Strelley Health Centre

Quality Report

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

Ratings

Overall rating for this service	Inadequate
Are services safe?	Inadequate
Are services effective?	Inadequate
Are services caring?	Requires improvement
Are services responsive to people's needs?	Inadequate
Are services well-led?	Inadequate

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Strelley Health Centre on 11 May 2017 and 23 May 2017. Overall the practice is rated as inadequate.

Strelley Health Centre is a registered location under the provider, The Beechdale Medical Group. All of the provider's four registered locations were inspected on 11 and 23 May 2017; all four locations have been rated inadequate for the well-led domain.

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, the practice had not addressed identified concerns with infection control and electrical safety.
- The risk to patients had not always been identified and addressed. For example there was no fire risk assessment specific to the areas of the building in which the practice provided services.
- Clinical audits were undertaken across the practice group. We saw evidence of improved care for patients following a recall of patients where issues had been identified.
- The practice had limited systems to keep clinicians up to date with national guidelines and guidance.
- Although we saw evidence that action was taken in response to MHRA alerts across the practice, we were not assured that there were effective systems in place to ensure staff working at this practice were kept informed about alerts.
- Staff were not clear about reporting incidents, near misses and concerns and there was no evidence of learning and communication with staff.
- Staff had not received regular appraisals; however, plans were in place to undertake appraisals.
- Not all staff had received the training required for them to perform their roles effectively and safely.
- The provider had not ensured that healthcare assistants were administering medicines within the legal framework allowing them to do so.

Summary of findings

- Appointment systems were not always operated effectively so patients did not always receive timely care when they needed it.
- Staff did not always demonstrate a commitment to patient confidentiality.
- The practice had a leadership structure but we were not assured that there was sufficient leadership capacity and there were limited formal governance arrangements.
- The majority of patients who responded to CQC comments cards said they were treated with compassion, dignity and respect.

The areas where the provider must make improvements are:

- Ensure care and treatment is provided in a safe way; including arrangements for responding to emergencies and the proper and safe management of medicines
- Ensure systems are operated effectively to assess, monitor and mitigate risk. This includes addressing identified concerns with infection prevention and control, fire risk and arrangements to manage incidents and significant events
- Ensure systems are in place to keep clinical staff up to date with national guidance and local guidelines.
- Ensure systems are operated effectively to respond to complaints
- Ensure suitable numbers of staff are deployed to meet the needs of patients and that staff are provided with training and supervision required to meet the scope of their role.
- Ensure that Statutory Notifications stipulated in the CQC (Registration) Regulations 2009 are submitted within the required timeframe.

The practice should:

- Improve the identification and review of carers
- Improve systems to provide patients with learning disabilities with annual reviews
- Review and act upon internal and external patient survey data

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

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

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

Professor Steve Field

CBE FRCP FFPH FRCGPChief 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 some investigations when there were unintended or unexpected safety incidents, lessons learned were not communicated.
- Although we saw evidence of action taken in response to alerts centrally within the practice group, we were not assured there was an effective system for ensuring that relevant staff were made aware of patient safety alerts.
- Patients were at risk of harm because systems and processes were not in place or had not been implemented in a way to keep them safe. For example we had concerns regarding safeguarding, infection control, coding, risk management and dealing with emergencies.
- Staff had not received the training required to keep people safe.
- Medicines were being administered by non-clinicians without the correct legal safeguards being in place.
- There were not enough staff to keep patients safe as there were insufficient numbers of GP and nurses.

Are services effective?

Inadequate

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

- There was limited evidence that the practice was making GPs and nursing staff aware of guidance such as that issued by NICE.
- Most staff had not received recent appraisals.
- There were gaps in training the practice had identified as mandatory for a number of staff.
- There was no system of clinical supervision in place for nurses working in advanced roles such as prescribing.
- The healthcare assistant did not receive any supervision and there was no evidence their practice had been observed by a clinician.

Are services caring?

Requires improvement

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

Summary of findings

- The majority of patients said they were treated with compassion, dignity and respect.
- Results from the national GP patient survey demonstrated patient satisfaction with the GP was below local and national averages. For example 66% of patients said the GP was good at listening to them compared with the clinical commissioning group (CCG) average of 88% and the national average of 89%.
- The practice had identified 34 carers which was equivalent to 0.8% of its patient list.
- Reception staff were aware that patients' privacy and dignity was a priority and had access to a private area to enable to discussions to take place out of public earshot.

Are services responsive to people's needs?

Inadequate

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

- On the day of the inspection the facilities met the needs of patients but we were made aware that due to premises issues within the building there had been occasions when clinical and other areas had been closed and put beyond the use of staff and patients.
- A clinical triage system was operated on a daily basis across the practice group to enable requests for urgent appointments and home visits to be managed centrally.
- Staff reported that managing patient expectations with so few appointments available was very difficult.
- Feedback from the national GP patient survey was below average in respect of indicators related to accessing appointments. For example 51% of patients described their experience of making an appointment as good compared with the CCG average of 71% and the national average of 73%.
- The practice was aware of issues with their telephone system and had plans in place to improve this.
- Feedback from patients reported that access to a named GP and continuity of care was not always available quickly, although urgent appointments were usually available the same day.
- Appointment systems were not working well and we were not assured that patients received timely care when they needed it.
- There was confusion about who the designated person responsible for handling complaints was and staff did not fully understand how to progress concerns and complaints from patients.

Summary of findings

- Patients could get information about how to complain in a format they could understand. However, there was no evidence that learning from complaints had been shared with staff to enable improvements to be made.

Are services well-led?

Inadequate

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

- Although the providers had a vision and strategy staff were not clear about their responsibilities in relation to it or how it would affect them.
- There was a clear leadership structure but not all staff felt supported by management.
- The practice had a number of policies and procedures to govern activity, but some of these had not been adhered to or acted upon.
- 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 that fully represented the patients of Strelley Health Centre.
- Systems were not operated effectively to ensure that staff received training relevant to their roles and received regular appraisals.

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 patients in this group. This is because the practice was rated as inadequate in the safe, effective, responsive and well-led key questions and requires improvement in the caring key question. The issues identified as inadequate overall affected all patients including this population group.

- Staff were able to recognise the signs of abuse in older patients and knew how to escalate any concerns.
- The practice offered proactive, personalised care to meet the needs of the older patients in its population.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs.
- The practice identified at an early stage older patients who may need palliative care as they were approaching the end of life. It involved older patients in planning and making decisions about their care, including their end of life care.
- The practice followed up on older patients discharged from hospital and ensured that their care plans were updated to reflect any extra needs.
- Where older patients had complex needs, the practice shared summary care records with local care services.
- In the absence of any verified data it was not possibleto show that outcomes for patients for conditions commonly found in older people were comparable to other practices.

People with long term conditions

Inadequate

The practice is rated as inadequate for patients in this group. This is because the practice was rated as inadequate in the safe, effective, responsive and well-led key questions and requires improvement in the caring key question. The issues identified as inadequate overall affected all patients including this population group.

- Nursing staff had lead roles in long-term disease management and patients at risk of hospital admission were identified as a priority.
- Unverified QOF data indicated that the practice was not performing as well as other practices. For instance, diabetes related indicators were lower than target achieving 67.56% of the total points available.

Summary of findings

- The practice followed up on patients with long-term conditions discharged from hospital and ensured that their care plans were updated to reflect any additional needs.
- There were emergency processes for patients with long-term conditions who experienced a sudden deterioration in health.
- All these patients had a named GP and there was a system to recall patients for a structured annual review to check their health and medicines needs were being met. For those patients with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Inadequate

The practice is rated as inadequate for patients in this group. This is because the practice was rated as inadequate in the safe, effective, responsive and well-led key questions and requires improvement in the caring key question. The issues identified as inadequate overall affected all patients including this population group.

- From the sample of documented examples we reviewed we found there were systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances.
- Immunisation rates for childhood vaccinations were relatively high and above 90% for children under two and aged five.
- The practice provided support for premature babies and their families following discharge from hospital.
- Long term reversible contraception was not offered at this practice but could be accessed at another practice in the group.
- The premises were suitable for children and babies; however the availability of appointments at this location outside of school hours was limited.
- The practice worked with midwives, health visitors and school nurses to support this population group. These healthcare professionals were located in the same building as the practice and there was evidence of good working relationships.
- The practice had emergency processes for acutely ill children and young people and for acute pregnancy complications.

Summary of findings

Working age people (including those recently retired and students)

Inadequate

The practice is rated as inadequate for patients in this group. This is because the practice was rated as inadequate in the safe, effective, responsive and well-led key questions and requires improvement in the caring key question. The issues identified as inadequate overall affected all patients including this population group.

- The practice offered online services such as repeat prescriptions and appointment booking.
- Patients were able to use the electronic prescription service.
- The age profile of patients at the practice was mainly those of working age, students and the recently retired but the services available at this location did not fully reflect the needs of this group.
- Health promotion advice was offered and there was accessible health promotion material available through the practice.
- Extended hours appointments were not available at this location due to being unable to open beyond core hours. However, patients could access extended hours appointments at other practices in the practice group.

People whose circumstances may make them vulnerable

Inadequate

The practice is rated as inadequate for patients in this group. This is because the practice was rated as inadequate in the safe, effective, responsive and well-led key questions and requires improvement in the caring key question. The issues identified as inadequate overall affected all patients including this population group.

- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice offered longer appointments for patients with a learning disability. However, we were informed by the practice that, of 27 patients recorded by the practice as having a learning disability only 7 had received a review in the last 12 months.
- The practice regularly worked with other health care professionals in the case management of vulnerable patients.
- The practice had information available for vulnerable patients about how to access various support groups and voluntary organisations.
- Staff interviewed knew how to recognise signs of abuse in children, young people and adults whose circumstances may

Summary of findings

make them vulnerable. They were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours. Information to guide staff was clearly displayed.
- However not all staff had received the appropriate level of safeguarding training.

People experiencing poor mental health (including people with dementia)

Inadequate

The practice is rated as inadequate for patients in this group. This is because the practice was rated as inadequate in the safe, effective, responsive and well-led key questions and requires improvement in the caring key question. The issues identified as inadequate overall affected all patients including this population group.

- The practice carried out advance care planning for patients living with dementia.
- The practice had a system for monitoring repeat prescribing for patients receiving medicines for mental health needs.
- Whilst no verified data was available, the provisional QOF data for 2016/17 indicated that 76% of patients diagnosed with dementia had their care plan reviewed in the previous 12 months. There was no benchmarking data available to make any comparison with other practices.
- Information provided by the practice indicated that they had undertaken 41 physform health checks between 1 April 2016 and 1 April 2017; physform is a tool to record an annual physical health overview for people with serious mental illness.
- The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those living with dementia.
- Patients at risk of dementia were identified and offered an assessment.
- The practice had information available for patients experiencing poor mental health about how they could access various support groups and voluntary organisations.
- The practice had a system to follow up patients who had attended accident and emergency where they may have been experiencing poor mental health.
- Staff interviewed had a good understanding of how to support patients with mental health needs and dementia. The practice had arranged for all staff to attend dementia awareness training.

Summary of findings

What people who use the service say

We reviewed the results of the national GP patient survey which were published following our inspection in July 2017. The results showed the practice performance was below local and national averages for a number of indicators. A total of 383 survey forms were distributed and 84 were returned. This represented a 22% response rate and was equivalent to 2% of the practice's patient list.

- 58% of patients described the overall experience of this GP practice as good compared with the CCG average of 84% and the national average of 85%.
- 51% of patients described their experience of making an appointment as good compared with the CCG average of 71% and the national average of 73%.
- 52% of patients said they would recommend this GP practice to someone who has just moved to the local area compared with the CCG average of 75% and the national average of 77%.

The practice had completed their own patient survey during an unspecified period in 2017 to which there had been 37 respondents. The practice had not carried out any review or analysis of the responses.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 23 comment cards which were generally positive about the standard of care received. However there were multiple adverse comments about the difficulty in getting an appointment and dissatisfaction with the telephone system. Six respondents had stated that it was very difficult to get an appointment with a GP and one said that getting an appointment outside of school hours was very difficult. One spoke of poor practice administration and leadership. The caring attitude and helpfulness afforded by the practice nurse and healthcare assistant was commented upon by 13 respondents.

NHS Friends and Family test results from May 2016 to May 2017 showed 592 of 740 patients surveyed said there were extremely likely or likely to recommend the practice; this was equivalent to 80%.

Areas for improvement

Action the service MUST take to improve

- Ensure care and treatment is provided in a safe way; including arrangements for responding to emergencies and the proper and safe management of medicines
- Ensure systems are operated effectively to assess, monitor and mitigate risk. This includes addressing identified concerns with infection prevention and control, fire risk and arrangements to manage incidents and significant events
- Ensure systems are in place to keep clinical staff up to date with national guidance and local guidelines.
- Ensure systems are operated effectively to respond to complaints
- Ensure suitable numbers of staff are deployed to meet the needs of patients and that staff are provided with training and supervision required to meet the scope of their role.
- Ensure that Statutory Notifications stipulated in the CQC (Registration) Regulations 2009 are submitted within the required timeframe.

Action the service SHOULD take to improve

- Improve the identification and review of carers
- Improve systems to provide patients with learning disabilities with annual reviews
- Review and act upon internal and external patient survey data

Strelley Health Centre

Detailed findings

Our inspection team

Our inspection team was led by:

An inspection of all four locations registered under the Beechdale Medical Group was undertaken on 11 May and 23 May. The team across the two days included four GP specialist advisors, two practice manager specialist advisors, a practice nurse specialist advisor and five CQC inspectors.

Background to Strelley Health Centre

Strelley Health Centre is the name of a GP practice located in Strelley Health Centre, which also houses community podiatry, dental, nursing and health visiting services.

It is single surgery location situated at Strelley Health Centre, 116 Strelley Road, Nottingham NG8 6LN and is registered for the regulated activities of:

Diagnostic and screening procedures

Family planning

Maternity and midwifery services

Surgical procedures

Treatment of disease, disorder or injury

The practice has been registered with CQC since 4 January 2017, although the contract between the provider and the CCG commenced on 1 June 2016. Since the provider took responsibility for the provision of services, there have been significant changes to staffing with one GP leaving the practice and changes in practice management.

The practice is part of the Beechdale Medical Group which has three further GP practices located within approximately one mile of Strelley Health Centre. Each practice holds a Primary Medical Services Contract with Nottingham City Clinical Commissioning Group and each has a separate patient list. Beechdale Medical Group is a partnership between a GP and nurse practitioner. The total list size of the four practices in the group is approximately 12,650 and all are situated in the NG8 district of Nottingham. The Strelley Health Centre practice provides primary medical services to approximately 4,200 patients, is the largest in the group and is located in an area of high deprivation.

Care and treatment at Strelley Health Centre is provided by one salaried GP and locum GPs. Combined they provide 10 GP sessions per week. The nursing team consists of a practice nurse (40 hours per week), who is a prescriber, and one healthcare assistant (32.5 hours per week). They are supported by a team of reception staff and administrative staff. In addition the partner GP and nurse practitioner also provide healthcare at the practice. There is no practice manager in post.

The whole time equivalent staffing (WTE) is 1.0 GP, 1.0 nurse and 1.0 healthcare assistant with some clinical support being provided by the GP partner, the advanced nurse practitioner partner and locum staff.

It is not a dispensing practice.

The practice is open between 8am and 6.30 Monday to Friday. Although extended hours appointments are not available from this location due to premises constraints, patients could access appointments from other locations within the group of practices. Extended hours appointments were offered across other locations including late evening and weekend appointments although not all patients were aware of this service.

Detailed findings

When the surgery is closed out-of-hours GP services are provided by Nottinghamshire Emergency Medical Services (NEMS) which is accessed by telephoning the NHS111 service.

Why we carried out this inspection

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

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations such as the clinical commissioning group and NHS England to share what they knew. We carried out announced visits on 11 and 23 May 2017. During our visits we:

- Spoke with a range of staff such as the nurses, healthcare assistant, receptionists, administration staff and GPs.
- Reviewed a sample of the personal care or treatment records of patients.
- Reviewed comment cards where patients and members of the public shared their views and experiences of the service.
- Visited the practice location.
- Looked at information the practice used to deliver care and treatment.

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

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

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

- older people
- people with long-term conditions
- families, children and young people
- working age people (including those recently retired and students)
- people whose circumstances may make them vulnerable
- people experiencing poor mental health (including people living with dementia).

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

Inadequate

Are services safe?

Our findings

Safe track record and learning

The practice was unable to produce any evidence to show how they consistently managed significant events.

- Staff told us they would inform the practice manager of any incidents but were unable to show us anything on the practice computers that supported staff in being able to raise concerns.
- The staff did not have access to the records of significant events or the learning derived from any investigation.
- The minutes of practice meetings that we looked at did not include significant events as an agenda item and there was no evidence of them being discussed.

The practice could not show us evidence that they carried out a thorough analysis of the significant events or that lessons were shared and action was taken to improve safety in the practice. We saw no evidence that the practice monitored trends in significant events and evaluated any action taken.

We were made aware that some GP performance issues had been identified in respect of a GP who was no longer working at the practice. We saw evidence that the partners had conducted a detailed and thorough investigation and had referred the matters appropriately to external organisations. The concerns raised as a result of the serious events investigations had prompted the partners to recall some 1,800 patients for review of their conditions and medications. There had been detailed reviews of a high number of patients and an examination of associated patient records. We saw evidence that the practice had worked to ensure prescribing for patients was brought into line with guidelines for safe prescribing.

- There was not an effective system in place to ensure that staff were made aware of patient safety alerts such as those issued by the Medicines and Healthcare Products Regulatory Authority (MHRA). A GP we spoke with told us that they had never seen any alerts in the surgery and were not aware of any hard copies being kept. However, system searches undertaken as part of the inspection showed that appropriate action had been taken in response to relevant MHRA alerts.

Overview of safety systems and processes

The practice did not have clearly defined and embedded systems, processes and practices in place to minimise risks to patient safety.

- Arrangements for safeguarding reflected relevant legislation and local requirements. Policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. The GP partner was the lead member of staff for safeguarding.
- Staff interviewed demonstrated they understood their responsibilities regarding safeguarding. However there was limited evidence available to illustrate that GPs had received any training or to what level. The practice nurse had completed children's safeguarding to level two. The healthcare assistant had undertaken safeguarding children training but this was overdue for review having last been undertaken in December 2013. Following the inspection, we were provided with evidence that the GP partner for the practice group had undertaken online safeguarding children level 3 training in June 2017.
- A notice in the waiting room and in treatment rooms advised patients that chaperones were available if required. All staff who acted as chaperones were trained for the role and had received a Disclosure and Barring Service (DBS) check.

The practice had not maintained appropriate standards of cleanliness and hygiene.

- We observed the premises to be clean and tidy. There were cleaning schedules and monitoring systems in place.
- The practice nurse had recently been appointed as the infection prevention and control (IPC) clinical lead. They told us they had not had the opportunity to liaise with the local infection prevention teams to keep up to date with best practice and that there was no time set aside for them to fulfil the role in addition to their normal duties.
- There was an IPC protocol, however there was no evidence that any member of staff had received any training since November 2014; there was no evidence that the healthcare assistant had ever received any training. Following the inspection we were provided with evidence to demonstrate that staff had been provided with infection control training in May 2017.
- We saw that infection control audits had been completed in June/July 2016. We saw some evidence

that action was taken to address improvements identified as a result; however there were other areas where concerns had been reported but not actioned. The audits had not been completed by practice staff and had not addressed specific issues related to general practice but had concentrated on the décor and cleanliness of the building as a whole.

- We saw that a sharps bin in one treatment room had been taken into use on 14 June 2016. It is recognised best practice that they are decommissioned and disposed of after three months or when three-quarters full, whichever is the sooner.
- The arrangements for managing medicines, including emergency medicines and vaccines, in the practice did not minimise the risks to patient safety (including obtaining, prescribing, recording, handling, storing, security and disposal).
- There were processes for handling repeat prescriptions which included the review of high risk medicines. Repeat prescriptions were signed before being dispensed to patients and there was a reliable process to ensure this occurred. The practice carried out regular medicines audits, with the support of the local clinical commissioning group pharmacy teams, to ensure prescribing was in line with best practice guidelines for safe prescribing.
- There were some systems in place to monitor patients prescribed potentially high risk medicines such as lithium and disease-modifying anti-rheumatic drugs. For example we saw one patient on immunosuppressive medication who was overdue a blood test. There was a screen alert to highlight the fact to clinicians.
- Although the patients we reviewed had the relevant blood tests done prior to prescribing, staff told us that there was currently no effective system for ensuring this. An effective recall system was being set up but was not complete.
- There was no system to record and track blank prescription forms and monitor their use. Blank prescription forms were routinely left in printer trays overnight, although staff told us that doors were locked. We were not provided with any assurances that contract cleaning staff, who had unrestricted access to these rooms out of hours, had been subject to any checks or risk assessment. This mean the practice could not be assured that blank prescriptions were stored securely in line with guidance.
- During our inspection, we were able to enter three treatment rooms that had been left temporarily unoccupied and unlocked. We found that the NHS Smart card for each room user was in situ in the computer and the computer logged on, which could have given people access to patient information.
- The arrangements for storing medicines that required refrigeration were effective. Fridge temperatures were recorded in line with best practice and stock was rotated.
- The practice nurse was an independent prescriber and could therefore prescribe medicines for clinical conditions within their expertise. They received mentorship and support from the medical staff for this extended role.
- Patient Group Directions had been adopted by the practice to allow nurses to administer medicines in line with legislation. The health care assistant was trained to administer vaccines and medicines using patient specific directions (PSDs) from a prescriber. However, we identified that there was no PSD in place for the administration of B12 injections which we saw the healthcare assistant had administered on the day of our inspection.
- We looked at the PSDs which related to the administration of flu jabs and found that it consisted of a loose piece of paper that contained a list of patient names, together with a sticker indicating the batch number of the vaccine. It did not contain any narrative or written directive. We looked at the computerised patient record and although it was recorded that the vaccine had been given, the vaccine batch number was not recorded, meaning that it would not be possible to check the patient details in the event of any alert or concerns regarding particular batches of vaccine.
- We reviewed five personnel files and found appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, evidence of satisfactory conduct in previous employment in the form of references, qualifications, registration with the appropriate professional body and the appropriate checks through the DBS. However, we identified that a DBS check had not been undertaken for a recently recruited nurse working across the practice group. Although this member of staff had provided a copy of a DBS checks undertaken by previous employers this was historic dating from 2011. The practice had not

undertaken a documented assessment of this risk. In addition, the practice had not obtained evidence of satisfactory conduct in previous employment in respect of the nurse.

Monitoring risks to patients

There were procedures for assessing, monitoring and managing risks to patient and staff safety but these were not effective.

- There was a health and safety policy available.
- The practice was unable to produce a fire risk assessment however we were made aware that an evacuation of the building had been carried out two days prior to our inspection due to an incident in another part of the health centre. Staff and patients had been successfully evacuated without incident. Following the inspection, the practice provided us with a copy of the fire risk assessment for the building undertaken by NHS Property Services; however, correspondence associated with this from the building centre manager indicated that the practice was required to complete their own fire risk assessment as their area was not covered by building assessment.
- Other than the fire evacuation of two days ago there was no evidence of regular fire drills for practice staff.
- All electrical and clinical equipment was checked and calibrated to ensure it was safe to use and was in good working order.
- A check of the electrical hard wiring of the whole health centre had been conducted in November 2016 which had resulted in action being identified. During the inspection, the practice were unable to show us evidence that action had been taken. Following the inspection, we were provided with confirmation from the building management that action was taken in January 2017.
- The practice had a variety of other risk assessments to monitor safety of the premises such as control of substances hazardous to health and infection control and legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings).
- The practice was unable to demonstrate what arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. Staff told us that there were insufficient staff to meet patient needs and that appointment availability was very difficult. For example we found that the next bookable GP appointment was on Tuesday 6 June. Patients also commented on the difficulty in obtaining appointments. We were told that staffing levels were decided upon centrally at Beechdale.
- We were told that prior to this provider taking over the contract there had been two full time GPs at Strelley Health Centre. Now there was the equivalent of one full time GP supported by locum GPs. However, there was input from the senior partner for one clinical session each week to oversee complex prescribing and input from advanced nurse practitioner.

Arrangements to deal with emergencies and major incidents

- There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency.
- Emergency medicines were available in a treatment room.
- Oxygen with adult and children's masks was available on the premises. A first aid kit and accident book were available.
- The practice did not have a defibrillator. The dental surgery housed in the same building had a defibrillator but staff in the medical practice would need to access it using four different keys in the event of a medical emergency. In the event that the dental surgery was closed staff told us that it would take about eight minutes to access the equipment and in their opinion it would be as quick to telephone for an ambulance. A recent example quoted was of an occasion when the defibrillator was required and it took as long to obtain from the dental surgery as it did for the ambulance to arrive. There was no risk assessment in place in respect of the lack of a defibrillator in the practice.
- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and stored securely.
- There was no evidence that the salaried GP or locum GP, or two of the receptionists had received training in basic life support.
- The practice had a comprehensive business continuity plan for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff.

Inadequate

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

There was no effective system to ensure that clinicians and nurses were kept appraised of relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines.

- Systems to keep clinical staff up to date were not always operated effectively. The salaried GP told us they received updates from NICE personally but had never seen any that had been disseminated by the practice.
- Practice staff told us that updates were received by a practice manager at another practice in the group and were emailed to some staff at Strelley Health Centre, but no hard copies were kept.
- We saw some evidence of medicines and other audits being undertaken across the practice group.

Management, monitoring and improving outcomes for people

The Quality and Outcomes Framework (QOF) is a system intended to improve the quality of general practice and reward good practice and performance against national screening programmes to monitor outcomes for patients. The provider had not held the contract for a sufficient period of time for there to be any verified QOF data available. We were however provided with the unverified, unpublished data for the financial year 2016/17.

Data from 2016/17 showed that the practice had achieved 481.9 out of a possible 545 points (88.42%) in the combined clinical and public health domains. There was no data available to show any comparison with CCG and national averages.

The unverified data for 2016/17 was higher than the previous providers 2015/16 achievement of 83.1% which was 10% lower than the CCG and 12% lower than the national average.

- Using the unverified data performance for diabetes related indicators we saw this was lower than target achieving 67.56% of the total points available.
- Performance for mental health related indicators was 73% of the total points available. Additionally information provided by the practice indicated that they had undertaken 41 physform health checks between 1 April 2016 and 1 April 2017; physform is a tool to record an annual physical health overview for people with serious mental illness.
- Performance for dementia related indicators was 89.8% of the total points available.
- Performance for cancer related indicators was 100% of the total points available.

We saw evidence of some quality improvement work within the practice. For example, as a result of the significant concerns identified the partners had reviewed a large number of patients and associated patient records. The practice was able to demonstrate positive changes in prescribing for patients within this group.

A range of audits were undertaken across the practice group. We saw evidence of a number of audits related specifically to the Strelley practice in respect of prescribing and guidelines. These were largely single cycle audits due to the length of time the contract had been in place and the need to focus on ensuring patient reviews had been undertaken.

Audits we were provided with included a bisphosphonate review (January 2017), an ACE inhibitor review (January 2017) and an audit considering prescribing of DMARDs (Disease-modifying anti-rheumatic drugs is a category of otherwise unrelated drugs defined by their use in rheumatoid arthritis to slow down disease progression).

Effective staffing

Evidence reviewed did not provide assurance that staff had the skills and knowledge to deliver effective care and treatment.

- There was limited evidence to show recording of inductions given to salaried or locum GPs. A handbook/ information file had been developed for locum GPs which contained essential information about the practice and the wider practice group.
- The practice could demonstrate how they ensured role-specific training and updating for relevant staff. For example, the practice nurse had completed a course concerning diabetes management.
- Staff administering vaccines and taking samples for the cervical screening programme had received specific training which had included an assessment of competence. Staff who administered vaccines could

Inadequate

Are services effective?

(for example, treatment is effective)

demonstrate how they stayed up to date with changes to the immunisation programmes, for example by access to on line resources and discussion at practice meetings.

- During our inspection we found that nursing staff did not have access to appropriate clinical supervision; however we were advised by the practice that the practice nurse did have supervision of their prescribing and met with the prescribing colleagues from the practice and the CCG in November 2016 for supervision.
- There had been limited appraisal of staff performance in the last 12 months. Two administration staff had received an appraisal within the last 12 months. The nurse told us they had last received an appraisal 18 months previously. The healthcare assistant's last recorded appraisal was in November 2015. There had been recent changes to management across the practice group with the manager for the location having recently left as well as the business manager for the provider having left. We were informed on the second day of our inspection that a new business manager covering all four locations, had been recruited and would be reviewing which staff needed appraisals and making arrangements to undertake these.
- Records showed that some staff received training that included: safeguarding, fire safety awareness, and basic life support and information governance. However we saw that of the seven members of staff that worked at the practice five had no record of any fire safety training, three no safeguarding training, two no infection prevention and control training and two no information governance and confidentiality training.
- In addition the member of staff who was responsible for coding and notes summarising had never received any training, other than when they worked in a hospital setting some 16 years previously.
- A nurse who triaged incoming patient calls had not received any training other than some years previously whilst working elsewhere as a children's nurse.
- The healthcare assistant did not receive any supervision or observed practice.
- Staff had access to and made use of e-learning training modules and in-house training.

Coordinating patient care and information sharing

The information needed to plan and deliver care and treatment was not always available to relevant staff in a timely and accessible way through the practice's patient record system and their intranet system.

- During our first visit, we looked at the task lists, including those for incoming pathology results and saw that there were 341 outstanding, 34 of which were from January 2017. We looked at one result which showed that the patient had a rheumatoid factor of 158. Although the patient had been into the surgery on an unconnected matter there was no record that any action had been taken in respect of this abnormal result. On our second visit we saw that this had been addressed.
- We further reviewed the tasks on the system at our second visit and found that the majority of these had been reviewed and actioned but had not been marked as completed. The practice undertook an audit of all uncompleted tasks following the second visit and acknowledged that there was a training need to ensure all clinical staff can effectively use the clinical computer system.
- We saw that there were 49 letters waiting to be processed. One was from December 2016 and four from January 2017.
- The member of staff responsible for making decisions on whether letters from secondary care was not a clinician, had received no training and told us they relied upon experience. There was no protocol in place to govern this activity. There was no audit of their work.

We saw evidence that staff worked together and with other health and social care professionals to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. This included when patients moved between services, including when they were referred, or after they were discharged from hospital. Information was shared between services, with patients' consent, using a shared care record. Meetings took place with other health care professionals on a monthly basis when care plans were routinely reviewed and updated for patients with complex needs. Meetings were held with the involvement of staff from all four practices in the group and were attended by a range of community based professionals including care coordinators, district nurses, health visitors and social workers. The practice were users of palliative care software in helping to meet patient needs.

Inadequate

Are services effective?

(for example, treatment is effective)

The practice ensured that end of life care was delivered in a coordinated way which took into account the needs of different patients, including those who may be vulnerable because of their circumstances.

Consent to care and treatment

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

- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005. Clinical staff had received the appropriate training.
- When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance.
- Where a patient's mental capacity to consent to care or treatment was unclear the GP or practice nurse assessed the patient's capacity and, recorded the outcome of the assessment.

Supporting patients to live healthier lives

The practice identified patients who may be in need of extra support and signposted them to relevant services. For example:

- Patients receiving end of life care, carers, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation and substance abuse.

We had no verified QOF data available for the practice's uptake for the cervical screening programme but the unverified and unpublished QOF data for 2016/17 indicated that the uptake was 80%. This was comparable with figures for published QOF data locally and nationally from 2015/16.

Childhood immunisations were carried out in line with the national childhood vaccination programme. Data provided by the practice for 2016/17 demonstrated the practice had exceeded the national expected coverage of 90% of vaccinations for children aged under two years of age. Immunisation rates for children under two ranged from 94% to 97%. The uptake rate for vaccines given to five year olds for was 93%.

There was a policy to offer telephone or written reminders for patients who did not attend for their cervical screening test. The practice demonstrated how they encouraged uptake of the screening programme by using information in different languages and for those with a learning disability and they ensured a female sample taker was available.

The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer. Data provided by the practice from eHealthscope demonstrated that the practice's uptake rate (as at September 2016) for bowel cancer screening was 41.5% and indicated that the practice ranked 47/57 for practices in the CCG. The update rate for breast cancer screening was 67.2% and the practice ranked 40/57 practices in the CCG.

We were informed by the practice that, of 27 patients recorded by the practice as having a learning disability only 7 had received a review in the last 12 months.

Patients had access to appropriate health assessments and checks. These included health checks for new patients and NHS health checks for patients aged 40–74. Appropriate follow-ups for the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.

Requires improvement

Are services caring?

Our findings

Kindness, dignity, respect and compassion

During our inspection we observed that members of staff were courteous and very helpful to patients and treated them with dignity and respect.

- Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- Consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- Reception staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.
- The availability of appointments for patients to consult with a GP of the gender of their choice were limited at the practice. However, patients could access appointments at the three other locations that are part of The Beechdale Medical Group.

Of the 23 patient Care Quality Commission comment cards we received 20 were positive about the service experienced. We also spoke with five patient participation group (PPG) members from across the practice group. Patients said they felt the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect. Three respondents commented on a rude GP, practice manager and receptionists.

CQC comments cards highlighted that staff responded compassionately when they needed help and provided support when required. They said their dignity and privacy was respected.

We reviewed the results of the national GP patient survey published following our inspection which demonstrated that satisfaction levels with GPs were significantly below local and national averages in a number of areas. For example:

- 66% of patients said the GP was good at listening to them compared with the clinical commissioning group (CCG) average of 88% and the national average of 89%.
- 71% of patients said the GP gave them enough time compared to the CCG average of 84% and the national average of 86%.
- 76% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 95% and the national average of 95%
- 60% of patients said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 84% and the national average of 86%.

Satisfaction scores for nurses and reception staff were in line with or above local and national averages. For example:

- 97% of patients said the nurse was good at listening to them compared with the clinical commissioning group (CCG) average of 90% and the national average of 91%.
- 97% of patients said the nurse gave them enough time compared with the CCG average of 90% and the national average of 92%.
- 99% of patients said they had confidence and trust in the last nurse they saw compared with the CCG average of 97% and the national average of 97%.
- 90% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 89% and the national average of 91%.
- 86% of patients said they found the receptionists at the practice helpful compared with the CCG average of 87% and the national average of 87%.

The practice had recently undertaken their own survey of patient experience across the practice group; however, the results of this had not been collated or analysed.

Care planning and involvement in decisions about care and treatment

Patient feedback was limited to the responses on the CQC comments cards. Two respondents stated that they felt listened to and supported by staff and were made aware of the treatment options.

Results from the national GP patient survey showed patient responses in respect of questions about their involvement in planning and making decisions about their care and treatment were mixed with patients being more positive about nursing staff.

Results for GPs were in significantly below local and national averages. For example:

- 66% of patients said the last GP they saw was good at explaining tests and treatments compared with the CCG average of 85% and the national average of 86%.

Requires improvement

Are services caring?

- 64% of patients said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 81% and the national average of 82%.

Results for nurses were above local and national averages. For example:

- 94% of patients said the last nurse they saw was good at explaining tests and treatments compared with the CCG average of 89% and the national average of 90%.
- 89% of patients said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average of 83% and the national average of 85%.

The practice provided facilities to help patients be involved in decisions about their care:

- Staff told us that interpretation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patients this service was available.
- Information leaflets were available in easy read format.
- The Choose and Book service was used with patients as appropriate. (Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital.

Patient and carer support to cope emotionally with care and treatment

Patient information leaflets and notices were available in the patient waiting area which told patients how to access a number of support groups and organisations. Information about support groups was also available on the practice website. Support for isolated or house-bound patients included signposting to relevant support and volunteer services.

The practice's computer system did not alert GPs or staff if a patient was also a carer. When we spoke to staff about this they said they had not been made aware of the importance of identifying carers and they took no steps to try and identify them. The practice had 34 patients coded as carers (0.8% of the practice list). Staff told us that no instructions had been given to consider carers needs or to offer longer appointments or appointments suited to the needs of the carer and cared for.

Written information was available to direct carers to the various avenues of support available to them.

GPs and other staff we spoke with were unable to provide us with evidence of a clear system or process for supporting 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 understood its population profile but had not used this understanding to meet the needs of its population:
- The practice was unable to offer extended hours appointments for patients who could not attend during normal opening hours from this location; this was due to there being no facility to open beyond core hours at the premises. However, patients could access services at other practices within the group in evenings and the weekend but feedback from patients indicated that this could be challenging and some patients were unaware of this.
- There were longer appointments available for patients with a learning disability.
- Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice.
- The practice took account of the needs and preferences of patients with life-limiting progressive conditions. There were early and ongoing conversations with these patients about their end of life care as part of their wider treatment and care planning.
- Staff told us that same day appointments were available for children and those patients with medical problems that require same day consultation. However given the limited number of GP appointments available we were not assured that this was always the case.
- From April 2017, the practice had commenced opening on Thursday afternoons as part of the primary care patient offer model operated locally. We were told that a new salaried GP had been recruited in April 2017 to work eight sessions per week at the Strelley practice. The senior partner also provided a complex prescribing clinic from this location on Tuesday evenings.
- Staff we spoke with told us that the re-call of some 1,800 patients for review over a short period of time had impacted significantly on appointment availability but now that process had been completed things had improved.
- The practice sent text message reminders of appointments.
- Patients were able to receive travel vaccines available on the NHS as well as those only available privately/ were referred to other clinics for vaccines available privately.
- On the day of the inspection the facilities met the needs of patients but we were made aware that due to water ingress into the fabric of the building there had been occasions when clinical and other areas had been closed and put beyond the use of staff and patients. The practice did not own the building and the facilities were managed by NHS property services. The practice had been identified by the CCG as a priority for development.
- There were accessible facilities, including good car parking, automatic opening doors and toilet facilities suitable for wheelchair users.
- Interpreter services were available.
- Other reasonable adjustments were made and action was taken to remove barriers when patients find it hard to use or access services.

Access to the service

The practice was open between 8am and 6.30pm Monday to Friday. GP appointments were from 9 or 9.30am to 11.30am every morning and either 1.30 or 2pm to 2.30 or 4.30 pm to daily depending upon which GP was working. After 4.30 there were no scheduled GP appointments and either the partner GP or partner nurse practitioner were on call until 6.30pm.

A clinical triage system was operated on a daily basis across the practice group to enable requests for urgent appointments and home visits to be reviewed and allocated centrally.

Extended hours appointments were not offered at Strelley although we did see evidence of Strelley patients accessing services at other practice location within the group. Extended hours (including weekend) appointments were offered at other sites; however, this would mean patients would have to travel to access these although all registered practices are situated relatively closely.

Pre-bookable appointments could be booked up to four weeks in advance; urgent appointments were also available for patients that needed them.

When we looked at appointment availability we found that the next bookable GP appointment was on 6 June and the next nurse practitioner appointment was on 19 May.

Inadequate

Are services responsive to people's needs?

(for example, to feedback?)

We looked at the number of GP appointments available in the week 8 to 12 May inclusive. The results were as follows:

8 May 19 appointments

9 May 7 appointments

10 May 30 appointments

11 May 43 appointments

12 May 15 appointments

Total 114

In the week from 8 to 12 May there were also 27 ANP appointment and 76 nurse appointments (or 183 nurse appointments including triage slots).

Following our inspection, we reviewed the results of the national GP patient survey which showed that patient satisfaction with access to appointments was significantly below local and national averages for a number of indicators. For example:

- 67% of patients were satisfied with the practice's opening hours compared with the clinical commissioning group (CCG) average of 76% and the national average of 76%.
- 50% of patients said they could get through easily to the practice by phone compared to the CCG average of 71% and the national average of 71%.
- 75% of patients said that the last time they wanted to speak to a GP or nurse they were able to get an appointment compared with the CCG average of 82% and the national average of 84%.
- 65% of patients said their last appointment was convenient compared with the CCG average of 79% and the national average of 81%.
- 51% of patients described their experience of making an appointment as good compared with the CCG average of 71% and the national average of 73%.
- 49% of patients said they don't normally have to wait too long to be seen compared with the CCG average of 54% and the national average of 58%.

The provider acknowledged that there had been some issues with their telephone system at this practice and had plans in place to improve this.

The practice had not reviewed or analysed their own survey results to assess patient satisfaction.

The practice had a system to assess:

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

This was done by either a GP or other clinician triaging incoming calls to assess clinical need. However the nurse who undertook triaging told us they had not received any training at this practice but had received some from a children's nurse some years previously. They told us that clinicians did not record this triage assessment in patient notes.

In cases where the urgency of need was so great that it would be inappropriate for the patient to wait for a GP home visit, alternative emergency care arrangements were made. Clinical and non-clinical staff were aware of their responsibilities when managing requests for home visits.

Comments cards made reference to the difficulty in getting through the practice by telephone and one mentioned having telephoned 105 times. The partners acknowledged it was a problem and that a new telephone system was due to be installed later in the month that would increase capacity.

Listening and learning from concerns and complaints

The practice had a system for handling complaints and concerns and we viewed the complaints policy. As no complaints records were made available to us at the inspection we were not able to assess any of the complaints received and so were unable to judge if it met with the recognised guidance and contractual obligations for GPs in England.

- Staff were unable to tell us who the designated responsible person who handled all complaints in the practice. The complaints literature stated that it was different person to who the staff thought it was.
- Our inspection identified that patients wishing to make complaints were not always followed up. This was highlighted to the practice during the inspection who assured us they would contact the patient.
- We saw that information was available to help patients understand the complaints system. For example notices and forms were available in patient waiting areas. Information on the practice website did not give any contact details or the member of staff responsible for dealing with complaints.
- There was no evidence that learning from complaints was cascaded to staff.

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 clear vision to deliver high quality care and promote good outcomes for patients. However, our inspection findings showed this was not always achieved.

- The practice had a clear strategy and supporting business plans which reflected the vision and values.
- This included a complete re-build of the Strelley Health Centre and re-locating and merging two other practices with that already in situ. We saw that the plans were well developed and supported by commissioners. It was hoped that the new build would be delivered by the end of the financial year 2018/19.
- The partners were actively seeking to recruit a business manager to oversee all the practices in the group. At our second visit we were informed that a start date had been agreed for a new business manager working across the group.
- The partners acknowledged that GP recruitment and retention was an ongoing problem and told us they were working closely with the CCG to try and resolve the issues.
- The practice told us they had declared themselves as being vulnerable as per the 5 year forward view and had worked closely with the CCG and Nottingham GP Alliance to identify areas of vulnerability and address them.

Governance arrangements

Governance arrangements were not always operated effectively to support the delivery of good quality care.

- There was a clear staffing structure and staff were aware of their own roles and responsibilities. The staffing structure identified that GPs and nurses had lead roles in key areas, for example in safeguarding and chronic disease management. However, we received reports from staff across the group of confusion in respect of who had responsibility for what, especially when patients were being seen at a location other than the one where they were registered.
- Practice specific policies were in place and were available to all staff. These were updated and reviewed regularly although we could not be assured that the most recent were always available to staff as there was no shared computer drive at the practice where they could be stored for all to view.
- Across the practice group, we identified issues where the registered partners had not formally notified the Commission (via a Statutory Notification) of events in line with legislation. For example, in relation to events reported to the CCG, NHS England and the GMC.
- Patient safety alerts, meeting minutes and NICE guidance could not be shared. Individual computer desktops had to be updated individually using external media sources. There was no policy or protocol in place for this to take place in a systematic and regular manner and therefore we could not be assured that all desktops were displaying the same and updated relevant information.
- The arrangements for identifying, recording and managing risks, issues and implementing mitigating actions were not effective.
- We did not see adequate evidence from minutes of meetings that demonstrated lessons were learned and shared following significant events and complaints. Recording of significant events did not always demonstrate that learning and actions had been identified or shared across the practice group.
- The practice website had not been reviewed or updated to reflect the change of provider. For example the site still referred to the previous GPs by name. In addition information about the times of consultations was inaccurate.
- During our inspection we identified an issue with the processing of tasks allocated on the clinical computer system. There was a large back log of tasks allocated to some members of staff which had not been marked as completed or actioned. We reviewed a sample of these and found that appropriate action had been taken to deal with these tasks in most cases. However, staff being unaware of how to operate the clinical system properly meant there was a risk of some things being missed. The practice acknowledged that the outstanding tasks could have presented a risk to safe and timely patient care and indicated that training needs would be addressed.

Leadership and culture

The Beechdale Medical Group partnership comprises a GP and an advanced nurse practitioner (ANP). We were concerned about the sustainability of this arrangement

Are services well-led?

Inadequate

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

specifically the capacity and capability to run four practices and ensure high quality care. The evidence gathered at all four sites overseen and managed by the provider and inspected on the same days demonstrated that the systems in place to ensure the partners could assess and monitor the quality of the service and identify, assess and manage risks were not effective as their limited resources were stretched.

The capacity of the partners had been reduced following the identification of issues at one of the group sites which had resulted in them having to dedicate more time to this location.

There was a clear leadership structure but not all staff felt supported by management.

- The practice held and minuted a range of multi-disciplinary meetings including meetings with district nurses and social workers to monitor vulnerable patients. GPs, where required, met with health visitors to monitor vulnerable families and safeguarding concerns.
- Staff told us the practice held regular team meetings.
- Staff told us there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and felt confident and supported in doing so. Minutes were available for practice staff to view but they were only available in hard copy.
- Staff said they felt respected and valued particularly by the partners in the practice. However staff told us that practice management was lacking and managers were very rarely seen at this particular location.
- Some members of staff told us that morale had been low but was improving. They put the low morale down to the new provider taking over and the changes that had brought about, the practice manager leaving and not being replaced, the loss of a long serving GP and increased workloads.
- Another member of staff said things had improved since the new provider had taken over the contract and they could see 'light at the end of the tunnel'.

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

- There was a patient participation group (PPG) although it was not specific to Strelley Health Centre as it represented the four practices in the Beechdale Medical Group. We were told that the PPG had three members who were Strelley patients. We were not provided with any information regarding any work undertaken by the group that specifically affected Strelley patients or the Strelley Health Centre. No minutes of meetings of the group were available to view on the practice website.
- NHS Friends and Family test results from May 2016 to May 2017 showed 592 of 740 patients surveyed said there were extremely likely or likely to recommend the practice.
- The practice's own patient survey had not been reviewed or analysed. Staff did not know what the underlying themes were that might drive or indicate areas for improvement.
- Staff told us that to the best of their knowledge there had been no staff survey.
- Some staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management but evidence indicated that not all staff felt listened to.
- Staff told us they did not feel involved and engaged to improve how the practice was run. They told us they were so busy that they had insufficient time to undertake any additional responsibilities or improvement work.

Continuous improvement

- We saw limited evidence of continuous learning and improvement work which specifically impacted on this practice location.
- The partners told us they were forward thinking and part of local pilot schemes to improve outcomes for patients in the area, however we were not provided with any evidence to show how this translated to improved outcomes for patients at Strelley.

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 Surgical procedures Treatment of disease, disorder or injury	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints The provider was not operating an effective and accessible system to respond to complaints. Staff were unclear with regards to systems for managing complaints and there was evidence of complaints not being responded to. This was in breach of regulation 16(1) 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 Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider did not do all that was reasonably practicable to assess, monitor, manage and mitigate risks to the health and safety of patients who use services. They had failed to ensure there were adequate arrangements in place to respond to emergencies; they were not ensuring the safe and proper management of medicines. This was in breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider did not operate systems effectively to improve the quality and safety of services and to assess, monitor and mitigate risk. Systems and processes to manage significant events, alerts related to patient safety, infection control and fire risk were not operated effectively. This was in breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing The provider was not ensuring that there were sufficient numbers of suitably skilled and qualified staff deployed

This section is primarily information for the provider

Enforcement actions

to meet the needs of patient. The provider was not ensuring that staff were provided with training and supervision to meet the requirements of their role. Staff were not provided with regular appraisals.

This was in breach of regulation 18(1)(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.