement or the effectiveness of any actions taken. Some relevant staff were unaware of the action and learning points from incidents and events. There was a risk staff were not made aware of the decisions made and the changes in practice required. There was no system in place for the management of safety alerts. Staff were unable to give examples of recent alerts relevant to the care they were responsible for. There was a risk that patients taking some medicines had not received an urgent review deemed necessary by the relevant safety alerts. Systems, policies and processes to manage and monitor risks to patients, staff and visitors to the practice were lacking. Staff were unaware of the existence of policies and protocols covering most areas of risk at the practice. There were no practice specific policies or up-to-date risk assessments in relation to health and safety including fire safety.

This section is primarily information for the provider

Enforcement actions

Risk assessments to determine why reception and administration staff acting as chaperones did not require criminal records checks had not been completed.

Systems to ensure patients received chronic condition reviews and had those documented appropriately were lacking. Patients were not always invited for and receiving chronic condition reviews. We reviewed the records of five patients with chronic conditions. The quality of information recorded varied considerably. Some records lacked basic data. We looked at the records of three patients with learning disabilities who had been offered and received a review. In one case, the review template was not completed. There was a risk patients would not receive the appropriate management, medication and review for their conditions. Also, some risks to their health and welfare might not be managed appropriately because they had not been documented correctly.

There was no programme of repeated (full cycle) clinical audit to demonstrate learning and the effectiveness of any changes made.

No record was kept of the minor surgery completed or the histology requests made. There was no system in place to identify if the histology requests made were received and the appropriate action was taken. No audits were completed or records maintained of the complications arising from minor surgery procedures.

There was a pattern of reduced achievement in the management of a range of chronic conditions. There was no suitable system in place for the practice to assure itself that patient outcomes were adequate and that the practice could measure its performance in those areas.

The lack of a formal system of review and clinical oversight of hospital referrals put patients at risk that their referrals were not made with sufficient urgency, lacked the required clinical details and might go to the wrong department.

Patients reported that the waiting time for pre-bookable appointments was long and access to the practice by phone was difficult. The practice had not made appropriate improvements to the quality of service as a result of assessing and evaluating the information provided by service users.

This section is primarily information for the provider

Enforcement actions

This was in breach of Regulation 17 (1) and (2) (a), (b), (c) and (f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.