Bayswater Medical Centre

Quality Report

46 Craven Road
London
W2 3QA
Tel: 020 3441 3002
www.baysmed.co.uk

Date of inspection visit: 4 June 2015
Date of publication: 30/07/2015

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?	Inadequate
Are services responsive to people's needs?	Inadequate
Are services well-led?	Inadequate

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Bayswater Medical Centre on 4 June 2015. We inspected the main practice located at 46 Craven Road, W2 3QA and the branch practice located at 7 Golborne Road, W10 5PN. Overall the practice is rated as inadequate.

Specifically, we found the practice inadequate for providing safe, effective, caring, responsive services and being well led. It was also inadequate for providing services for 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 and people experiencing poor mental health (including people with dementia).

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

- Patients were at risk of harm because systems and processes were not in place to keep them safe. For example, appropriate recruitment checks on staff had not been undertaken prior to their employment.
- Staff were not clear about reporting incidents, near misses and concerns and there was no evidence of learning and limited communication with staff.
- There was insufficient assurance to demonstrate people received effective care and treatment. For example there was no information available to indicate that any patients with a learning disability had received an annual health check and review of their care.
- Patients said they were treated with dignity and respect.
- Patients said they experienced significant difficulties in booking an appointment and had to wait long periods of time to be seen for their appointment in the practice. The availability of GP appointments at the main and branch practice was unclear for patients.

Summary of findings

- The practice had no clear leadership structure, insufficient leadership capacity and limited formal governance arrangements.

The areas where the provider must make improvements are:

- Ensure there is adequate clinical staff employed in the practice and with the right skills to meet the needs of patients. Ensure recruitment arrangements include all necessary employment checks for all staff and document all recruitment and employment information in staff files.
- Ensure staff receive appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out their duties they are employed to perform including providing clinical care and treatment in line with national guidance and guidelines.
- Ensure there are systems in place for effective care and monitoring of patients experiencing poor mental health (including people with dementia); those with circumstances that make them vulnerable; patients with long term conditions and patients identified as at risk.
- Ensure audits of practice are undertaken, including completed clinical audit cycles to monitor and drive improvement in patient care.
- Establish effective systems, including monitoring and regular audit of practice, to meet current guidance to ensure infection prevention and control measures are met and the cleanliness and hygiene of the practice is maintained and assured. Introduce a legionella risk assessment and related management schedule.
- Make suitable arrangements for training staff in safeguarding adults and children.
- Ensure arrangements are in place for annual testing of all electrical equipment.
- Implement a safe system for medicines management including the development of a cold chain procedure and stock control of emergency medicines to ensure these are in date and fit for use.
- Ensure there are formal governance arrangements in place including systems for assessing and monitoring risks and the quality of the service provision. Ensure staff have appropriate policies and guidance to carry out their roles in a safe and effective manner which is reflective of the requirements of the practice. Clarify the leadership structure and ensure there is leadership capacity to deliver all improvements. The service must seek and act on feedback from staff, patients and external agencies on the services provided and evaluate and improve their practice in respect of this information.

The areas where the provider should make improvement are:

- Provide explicit information for patients on the practice website regarding GP appointments.
- Develop a system for the effective identification and support of patients who are carers.
- Ensure staff are familiar with organisations to signpost patients who are carers or patients who have experienced bereavement or are experiencing a significant health issue.

On the basis of the ratings given to this practice at this inspection, I am placing the provider into special measures. Bayswater Medical Centre are not to carry out any regulated activities at the branch site and not to register any new patients at the main practice except for family members of existing patients for a period of six months.

On 8 June 2015 we served the practice a Section 31 of the Health and Social Care Act 2008 ("the Act") notice to impose these conditions in relation to their registration as a service provider. This will be for a period of six months. We will inspect the practice again in six months to consider whether sufficient improvements have been made. If we find that the provider is still providing inadequate care we will take steps to cancel its registration with CQC.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Inadequate

The practice is rated as inadequate for providing safe services and improvements must be made.

Staff were not clear about reporting incidents, near misses and concerns. Although the practice carried out investigations when things went wrong, lessons learned were not communicated and so safety was not improved. Patients were at risk of harm because systems and processes were not in place in a way to keep them safe. There was insufficient information to enable us to understand and be assured about safety because the practice did not maintain a risk log.

Are services effective?

Inadequate

The practice is rated as inadequate for providing effective services and improvements must be made.

Knowledge of and reference to national guidelines were inconsistent. Data showed that some patient outcomes were significantly below average for the locality. Patient outcomes were hard to identify as little or no reference was made to audits, there was no evidence of any completed audit cycles and there was no evidence that the practice was comparing its performance to others - either locally or nationally. There was minimal engagement with other providers of health and social care. There was limited recognition of the benefit of an appraisal process for staff and little support for any additional training that may be required.

Are services caring?

Inadequate

The practice is rated as inadequate for providing caring services, as there are areas where improvements should be made.

Data showed that patients rated the practice lower than others for some aspects of care. The majority of patients said they were treated with dignity and respect. However, not all felt cared for, listened to and supported to cope emotionally with care and treatment. The practice did not effectively identify patients who were carers and there was no carers register. Staff were unfamiliar with any organisations to which they could signpost patients who were carers or patients who had experienced a bereavement or who were experiencing a significant health issue such as cancer.

Are services responsive to people's needs?

Inadequate

The practice is rated as inadequate for providing responsive services and improvements must be made.

Summary of findings

The practice had not reviewed the needs of its local population. The practice was not working with the NHSE Area Team and Clinical Commissioning Group (CCG) to review information about the local population and to secure service improvements. Patients reported considerable difficulty in accessing a named GP. Appointment systems were not working well so patients did not receive timely care when they needed it. The branch practice was not well equipped to treat patients and the premises needed upgrading. The practice was not proactive in gaining patient feedback. There was no Patient Participation Group (PPG) in place, the practice did not participate in the Friends and Family Test and a patient satisfaction survey had not been undertaken since 2013.

Are services well-led?

Inadequate

The practice is rated as inadequate for being well-led and improvements must be made.

It did not have a clear vision and strategy. Staff we spoke with were not clear about their responsibilities in relation to the vision or strategy. There was no clear leadership structure and staff did not feel supported by management. The practice had a limited number of policies and procedures to govern activity but staff were unaware of these policies or their location. The practice did not hold regular governance meetings and issues were discussed at ad hoc meetings. The practice had not proactively sought feedback from staff or patients and did not have a patient participation group (PPG). Staff told us they had not received regular performance reviews and did not have clear objectives.

Summary of findings

The six population groups and what we found

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

Older people

Inadequate

The provider was rated as inadequate for safe, effective, responsive and for well-led and requires improvement for caring. The concerns which led to these ratings apply to everyone using the practice, including this population group.

The practice is rated as inadequate for the care of older people.

Care and treatment of older people did not always reflect current evidence-based practice. The safety of care for older people was not a priority and there were limited attempts at measuring safe practice. If patients arrived at the branch practice requesting an appointment on days of the week outside of Wednesday and Thursday mornings, they were instructed to go to the main practice which was approximately at 40 minute commute on public transport as there were no GP appointments available. Longer appointments and home visits were available for older people when needed. Services for older people were reactive and there was a limited attempt to engage this patient group to improve the service.

People with long term conditions

Inadequate

The provider was rated as inadequate for safe, effective, responsive and for well-led and requires improvement for caring. The concerns which led to these ratings apply to everyone using the practice, including this population group.

The practice is rated as inadequate for the care of people with long-term conditions.

Longer appointments and home visits were available when needed. However, not all these patients had a named GP, a personalised care plan or structured annual review to check that their health and care needs were being met. The practice did not have a robust recall system for patients' long- term conditions to have monitoring checks.

Families, children and young people

Inadequate

The provider was rated as inadequate for safe, effective, responsive and for well-led and requires improvement for caring. The concerns which led to these ratings apply to everyone using the practice, including this population group.

The practice is rated as inadequate for the care of families, children and young people.

There were no systems to identify and follow up patients in this group who were living in disadvantaged circumstances and who

Summary of findings

were at risk. Some staff knew how to recognise signs of abuse in children and young people, but they were not aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies out of normal working hours. There were no regular, formal meetings held between the practice and Health Visitors.

Patients told us that children were prioritised for appointments however appointments were available outside of school hours at the main practice and not the branch. The branch premises were not suitable for this population group because there were numerous health and safety risks particularly for children such as exposed wires under the waiting room chairs and heaters which could cause injury if touched and were potential trip hazards.

Working age people (including those recently retired and students)

Inadequate

The provider was rated as inadequate for safe, effective, responsive and for well-led and requires improvement for caring. The concerns which led to these ratings apply to everyone using the practice, including this population group.

The practice is rated as inadequate for the care of working-age people (including those recently retired and students).

The age profile of patients at the practice is mainly those of working age, students and the recently retired but the services available did not fully reflect the needs of this group. There were some extended opening hours for patients but these were available at the main practice and not the branch. There was no online appointment booking system and the majority of patients we spoke with told us that they experienced significant difficulties in booking an appointment. Repeat prescriptions could be ordered in person, by post and online. There was limited accessible health promotion material available in both practices.

People whose circumstances may make them vulnerable

Inadequate

The provider was rated as inadequate for safe, effective, responsive and for well-led and requires improvement for caring. The concerns which led to these ratings apply to everyone using the practice, including this population group.

The practice is rated as inadequate for the care of people whose circumstances may make them vulnerable.

The practice worked with multi-disciplinary teams in the case management of vulnerable people, however there was no system in place to identify or monitor patients living in vulnerable circumstances and there was no system to establish that these patients had received an annual health check. If patients arrived at

Summary of findings

the branch practice requesting an appointment on days of the week outside of Wednesday and Thursday mornings, they were instructed to go to the main practice which was approximately at 40 minute commute on public transport, as there were no GP appointments available. Some staff knew how to recognise signs of abuse in vulnerable adults and children, but they were not aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies out of normal working hours.

People experiencing poor mental health (including people with dementia)

Inadequate 

The provider was rated as inadequate for safe, effective, responsive and for well-led and requires improvement for caring. The concerns which led to these ratings apply to everyone using the practice, including this population group.

The practice is rated as inadequate for the care of people experiencing poor mental health (including people with dementia).

Not all patients experiencing poor mental health had received an annual physical health check. There was no benchmarking for the recording of a diagnosis of dementia. We were not provided with any evidence of advance care a planning for patients with dementia. There was no evidence of information available in either of the practice premises for patients with mental health needs about how to access various support groups and voluntary organisations. None of the administrative staff had received training on how to care for people with mental health needs, including dementia.

Summary of findings

What people who use the service say

We spoke with 14 patients during our inspection and received one completed Care Quality Commission (CQC) feedback card.

Patients told us that they were treated with dignity and respect.

The majority of patients we spoke with told us that they didn't feel that the GP gave them enough time and felt rushed during their consultation and they found it difficult to book an appointment.

Patients told us that consent was asked for routinely by staff when carrying out an examination or treatment. They also told us that staff always waited for consent or agreement to be given before carrying out a task or making personal contact.

Patients were not positive about the emotional support provided by the practice.

Areas for improvement

Action the service MUST take to improve

- Ensure there is adequate clinical staff employed in the practice and with the right skills to meet the needs of patients. Ensure recruitment arrangements include all necessary employment checks for all staff and document all recruitment and employment information in staff files.
- Ensure staff receive appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out their duties they are employed to perform including providing clinical care and treatment in line with national guidance and guidelines.
- Ensure there are systems in place for effective care and monitoring of patients experiencing poor mental health (including people with dementia); those with circumstances that make them vulnerable; patients with long term conditions and patients identified as at risk.
- Ensure audits of practice are undertaken, including completed clinical audit cycles to monitor and drive improvement in patient care.
- Establish effective systems, including monitoring and regular audit of practice, to meet current guidance to ensure infection prevention and control measures are met and the cleanliness and hygiene of the practice is maintained and assured. Introduce a legionella risk assessment and related management schedule.
- Make suitable arrangements for training staff in safeguarding adults and children.
- Ensure arrangements are in place for annual testing of all electrical equipment.
- Implement a safe system for medicines management including the development of a cold chain procedure and stock control of emergency medicines to ensure these are in date and fit for use.
- Ensure there are formal governance arrangements in place including systems for assessing and monitoring risks and the quality of the service provision. Ensure staff have appropriate policies and guidance to carry out their roles in a safe and effective manner which is reflective of the requirements of the practice. Clarify the leadership structure and ensure there is leadership capacity to deliver all improvements. The service must seek and act on feedback from staff, patients and external agencies on the services provided and evaluate and improve their practice in respect of this information.

Action the service SHOULD take to improve

- Provide explicit information for patients on the practice website regarding GP appointments.
- Develop a system for the effective identification and support of patients who are carers.

Summary of findings

- Ensure staff are familiar with organisations to signpost patients who are carers or patients who have experienced bereavement or are experiencing a significant health issue.

Bayswater Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector and the team included a second CQC inspector, the Chief Inspector of General Practice, a GP specialist advisor, a Practice Manager Specialist Advisor and an Expert by Experience.

Background to Bayswater Medical Centre

Bayswater Medical Centre provides GP primary medical services to approximately 8000 patients living in the London Borough of Westminster. Bayswater Medical Centre consists of two GP practices: the main practice located at 46 Craven Road, W2 3QA and the branch practice located at 7 Golborne Road, W10 5PN. The practices are approximately a 40 minute commute on public transport between each other.

The practice has a mixed patient population with a combination of patients who are professionals and some people living in deprivation. Patients registered at the practice are from a number of different ethnic backgrounds and a large proportion of the patients speak English as a second language.

The practice team is made up of two male GPs (one a partner) and two locum female GPs, a locum practice nurse, two healthcare assistants, practice manager (a partner) and ten administrative staff. The salaried GP works four days per week which includes a morning at the branch practice.

Opening hours are between 08:00 - 18:30 on Monday, Thursday and Friday and 08:00-20:00 on Tuesday and Wednesday at the main practice. Opening hours are between 09:00-13:00 and 14:00-17:00 on Monday, Tuesday, Wednesday, Friday and 9:00-13:00 on Thursday at the branch practice.

GP appointments are available between 8:00 -18:30 on Monday, Thursday and Friday 08:00 – 20:00 on Tuesday and Wednesday at the main practice. GP appointments are available between 9:00 -13:00 on Wednesday and Thursday at the branch practice. Telephone access is available during core hours and home visits are provided for patients who are housebound or are too ill to visit the practice.

The practice has a General Medical Services (GMS) contract (GMS is one of the three contracting routes that have been available to enable the commissioning of primary medical services).The practice has opted out of providing out of hours (OOH) services to their own patients and refers patients to the '111' service for healthcare advice when the surgery is closed.

The practice is registered with the Care Quality Commission to provide the regulated activities of

diagnostic and screening procedures, family planning, maternity and midwifery services, surgical procedures and treatment of disease, disorder and injury.

The practice provides a range of services including child development checks, children's immunisations, adult immunisations, travel advice, maternity care, family planning, cervical smears and healthy lifestyle advice.

Detailed findings

Why we carried out this inspection

We inspected both the main practice and the branch as part of our new comprehensive inspection programme.

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. 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, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

How we carried out this inspection

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)

We carried out an announced visit on 4 June 2015. During our visit we spoke with a range of staff (GPs, nurses, the practice manager and administrative staff) and spoke with patients who used the service. We observed how the practice was run, interactions between patients, staff and the overall patient experience and reviewed treatment records of patients.

Inadequate

Are services safe?

Our findings

Safe track record

The practice had not prioritised safety and did not utilise information from reported incidents, national patient safety alerts and comments and complaints from patients to identify risks and improve patient safety. There was no clear system in place for the reporting of significant events, incidents and near misses. Staff we spoke with were aware of their responsibilities to raise concerns and escalated these verbally to the practice manager, but were unsure as to what constituted an incident and near miss in their practice.

We requested evidence of significant events and were provided with three events that had been reported. However, we were unable to verify when these had occurred as the documentation was undated. National patient safety alerts and other safety guidance such as Medicines and Health Regulatory Agency alerts, were not disseminated within the practice in a formal way and there was no system to record that these had been appropriately dealt with.

Regular practice meetings were not held to review and monitor risks There were no meeting minutes available to evidence the discussion of significant events, incidents and patient safety alerts amongst practice staff and to demonstrate a safe track record.

Learning and improvement from safety incidents

The practice did not have a system in place for reporting, recording and monitoring significant events, incidents and accidents. There was no log kept to record significant events that had occurred and the three significant events forms which were made available to us were undated and therefore it was unclear when these events had occurred. The three significant event forms we reviewed detailed actions that had been taken in response to these occurrences . However there was no information detailed within these forms regarding any learning from these incidents and not all clinical staff were aware of these incidents. There were no practice minutes available to demonstrate the discussion of significant events with staff and specific significant events meetings were not held to review actions from past significant events and complaints. There was no evidence that appropriate learning had taken place and that the findings were disseminated to relevant staff.

We found no evidence of an incident reporting policy or procedure in place and there were no incident forms available to facilitate the reporting of incidents and near misses by practice staff. Staff we spoke with were unsure what constituted an incident or near miss within the practice, however staff informed us that they escalated any concerns they had to the practice manager. Some staff we spoke with said that they utilised the instant messaging service on the practice's electronic system to report any concerns. The practice were unable to evidence any action taken as a result of incidents that had occurred.

The clinical staff informed us that there was no formal process for the dissemination within the practice of national patient safety alerts. Staff we spoke with were unable to give examples of recent alerts that were relevant to the care they were responsible for. There was no system to record that safety alerts received had been appropriately dealt with and any necessary actions implemented.

Reliable safety systems and processes including safeguarding

The practice had some systems in place to manage and review risks to vulnerable children, young people and adults. The practice had appointed the GP partner as the dedicated lead for safeguarding vulnerable adults and children. The safeguarding lead had been trained to Level 3 child protection training in accordance with national guidance to fulfil this role. The salaried GP had also received Level 3 training, however there were no training records available to confirm the levels of safeguarding training undertaken by the remainder of the clinical team. There was a mixed response from staff we spoke with in relation to the identity of the safeguarding lead and who to speak with in the practice if they had a safeguarding concern.

The majority of administrative staff we spoke with had not attended safeguarding training. We were told that safeguarding training was provided for staff in January 2013. However, all staff members joining the practice following this date had not been provided with training.

The majority of staff we spoke with could not describe the various types of abuse and were not aware of their

responsibilities regarding information sharing and documentation of safeguarding concerns or how to contact the relevant agencies during working hours and out of hours. There were no safeguarding policies in place and we saw no evidence of multi-agency safeguarding information and contact details available for staff to refer to in administrative or clinical areas.

Clinical and administrative staff we spoke with told us that the practice did not operate a system to highlight vulnerable patients on the practice's electronic records. Therefore staff were unaware of any relevant issues when patients attended appointments; for example children subject to child protection plans.

There was no chaperone policy in place, however we observed posters in the waiting room noticeboards and consulting rooms offering this service to patients. All of the administrative staff we spoke with had acted as chaperones, however only one member of staff within the practice had attended formal chaperone training. Administrative staff we spoke with were unsure about their responsibilities when acting as chaperones, including where to stand in order to be able to observe the examination. Disclosure and Barring Service checks had been performed for clinicians. However administrative staff providing chaperone duties had not undergone a criminal records check and a comprehensive risk assessment to support this decision had not been undertaken. (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).

Medicines management

The practice had a medicines management policy, however we found that this was out of date and had not been reviewed since 2013. Following a review of this policy, we noted that it contained incorrect information, for example, information relating to Primary Care Trusts.

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were not stored securely and therefore not accessible only to authorised staff. At the branch practice we found medicines were stored on bookshelves in the treatment rooms. No medicines requiring refrigeration were stocked at the branch practice as we were informed that the fridge facility was not fit for use. If medicines such as vaccines were administered from the branch practice, we were told that these would be transported to the branch in an ice cooler box. At the main practice we found that medicines were stored in the cupboards of treatment rooms. However medicines requiring refrigeration were stored in unlocked fridges. We found two anaphylaxis Epipen medicines were incorrectly stored in a fridge against the manufacturer's guidelines. During our inspection we requested that these medicines be disposed of.

There was no cold chain procedure for ensuring that medicines were kept at the required temperatures and describing the action to take in the event of a potential failure. The fridge temperature was checked and documented twice a day and we saw records of these checks, including the minimum, maximum and actual temperatures being undertaken and that the appropriate temperature range had been maintained.

There were no clear processes in place to check medicines were within their expiry date and suitable for use or which members of staff were responsible for performing this duty. At the branch site we found expired medicines including diazepam, adrenalin and Ventolin used for the emergency for treatment of seizures, anaphylaxis and asthma attacks respectively. At the main practice we found two anaphylaxis Epipens and hydrocortisone were out of date which were stored in one of the emergency medicines box. We requested that these medicines be disposed of and replaced with in date anaphylaxis Epipens, prior to any further vaccinations being given to patients. Expired and unwanted medicines were disposed of in line with waste regulations.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Prescriptions (FP10s) were logged when they arrived at the practice and when they were given to a GP and we saw evidence of this log. Both blank prescription forms for use in printers and those for hand written prescriptions were handled in accordance with national guidance and were tracked through the practice and kept securely at all times.

Cleanliness and infection control

We observed the premises at the main practice to be clean and tidy, however prior to our inspection CQC received

complaints regarding a cockroach infestation at the main practice. During our inspection we observed that pest control preventative measures had been taken in response to this issue.

We found that infection control and cleanliness of the branch practice premises were not well managed. Surfaces within the consultation rooms which held medicines and clinical equipment had high levels of dust and we observed cobwebs throughout the practice. There were cracks and crumbling of some of the walls and areas of the floor throughout the practice. The walls, flooring and windows throughout the practice were dirty, stained and marked. The practice manager confirmed that there were no cleaning schedules in place or cleaning records for the main or branch practice.

We tested the water temperature of the sink taps of the patient and staff toilets and the consultation room sinks. We found that there was no hot water available from any of the sink taps throughout the branch practice.

We observed that notices about hand hygiene techniques were displayed in staff and patient toilets in the main practice but not the branch practice. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available however in treatment rooms of both practices.

There was no policy for the management, testing and investigation of legionella (a bacterium which can contaminate water systems in buildings). There were no records available to confirm that legionella testing had been performed or a risk assessment for legionella had been undertaken to reduce the risk of infection to staff and patients.

We saw no evidence of an infection control policy or supporting procedures available for staff to enable them to plan and implement measures to control infection. However, we found that personal protective equipment, including disposable gloves, aprons and coverings, was available for staff to use.

There was no policy available to inform staff of the procedure to follow in the event of a needle stick injury. At the branch site we found a sharps bin in the nurse consulting room which had been in use from January 2015 and was full to capacity above the manufacturer's line to indicate full status. The sharps bin was overdue for disposal as infection control guidelines indicate that sharps bins must be disposed of every three months. External contractors provided the collection and removal of clinical waste and clinical specimens. At the main site we observed that specimens were collected in cardboard boxes placed on a table located in the thoroughfare between the waiting area and consultation rooms. We noted that these boxes could be knocked over by staff or patients moving between these areas.

The GP partner was the practice lead for infection control. Staff had not been provided with infection control training specific to their role and did not receive annual updates. We saw no evidence that the lead had carried out any infection control audits to identify any improvements for action.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. We saw evidence of annual calibration of relevant equipment; for example weighing scales and blood pressure measuring devices at both the main practice and the branch.

We checked portable electrical equipment at the main practice and the branch and found that equipment had been tested at the main practice. Equipment at the main practice displayed stickers indicating the last Portable Appliance Testing (PAT) date which was June 2015, however the practice manager confirmed that, prior to the most recent test, equipment was checked approximately five years ago. We found clinical equipment at the branch practice where PAT testing was overdue included an ultrasound machine, carbon monoxide monitor (used for smoking cessation), nebuliser and a consultation couch lamp. Clinical staff stated that the ultrasound equipment was unreliable but was still in use at the branch practice. The computer monitor and printers in the treatment rooms were also overdue for PAT testing.

During our inspection we noted that the waiting area and reception were very warm. The practice manager informed us that there had been problems with the air conditioning unit and it had not been serviced for approximately 18 months.

Staffing and recruitment

The practice had an up to date recruitment policy that set out the standards to be followed when recruiting clinical and non-clinical staff. Records we looked at identified that

the recruitment policy had not been followed and contained evidence that recruitment checks had not been undertaken prior to employment for all members of staff. For example, the salaried GP had not been provided with a contract and we found no evidence of a curriculum vitae within the personnel file. We found no evidence of references being obtained for either the Health Care Assistant (HCA) or the three administrative staff members. We found no evidence of criminal record checks through the Disclosure and Barring Service win any of the staff files we checked. (These checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable). The Hepatitis B status of clinical staff was not recorded in any of the staff files.

Staff told us there were not enough clinical staff members to maintain the smooth running of the practice and to keep patients safe. One of the GPs we spoke with was not involved with any aspects of management of the practice and had a purely clinical role due to the lack of clinical staff. The practice manager told us they were aware that GP staffing levels were too low. Administrative staff we spoke with told us that they felt unsafe when working at the branch practice as there was often only one member of staff timetabled to work there on some days of the week. During our inspection of the branch practice we observed that the reception area was intermittently b unmanned because the administrative staff member on duty had to keep leaving the practice in in order to top up the parking meter for the GP's car, as there were no parking facilities at the practice. There were no arrangements for the planning and monitoring of the number of staff and skill mix and no recorded method of identifying risks or increased demands to meet patient's needs. Patients we spoke with told us they found it difficult to get an appointment, which they felt was because f there were not enough GPs at the practice.

Monitoring safety and responding to risk

The practice did not have systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice.

There was no evidence that a complete risk assessment of the main or the branch practice had been carried out and there were no regular checks of the buildings and environment at the branch practice. For example, there was no risk assessment outlining the control of substances hazardous to health (COSHH) and no overall health and safety risk assessment in place.

We found no evidence of a Health and Safety policy and the practice had not fully evaluated potential risks posed to patients and staff. For example, at the branch practice in the waiting area we found a halogen heater which had not been PAT tested with a wire that presented a trip hazard and could potentially cause an injury to patients if knocked over. We found a fan heater which was out of date for a PAT test; and was situated next to the water cooler. The appliance presented a potential risk to patients and staff being an electrical item located next to a water source and a trip hazard. We observed one of the skirting boards had become loose from the wall and was exposing electrical cabling. One of the windows had a small hole and showed signs of shattering. There was a potential risk of the window shattering which could cause significant harm to staff and patients in the waiting area and also to members of the public outside the practice.

In the entrance of the practice we found that the electric meter box was open with no locking facility which could pose a risk to patients, staff and the practice facilities if tampered with. Next to the meter box there was a wooden window opening pole propped against the wall which could inflict an injury on patients or staff if knocked over.

Staff we spoke with informed us that they felt unsafe working at the branch practice on their own and had escalated this concern to management, but the practice had not carried out a lone worker risk assessment.

Arrangements to deal with emergencies and major incidents

The practice had some arrangements in place to manage emergencies. Records showed that staff had received training in basic life support. At the main practice emergency equipment was available including oxygen and an Automated External Defibrillator (AED), used to attempt to restart a person's heart in an emergency. All staff asked knew the location of this equipment however they were unsure how to operate the AED. At the branch practice we found oxygen was available however staff were unsure if there was an AED in the practice which we subsequently confirmed there was not.

Inadequate

Are services safe?

Emergency medicines were available in secure areas of the main and branch practice however not all staff we spoke with knew of their location. Emergency medicines included those for the treatment of seizures, anaphylaxis, cardiac arrest, asthma attacks and hypoglycaemia. There was no formal process in place to check that emergency medicines were within their expiry date and suitable for use. At both the main practice and the branch site we found expired emergency medicines which were not fit for use.

At the main practice we found that the Biohazard Spill Kit used for sudden and unexpected spillages of blood or any other body fluid, had expired in August 2014.

A fire risk assessment had not been completed for over eight years. Although the practice had an up to date fire policy however, there were no records to show that staff were up to date with fire training or that they practised regular fire drills. At the branch practice there were no fire extinguishers, no fire alarm, no fire exit signage and no fire exit other than the entrance to the building. There was no fire evacuation plan which identified the layout of the building or directed patients and staff to their nearest exit. Following the inspection visit we made our concerns known to the local fire brigade.

The main practice had a burglar alarm and this was serviced in July 2014 however, there was no burglar alarm provided at the branch practice.

The practice informed us that there was a business continuity plan developed which required updating but evidence of this plan was unavailable.

Inadequate

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The clinical staff we spoke with could not clearly outline the rationale for their treatment approaches. We discussed with the clinical staff how National Institute for Health and Care Excellence (NICE) guidance was received into the practice. They told us there was no formal process for the receipt or dissemination of NICE guidance to staff. There were no arrangements in place to review or discuss clinical guidelines either internally or with other practices. Clinical staff were unable to provide us with any examples of recent guidelines they had implemented and were unaware of current guidance regarding antibiotic prescribing. We found no evidence of GPs receiving regular updates from the CCG in any other means than through attendance at monthly practice meetings.

We found that comprehensive assessments which covered all health needs for patients were not being carried out or reviewed at required intervals to ensure their treatment remained effective. For example, GPs told us they had a register of all patients who had a learning disability but were unable to provide the template used to demonstrate the care provided for these patients and were unaware how many patients had received an annual review.

There was no method of risk profiling of the practice population to identify patients who were at high risk of admission to hospital. We found no evidence of partnership working with other health and social care

professionals and services to avoid unplanned hospital admissions of patients.

Discrimination was avoided when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were cared for and treated based on need and the practice took account of patient's age, gender, race and culture as appropriate.

Management, monitoring and improving outcomes for people

Information about people's care and treatment, and their outcomes, was not routinely collected, monitored and used to improve care.

A clinical audit is a process or cycle of events that help ensure patients receive the right care and the right treatment. This is done by measuring the care and services provided against evidence based standards and implementing changes to align with best practice. There was no clinical audit policy and there were no audits available at the practice to review. We found no evidence of any completed clinical audit cycles

There were no practice meetings to discuss performance against the quality and outcomes framework (QOF). (QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). The GPs we spoke with were unaware of the practice's QOF score for the last year or the current QOF performance. From information we sourced from the Health and Social Care Information Centre, we found some patient outcomes were significantly worse than expected when compared with other similar services. For example, the practice's QOF performance for depression was 57.2% below the local CCG average, performance for learning disability 14.6% below the local CCG and performance for hypertension was 12.4% below the local CCG average.

The practice did not participate in any local benchmarking run by the CCG. This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area for indicators such as A&E attendance and referral data.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. Administrative staff told us they had received a limited induction and had not attended any role specific training. Review of staff files showed no evidence of induction for administrative staff. One of the GPs had not received a formal induction programme and had not been provided with an information pack with key contact details. We saw evidence of a staff handbook, however none of the staff we spoke with told us that they had received a copy when starting employment at the practice and we noted that the handbook had not been reviewed for over two years.

Practice nurses and the health care assistants had job descriptions outlining their roles and responsibilities and we saw training certificates to evidence that they were trained appropriately to fulfil these duties.

Inadequate

Are services effective?

(for example, treatment is effective)

All GPs were up to date with their yearly continuing professional development requirements and all either have been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England). We asked GPs how they kept their skills and knowledge up to date and they told us they did this through reading 'Pulse,' (Pulse is a monthly medical magazine for general practitioners) and information received from the local CCG.

We found that annual appraisals were not provided for staff. Staff we spoke to who had received an appraisal during their employment at the practice, told us that there were no development or training opportunities offered to them. However, we were provided with evidence of a Training Needs Assessment which had been developed in 2010.

Working with colleagues and other services

The practice worked with other service providers to meet patients' needs and manage patients with complex needs. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours (OOH) GP services and the 111 service both electronically and by post. The practice did not have a policy outlining the responsibilities of all relevant staff in passing on, reading and actionning any issues arising from communications with other care providers on the day they were received however, all the staff we spoke with understood the process. Information received from hospital outpatients and following admission or discharge were received via paper letters which were stamped, GP annotated, read coded and given to administrative staff to process. Information from other services such as OOH, NHS 111 and ambulance services was received in paper form and stamped on receipt and acted on in the same way as the hospital letters.

The practice held monthly multidisciplinary meetings to discuss patients with complex needs and we saw evidence of the minutes of four such meetings dealing, for example, with patients with multiple long term conditions. These meetings were attended by district nurses, the primary care coordinator, a social worker, community pharmacist, GPs, the practice manager, the Health Care Assistant and practice nurse. Staff felt this system worked well. However we were informed that the long term locum GPs rarely attended this meeting. There had been no formal meetings between the practice clinical staff and the Health Visitors for over six months.

Information sharing

The practice had systems in place to provide staff with the information they needed. An electronic patient record was used by all staff to coordinate, document and manage patients' care. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference. We saw no evidence that audits had been carried out to assess the completeness of these records and that action had been taken to address any shortcomings identified.

Electronic systems were in place for making referrals. A template was used from the electronic system which was printed off and this was the processed by the administrative staff. Staff reported that this system worked well and there were no delays in the referral process. Patients we spoke with told us they were not offered any choices of location for treatment when being referred.

For patients who were referred to hospital in an emergency, the practice manager provided the GPs each week with details of A&E attendances as a hard copy. There was no formal policy in place for the care of patients with high A&E attendances although we were told that GPs would normally telephone these patients. We asked to see the clinical record of such patient encounters, but none was provided. The clinical staff we spoke with did not know if the practice used the Summary Care Records system.(Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours).

Consent to care and treatment

Patients told us that consent was asked for routinely by staff when carrying out an examination or treatment. They also told us that staff always waited for consent or agreement to be given before carrying out a task or making personal contact. The was no practice policy however in place for the documenting of consent for specific interventions to support staff.

Inadequate

Are services effective?

(for example, treatment is effective)

We found that staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it.

Clinical staff we spoke with described a clear understanding of Gillick competencies and were able to provide an example of the implementation of this guidance. (These help clinicians to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment).

We were told that patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing but GPs were not able to locate any evidence of these and were unable to confirm which of these patients had received an annual review.

Health promotion and prevention

The practice had not used information about the needs of the practice population identified by the Joint Strategic Needs Assessment (JSNA) undertaken by the local authority to help focus health promotion activity. The JSNA pulls together information about the health and social care needs of the local area.

It was practice policy to offer all new patients registering with the practice a health check with the health care assistant. The GP was informed of all health concerns detected and these were followed up. The practice was unable to provide any data to demonstrate the uptake of the new patient checks.

We were told that the practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance but the practice were unable to provide any data to indicate the practice's performance for immunisations. A baby clinic was provided by a Health Visitor on a weekly basis at the main practice however, no formal meetings between clinical staff and the Health Visitor had taken place in over six months. There were no services to promote health and well-being for children and mothers except through GP consultations.

The practice was not aware of how they were performing regarding patient cervical smear uptake.

A smoking cessation clinic was provided by a nurse from the local CCG each week at the main practice. There were no services offered to patients for the management of obesity.

There was limited health information displayed in the patient waiting rooms at the main and branch practice which included meningitis, healthy eating, cancer and septicaemia. Patients we spoke with told us that were not asked about their general health including diet and exercise habits during consultations. The practice website provided health information for patients including family health, long term conditions and minor illnesses so patients could make informed decisions about their health.

Inadequate

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction from the GP national patient survey. Seventy-nine percent of respondents stated that the last GP they saw or spoke with was good at treating them with care and respect.

There were a number of negative comments recently posted on the NHS Choices website where patients expressed unhappiness about telephone access to the practice, long waits for an appointment and staff attitude. The overall rating of the practice was 2.5 out of 5.

We also spoke with 14 patients on the day of our inspection. The majority of patients we spoke with said that they had found practice staff to be helpful and caring. The national GP survey showed that 79% of respondents found the receptionists at the practice to be helpful.

The majority of patients we spoke with told us that they didn't feel that the GP gave them enough time and felt rushed during their consultation. We observed posters in the waiting areas of both the main practice and the branch which instructed patients that appointments were for one problem at a time. One patient we spoke with told us this caused difficulty as he had a serious health condition and was experiencing multiple symptoms . However, the results of the national GP survey showed that 78% of respondents felt that the GP gave them enough time which was similar to the local CCG average.

Staff and patients told us that all consultations and treatments were carried out in a consulting room. Disposable curtains were not provided in the consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. However, patients we spoke with told us that prior to an examination the consulting room door was locked to maintain privacy. We noted that consultation room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

The practice had a confidentiality policy, however, we found no evidence in staff files of sign-up to this policy and there was no provision for visitors to the practice to sign any form of confidentiality agreement.

The reception areas at both the main and the branch practice had open plan reception desks which made it difficult to maintain patient privacy. Patients we spoke with told us that they often overhead private conversations at the reception desk. We observed that there was no signage to request that patients approached the reception desks one at a time as a means of mitigating this risk.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded negatively to questions about their involvement in planning and making decisions about their care and treatment. For example, data from the national patient survey showed 72% of respondents said the last GP they saw was good at involving them in decisions about their care which was below the CCG average of 81%. 68% of respondents felt that the last nurse they saw or spoke with was good at involving them in decisions about their care which was below the CCG average of 80%.

We had a mixed response from patients we spoke with on the day of our inspection regarding health issues being discussed with them and being involved in the decision making about their care and treatment. Staff told us that translation services were available for patients who did not have English as a first language. We did not see any notices in the reception areas informing patients that a translation service was available but we observed posters displayed which stated, 'Please do not ask staff to act as interpreters.' We discussed these posters with the practice manager who explained that this was in reference to staff accompanying patients into consultations. We fed back to the practice manager that the language used in the posters may mislead patients into thinking that there was no interpreting service available to them.

Patient/carer support to cope emotionally with care and treatment

Patients we spoke to on the day of our inspection were not positive about the emotional support provided by the practice. They felt that staff were very 'physically orientated' and so would seek emotional support from other sources if required.

We observed there were no notices in the patient waiting areas signposting people to support groups and

Inadequate

Are services caring?

organisations. The practice's computer system recorded if a patient had a carer but the GPs were unable to provide information on how many carers were registered at the practice and there was no carers register.

Staff told us that if families had suffered bereavement, the practice used to send a sympathy card but this had been stopped a while ago. All of the staff we spoke with were unfamiliar with any organisations they could signpost patients who were carers or patients who had experienced a bereavement.

Inadequate

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice was unable to demonstrate an understanding of the needs of the local population. The practice had not engaged with Public Health, NHSE or CCG in order to define the needs of the population and adapt the services they delivered for patients.

We found the practice was not responsive to patients' needs and the needs of the practice population requiring specialist care such as people with a learning disability or dementia. There was a register of patients however, not all GPs were aware how to access this information and could not identify which patients had received an annual review.

There had been a high turnover of staff in recent years and this had impacted on the practices ability to provide continuity of care and accessibility to appointments with a clinical staff member of choice. Patients we spoke with told us that they often had appointments with different GPs and for those with serious conditions, this meant repeating details of their illness and medical history each time with the GP. The results of the GP national survey showed that 45% of the respondents who had a preferred GP, usually got to see or speak to that GP, which below the CCG average of 65%.

There was a 'Primary Care Navigator' based at the practice that provided assistance for patients aged 55 years and over. Primary Care Navigators proactively find and co-ordinate health, social care and volunteer services for people with long term conditions with an objective to reduce A&E visits, out of hours calls to GPs, and overall GP visits. We saw posters in the waiting areas advertising this service and staff we spoke with said that this provision was well received by patients.

The practice did not have a Patient Participation Group (PPG) and the practice had not carried out a patient satisfaction survey since 2013.

Tackling inequity and promoting equality

The practice had access to a translation service and practice staff spoke a number of languages such as Portuguese, Greek, German, Arabic, Farsi, Bengali and Persian. There was no information available to patients in other languages than English. There was a deaf loop system in the main practice but not at the branch practice to assist patients with reduced ranges of hearing.

The premises of the main and the branch practice had not been fully adapted to meet the needs of people with disabilities. At the main practice there was a disabled toilet and a ramp at the entrance however the entrance doors were difficult to open fully to allow wheelchair access. At the branch practice there was no disabled toilet facility and the entrance also did not allow for ease of access with a wheelchair. In both the main and the branch practice there were consultation rooms available on the ground floor.

There were two male GPs and two female locum GPs in the practice; therefore patients could choose to see a male or female doctor and patients we spoke to told us that they had not experienced any problems arranging an appointment with a female GP when requested.

The practice had not provided equality and diversity training for staff. Staff we spoke with did not have a good understanding of equality and diversity issues.

Access to the service

The national GP patient survey information we reviewed showed patients responded negatively to questions about access to appointments and generally rated the practice as poor in these areas. For example, 79% of respondents said the last appointment they were given was convenient which was below CCG average of 91%. Sixty-seven percent of respondent described their experience of making an appointment as good. The majority of patients we spoke with told us they experienced difficulty in making an appointment with the practice. Prior to our inspection CQC also received information from patients indicating difficulties with booking an appointment.

The national GP patient survey also showed that 41% of respondents said they don't normally have to wait too long to be seen. The majority of patients we spoke with told us they were not satisfied with the waiting times within the practice to be seen for their appointment.

Opening hours were between 08:00-18:30 on Monday, Thursday and Friday and 08:00-20:00 on Tuesday and

Inadequate

Are services responsive to people's needs?

(for example, to feedback?)

Wednesday at the main practice. Opening hours were between 09:00-13:00 and 14:00-17:00 on Monday, Tuesday, Wednesday, Friday and 9:00-13:00 on Thursday at the branch practice.

GP appointments were available between 8:00 -18:30 on Monday, Thursday and Friday 08:00 – 20:00 on Tuesday and Wednesday at the main practice. GP appointments were available between 9:00 -13:00 on Wednesday and Thursday at the branch practice. However, at the time of our inspection, information available to patients about appointments for the branch practice on the practice website and displayed at the entrance was not easy to understand for the branch practice, which advertised being open Monday to Friday but GP appointments were only available on Wednesday and Thursday mornings. If patients arrived at the branch practice wanting an appointment with a GP apart from Wednesday and Thursday morning, they were instructed to travel to the main practice which took approximately 40 minutes by public transport.

Telephone access was available during core hours and home visits are provided for patients who are housebound or are too ill to visit the practice

If patients telephoned the practice when it was closed, an answerphone message gave the telephone number they should ring, depending on the circumstances. Information on the out-of-hours service was provided to patients.

There was no online appointment booking system and the majority of patients we spoke with told us that they experienced significant difficulties in booking an appointment. Repeat prescriptions could be ordered in person, by post and online.

The practice told us longer appointments were available for older patients, those experiencing poor mental health, patients with learning disabilities and those with long-term conditions. Home visits were provided for patients who were housebound or too ill to attend the practice and these appointments were shared between the GPs.

Listening and learning from concerns and complaints

The practice had a policy and system in place for handling complaints and concerns. The practice manager was the designated responsible person who handled all complaints in the practice. We observed a complaints leaflet in the main practice reception was available to help patients understand the complaints system. Complaints were discussed between the GP partners but were not discussed in any practice team meetings.

There was no complaints log to enable complaints to be reviewed annually to detect themes or trends. The practice manager did not review or respond to comments made on the NHS Choices website.

Are services well-led?

Inadequate

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

Our findings

Vision and strategy

The practice did not have a clear vision to deliver high quality care and promote good outcomes for patients. We found they had a statement of purpose which stated their aim was to provide a patient friendly and convenient service, to encourage patients to be involved in their choice of care and their objective was to provide effective treatment to patients enabling them to recover from acute conditions and provide an ongoing service to patients with long term conditions to make life as comfortable as possible and pain free. However, all of the staff we spoke with were not aware of the statement of purpose or any vision and values for the practice.

A strategy and business plan for the practice had not been developed.

Governance arrangements

The practice did not have any clear governance arrangements in place. There was no clear leadership structure with named members of staff in lead roles and staff were unsure who the lead was for infection control and safeguarding.

The practice had developed a limited number of policies and procedures to govern activity however, all of the staff we spoke with were unaware of the policies and where they were located.

The practice held practice meetings approximately every two months however staff we spoke with told us that governance issues were not discussed. Management meetings were informal and were not minuted.

There was no evidence that the practice used the Quality and Outcomes Framework (QOF) to measure their performance. QOF data was not discussed at practice meetings and clinical staff were unaware how the practice was performing with clinical outcomes for patients. No action plans were produced to maintain or improve QOF outcomes.

The practice did not have programme of clinical audits used to monitor quality and systems to identify where action should be taken. We found no evidence of any completed clinical audit cycles.

The practice did not have any systems in place to monitor and manage risk.

Leadership, openness and transparency

The practice did not have a clear leadership structure which had named members of staff in lead roles. Staff were not clear about who the lead was for all areas such as infection control and safeguarding. There was no clear understanding by any of the staff we spoke with regarding how the practice was performing in respect of delivering high quality care in a safe environment.

There was no obvious clinical leadership in the practice and we noted that one of the GPs was not involved in the management of the practice in any way and had a purely clinical role.

The partners in the practice were visible in the practice, however staff told us that they didn't feel they were always approachable. Staff were not involved in discussions about how to run the practice and how to develop the practice. Staff we spoke with told us the partners did not encourage staff to identify opportunities to improve the service delivered by the practice.

There were no formal management meetings however, practice meetings were held approximately every two months. Staff told us that they were not encouraged to raise issues and didn't feel that there was an open culture within the practice. Staff said they did not feel respected, valued and supported by the partners in the practice and we noted that there was a high turnover of staff.

Seeking and acting on feedback from patients, public and staff

The practice did not encourage feedback from patients. There was no PPG in place, the practice was not participating in the Friends and Family Test, (the Friends and Family Test enables patients to provide feedback on the services that provide their care and treatment) and had not undertaken a patient survey since 2013. The results of the survey were not displayed, staff were unaware of the results of this survey and the practice was unable to demonstrate any improvements they had made as a result of this feedback. The practice did not review or respond to comments made on the NHS Choices website and we saw no evidence that the practice had reviewed its' results from the national GP survey to see if there were any areas that needed addressing.

Are services well-led?

Inadequate

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

There were no processes in place to gather feedback from staff.

Management lead through learning and improvement

We looked at staff files and saw that regular appraisals did not take place. Staff told us that the practice did not support them to attend training and that they did not have staff away days.

The practice had not shared with staff any completed reviews of significant events or other incidents.