Dr Kandiah Pathmanathan

Quality Report

Covent Garden Medical Centre
47 Shorts Gardens
London
WC2H 9AA
Tel: 020 7379 7209
Website: www.coventgardenmedicalcentre.nhs.uk

Date of inspection visit: 8 November 2016
Date of publication: 16/02/2017

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?	**Requires improvement**
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 Dr Kandiah Pathmanathan's practice on 8 November 2016. We had previously inspected the practice in March 2015. At that inspection we had identified concerns relating to safe, effective and well-led services. We served a requirement notice under Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, relating to Good governance, and we rated the practice overall as Requires Improvement. Following the publication of our inspection report, the practice sent us a plan of the actions it intended to take to address the concerns and to meet the requirements of the Regulations. We carried out this inspection to check on the implementation of the actions. We established that a significant number of actions had not been implemented adequately and, additionally, we identified further concerns.

Overall the practice is rated as inadequate.

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 in a way to keep them safe. For example, we had concerns in relation to how significant incidents were managed, including learning and reflective practice; with infection prevention and control measures; the management of medicines; health and safety; and arrangements for dealing with emergencies.
- Risks to patients were not consistently assessed, monitored or managed. For example we identified a number of pathology test results which had not been reviewed and processed for several weeks; and from a review of patients on high risk medication we found no evidence of regular blood tests being carried out to ensure that patients were being prescribed medication safely.
- Patients' care and treatment did not consistently reflect current evidence-based guidelines.
- Multidisciplinary working was taking place, but record keeping was limited.

Summary of findings

- Data from the Quality and Outcomes Framework (QOF) showed patient outcomes were generally below local and national averages.
- Although staff were up to date with mandatory training needs, they remained insufficiently trained to make full and effective use of the practice's clinical computer system.
- Patient feedback indicated delays in obtaining routine appointments. There was a lack of clarity regarding the appointments system, including the availability of emergency slots and the discontinued walk in service.
- The needs of the patient group were not fully taken into account when planning services. For example, the provider told us that due to pressure of work he had to concentrate on patients with acute healthcare issues, leaving the practice nurse to manage patients with long-term conditions. The practice nurse was not present at the inspection and was due to leave the practice in late December 2016
- The practice's aims and objectives were set out in its statement of purpose, but this was out of date and in need of revision. There were no detailed or realistic plans to achieve the aims and objectives.
- The delivery of high-quality care was not assured by the governance arrangements in place. The practice had a number of policies and procedures to govern activity, but some of these were overdue a review. There was no effective system for monitoring performance by means of frequent audits or effective use of the practice management computer system.

The areas where the provider must make improvements are:

Ensure that care and treatment is provided in a safe way, including –

- Regularly assessing the risks to the health and safety of patients and staff and putting in place appropriate arrangements to mitigate, manage and monitor any risks.
- Ensuring that sufficient numbers of suitably qualified, competent and skilled staff are deployed and that they receive appropriate support, training and supervision as is necessary to enable them to safely carry out their duties.
- Ensuring that the emergency medical equipment is safe and is used in a safe way.
- Ensuring the proper and safe management of medicines.
- Ensuring that the risk of, and preventing, detecting and controlling the spread of, infections, including those that are health care associated, are assessed and put in place and that there are appropriate arrangements to mitigate, manage and monitor any risks.
- Ensuring patients' care and treatment reflects current evidence-based guidelines.
- Maintaining accurate, complete and contemporaneous records of patients' care and treatment, including decisions taken in relation to the care and treatment, and ensuring that all patients' test results are reviewed and processed in a timely manner.
- Establishing governance systems or processes and operating them effectively to assess, monitor and improve the quality and safety of the services. For example the management, investigation and learning from significant incidents; and having a system of regular clinical audits relevant to the service, with suitable reflection and learning.

In addition the provider should:

- Continue with efforts to appoint a female GP, or make use of female locums, to provide an appropriate and full healthcare service for female patients.
- Take steps to improve the standard of recording of both internal meetings and those with other healthcare professionals, such as multi-disciplinary team meetings;
- Improve methods of communicating with patients, including providing clarification of the appointments system, the availability of emergency slots and the status of the walk-in service. Publicise the available translation service at the premises and on the practice website;
- Obtain an induction loop to assist patients with a hearing impairment.

I am placing this practice in special measures. Practices 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

Summary of findings

they do not improve. The practice 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 vary the provider's registration to remove this location or cancel the provider's registration.

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. People were unsafe or at risk of avoidable harm.

- Patients were at risk of harm because systems and processes were not in place in a way to keep them safe. For example, we had concerns in relation to how significant incidents were managed; with infection prevention and control measures; the management of medicines; health and safety; and arrangements for dealing with emergencies.
- Risks to patients were not consistently assessed, monitored or managed. For example, we identified a number of pathology test results which had not been reviewed and processed for several weeks; and from a review of patients on high risk medication we found no evidence of regular blood tests being done to monitor the patients' health.

Are services effective?

Inadequate

The practice is rated as inadequate for providing effective services. People receive ineffective care or there is insufficient evidence in place to demonstrate otherwise.

- Patients' care and treatment did not consistently reflect current evidence-based guidelines.
- There was limited evidence that audit was driving improvement in patient outcomes.
- Multidisciplinary working was taking place, but record keeping was limited.
- Data from the Quality and Outcomes Framework (QOF) showed patient outcomes were significantly below local and national averages. The practice achieved 68.4% of the total number of points available. This was 19.5% below both the local and national averages.
- Although staff were up to date with mandatory training needs, they remained insufficiently trained to make full and effective use of the practice's clinical computer system.

Are services caring?

Requires improvement

The practice is rated as requires improvement for providing caring services. There are times when people do not feel supported or cared for.

Summary of findings

- Results from the national GP patient survey were below local and national averages and in a number of cases were lower than the last published results.
- The practice made limited use of templates and care plans, which patients could sign to confirm their agreement.
- Information for patients about the services available was easy to understand and accessible. However, the translation service available was not publicised at the premises or on the practice website.

Are services responsive to people's needs?

Requires improvement

The practice is rated as requires improvement for providing responsive services. Services do not always meet people's needs.

- Patient feedback indicated delays in obtaining routine appointments, but they told us emergency appointments were available. There was a lack of clarity regarding the appointments system, including the availability of emergency slots and the discontinued walk in service.
- The needs of patients were not fully taken into account when planning services. For example, the provider told us that due to pressure of work he had to concentrate on patients with acute healthcare issues, leaving the practice nurse to manage patients with long-term conditions.
- Feedback received via the Patient Participation Group was that some female patients would prefer to see a female practitioner.

Are services well-led?

Inadequate

The practice is rated as inadequate for being well-led. The delivery of high-quality care is not assured by the leadership, governance or culture in place.

- The practice's aims and objectives were set out in its statement of purpose, but this was out of date and in need of revision. There were no detailed or realistic plans to achieve the aims and objectives.
- The delivery of high-quality care was not assured by the governance arrangements in place. There was little or no evidence of arrangements for identifying, recording and managing risks, or for implementing mitigating actions. For example, infection prevention and control measures; the management of medicines; health and safety; and arrangements for dealing with emergencies.
- The practice had a number of policies and procedures to govern activity, but some of these were overdue a review.

Summary of findings

- There was no effective system for monitoring performance, by frequent audits or effective use of the practice management computer system.
- There was little evidence of appropriate management of significant events, including learning and reflective practice.
- Staff appraisal records referred to significant levels of stress and work overload, reducing the practice's capacity to offer an effective service. The provider told us of his own heavy workload.

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 being safe, effective and well led and as requires improvement for caring and responsive services. The concerns which led to these ratings apply to everyone using the practice, including this population group, older people.

- The practice maintained a register of 69 patients at high risk of admission to hospital. But patients discharged were followed up only on an opportunistic basis.
- We saw evidence of multi-disciplinary case management meetings taking place, but these were not well-recorded.
- Performance for heart failure related indicators was 69%, being 20.8% below the CCG average and 29.1% below the national average.
- Performance for rheumatoid arthritis related indicators was 16.7%, being 67.2% below the CCG Average and 79% below the national average.

People with long term conditions

Inadequate

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

- The provider told us he had to concentrate on patients with acute conditions. Only occasionally, and usually opportunistically, was he able to carry out reviews of patients with long term health conditions.
- Performance for diabetes mellitus related indicators was 51.8%, being 27.9% below the CCG average and 38.1% below the national average.
- The percentage of patients with diabetes, on the register, whose last measured total cholesterol (measured within the preceding 12 months) is 5 mmol/mol or less was 51.89%, compared with the CCG average of 74.27% and the national average of 78.01%.
- The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 64 mmol/mol or less in the preceding 12 months was 56.08%, compared with the CCG average of 74.04% and the national average of 80.22%.

Summary of findings

- Performance for asthma related indicators was 70.2%, being 24.5% below the CCG Average and 27.1% below the national average.
- Performance for chronic obstructive pulmonary disease related indicators was 48.9%, being 33% below the CCG average and 47% below the national average.

Families, children and young people

Inadequate

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

- Childhood immunisation rates were below average for all standard childhood immunisations.
- The practice had not made progress in appointing a female GP or making more use of female locums, despite the concern having been raised previously by the Patient Participation Group and noted in our last inspection report.
- The practice's uptake for the cervical screening programme was significantly low at 52.94%, compared with the CCG average of 72.99% and the national average of 81.43%.
- Performance for contraception related indicators was 57.1%, being 32.7% below the CCG average and 39% below the national average.

Working age people (including those recently retired and students)

Inadequate

The provider was rated as inadequate for being safe, effective and well led and as requires improvement for caring and responsive services. The concerns which led to these ratings apply to everyone using the practice, including this population group, working age people (including those recently retired and students).

- Patients told us there were delays in making routine appointments and some were unsure regarding the appointments system, including the availability of emergency slots and the discontinued walk in service.
- In 2014/15, the practice had completed health checks on 19 patients; in 2015/16 it had completed 151 health checks; and between April and November 2016 it had completed 100 checks.
- The practice had carried out 1,199 blood pressure checks (35.6% of the eligible patients)

Summary of findings

People whose circumstances may make them vulnerable

Inadequate

The provider was rated as inadequate for being safe, effective and well led and as requires improvement for caring and responsive services. The concerns which led to these ratings apply to everyone using the practice, including this population group, people whose circumstances may make them vulnerable.

- The practice held a register of patients living in vulnerable circumstances including six patients with a learning disability. At the time of the inspection there were no homeless patients registered.
- The practice offered longer appointments for patients with a learning disability.
- The six of the patients on the learning disability register had had their care reviewed in the last 12 months. Three patients had attended for a follow up review by the time of our inspection.

People experiencing poor mental health (including people with dementia)

Inadequate

The provider was rated as inadequate for being safe, effective and well led and as requires improvement for caring and responsive services. The concerns which led to these ratings apply to everyone using the practice, including this population group, people experiencing poor mental health (including people with dementia).

- Performance for mental health related indicators was 45.9%, being 39.3% below the CCG average and 46.9% below the national average.
- The practice maintained a register of 37 patients experiencing poor mental health. Of whom, 18 had received an annual health check by the date of the inspection.
- The percentage of patients experiencing poor mental health who had a comprehensive, agreed care plan documented in the record, in the preceding 12 months was 38.46%, compared with the CCG average of 86.39% and national average of 88.77%
- Performance for dementia related indicators was 45.3%, being 42.7% below the CCG average and 51.3% below the national average.
- The percentage of patients diagnosed with dementia whose care plan had been reviewed in a face-to-face review in the preceding 12 months was 45.45%, compared with the CCG average of 87.01% and the national average of 83.77%.

Summary of findings

What people who use the service say

The most recent national GP patient survey results were published in July 2016 and related to the periods July - September 2015 and January - March 2016. The results showed a reduction in performance since last year and that the practice was consistently performing below local and national averages. Three hundred and fifty-seven survey forms were distributed and 88 were returned. This represented roughly 3.1% of the practice's list of approximately 2,800 patients.

- 91% of patients found it easy to get through to this practice by phone, compared to the local average of 82% and the national average of 73%.
- 74% of patients were able to get an appointment to see or speak to someone the last time they tried, compared to the local average of 82% and the national average of 85%.
- 75% of patients described the overall experience of this GP practice as good, compared to the local average of 81% and the national average of 85%.
- 69% of patients said they would recommend this GP practice to someone who has just moved to the local area, compared to the local average of 75% and the national average of 78%.

As part of our inspection we also asked for CQC comments cards to be completed by patients prior to our inspection. We received 46 comment cards, most of which were positive about the standard of care received. Patients stated that they received kind, compassionate care and treatment which met their needs. Patients said they felt well supported and felt staff were approachable and understanding. However, four patients' comments cards complained of having to wait a week or two for a routine appointment and one was critical of a clinician's attitude. We spoke with seven patients during the inspection, whose views reflected those who had completed comments cards.

Areas for improvement

Action the service MUST take to improve

Ensure that care and treatment is provided in a safe way, including –

- Regularly assessing the risks to the health and safety of patients and staff and putting in place appropriate arrangements to mitigate, manage and monitor any risks.
- Ensuring that sufficient numbers of suitably qualified, competent and skilled staff are deployed and that they receive appropriate support, training and supervision as is necessary to enable them to safely carry out their duties.
- Ensuring that the emergency medical equipment is safe and is used in a safe way.
- Ensuring the proper and safe management of medicines.
- Ensuring that the risk of, and preventing, detecting and controlling the spread of, infections, including those that are health care associated, are assessed and put in place and that there are appropriate arrangements to mitigate, manage and monitor any risks.
- Ensuring patients' care and treatment reflects current evidence-based guidelines.
- Maintaining accurate, complete and contemporaneous records of patients' care and treatment, including decisions taken in relation to the care and treatment, and ensuring that all patients' test results are reviewed and processed in a timely manner.
- Establishing governance systems or processes and operating them effectively to assess, monitor and improve the quality and safety of the services. For example, the management, investigation and learning from significant incidents; and having a system of regular clinical audits relevant to the service, with suitable reflection and learning.

Action the service SHOULD take to improve

- Continue with efforts to appoint a female GP, or make use of female locums, to provide an appropriate and full healthcare service for female patients.

Summary of findings

- Take steps to improve the standard of recording of both internal meetings and those with other healthcare professionals, such as multi-disciplinary team meetings;
- Improve methods of communicating with patients, including providing clarification of the appointments system, the availability of emergency slots and the status of the walk-in service. Publicise the available translation service at the premises and on the practice website;
- Obtain an induction loop to assist patients with a hearing impairment.

Dr Kandiah Pathmanathan

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector**.** The team included a second inspector, a GP specialist adviser, a nurse specialist adviser and an Expert-by-Experience.

Background to Dr Kandiah Pathmanathan

Dr Kandiah Pathmanathan's practice, also known as the Covent Garden Medical Centre, operates from 47 Shorts Gardens, London WC2H 9AA. The premises are leased from the local authority and occupy the ground floor of a residential block.

The practice provides NHS primary medical services through a General Medical Services (GMS) contract to approximately 2,800 patients. It is part of the NHS Central London (Westminster) Clinical Commissioning Group (CCG) which is made up of 37 general practices. The practice is registered with the CQC to provide the regulated activities Diagnostic and screening procedures, Family planning, Maternity and midwifery services, and the Treatment of disease, disorder or injury.

The patient profile indicates a population of more working age people than the national average, with a particularly high proportion of younger adults. Many of the patients registered with the practice are adults working or studying in the area. There is a lower proportion of families with young children and teenage patients in the area, compared with the national average. The deprivation level for the practice area is in the fourth "more deprived decile".

The provider, Dr Pathmanathan, is a sole practitioner, who has operated the practice for over twenty years, originally in partnership with other GPs. He has worked on his own for the last nine years. The provider works ten clinical sessions a week. A part-time practice nurse, who works three days a week, had been appointed in April 2015, shortly after our last inspection, but was due to leave in December 2016. A recruitment process to replace her was underway. The administrative team of three staff is made up of the practice manager, deputy practice manager and head of reception.

The practice's morning opening hours are between 8.00 am and 1.00 pm, Monday to Friday. The afternoon hours are 2.00 pm to 6.30 pm on Monday, Tuesday, Thursday and Friday; and 5.00 pm to 8.00 pm on Wednesday. GP's consulting hours are between 9.00 am and 12.00 noon on Monday, Tuesday, Wednesday and Thursday; and from 8.00 am to 12.00 noon on Friday. Afternoon sessions are between 3.00 pm and 6.30 pm on Monday, Tuesday and Friday; 5.30 pm to 8.00 pm on Wednesday; and 5.30 pm to 6.30 pm on Thursday. Appointments with the practice nurse, who works on Monday, Tuesday and Wednesday, begin at 8.30 am.

The practice is closed at weekends. It has opted out of providing an out-of-hours service. Patients calling the practice when it is closed are connected with the local out-of-hours service provider. There is information given about the out-of-hours provider and the NHS 111 service on the practice website.

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

Detailed findings

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.

We had last inspected the practice in March 2015, when we identified concerns relating to safe, effective and well-led services. We served a requirement notice under Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, relating to Good governance, and we rated the practice as overall Requires Improvement. Following the publication of our report, the practice sent us a plan of the actions it intended to take to address our concerns and to meet the requirements of the Regulations. We programmed a follow up inspection to check on the implementation of the actions in early 2016, but postponed it when we were informed of the planned absence of the practice nurse and practice manager. We planned a full inspection for September 2016, but this was also postponed for health and safety reasons due to flooding at the practice and it was rearranged for 8 November 2016.

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 8 November 2016. During our visit we:

- Spoke with the provider, the practice manager and the head of reception. The practice nurse and the deputy practice manager were absent on the day. We also spoke with seven patients who used the service.
- Observed how patients were being cared for and talked with carers and/or family members
- Reviewed an anonymised sample of the personal care or treatment records of patients.
- Reviewed 46 comment cards where patients and members of the public shared their views and experiences of the service.
- Reviewed the practice's action plan produced after our inspection in 2015.

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 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. We had access to the overall results for the year 2015/16, but some data was provided by the practice.

Inadequate

Are services safe?

Our findings

At our inspection in March 2015, we had rated the practice as requires improvement in relation to providing safe services. Although risks to patients who used services were assessed, the systems and processes to address these risks were not implemented well enough to ensure patients were kept safe. Staff were not sufficiently trained to make full use of the practice's clinical computer system to monitor and fully assess risks to patients' health.

Safe track record and learning

At this inspection, we found that systems, processes and practices did not keep people safe. There was limited evidence of learning from significant events and of actions being taken to improve safety.

There was a system in place for reporting significant events, including a standard reporting form available to all staff on the shared computer drive. However, the process was not used effectively. For example, before our inspection we asked the practice to send us a summary of significant events that occurred in the last 12 months. In response, the practice sent us a statement, "Throughout the past 12 months, we had the same problems with leaks in filling room and in nurse's room which resulted in electrical faults in the disabled patient's toilet [sic]." At the inspection, we discussed significant events with the provider, who told us that staff would report any incidents to him, but that he could not recall any. The provider mentioned a prescribing error which occurred this year. Such would usually be processed as a significant event, warranting investigation, but there was no evidence that the incident had been treated as a significant event. The provider told us that the error had occurred at a time when prescriptions were signed in mid-surgery, i.e. between patients' appointments. The provider had since adopted a new practice of signing prescriptions at the end of the day, but there were no written records of the incident. The only record of an incident we saw were the minutes of a staff meeting in early September 2016, when the flooding and temporary closure of the premises had been discussed.

At the inspection, we reviewed the care of a number of patients being prescribed high risk medicines and noted an absence of any records regarding regular blood tests being done, as is appropriate for such patients. We also found that 92 pathology test reports had not been reviewed and processed for several weeks. We brought both these issues to the provider's attention. Shortly after the inspection, the provider sent us two significant event forms relating to these issues. The forms showed that staff had met the following day to review the incidents. With regard to the patients on high risk medicines, the provider had contacted them and advised them to arrange for the necessary blood tests as soon as possible. The provider had reviewed the patients' health care records and in some cases had found that the patients' blood tests were being monitored by hospitals. The practice planned to contact the hospitals for copies of the results. With the forms, the provider sent us the practice's clinical protocols in respect of monitoring patients prescribed Methotrexate and Warfarin and another relating to patients on Lithium, both of which had been revised as a consequence of the incidents. However, the protocol for Methotrexate and Warfarin was not sufficiently detailed. For instance, it made no reference to the need for frequent monitoring when Methotrexate is initially prescribed, nor for test results to be recorded on the patients' notes, although it did for Warfarin tests. Further, the Lithium protocol was too complex, containing a lot of detail not relevant to general practice and likely to confuse.

The significant event form relating to the pathology test reports stated that all staff "took part in the discussion and the GP agreed that it was a lapse on the part of the surgery for not processing appropriately and filing the reports in the timely manner. All the results have been filed in the patients' records." When reviewing the pathology test reports with the provider, we had noted that one of the results showed as abnormal, warranting a repeat of the test. However, the provider had started to file it as a "normal" result before we questioned his actions.

In both the stated cases, neither of the significant event forms included an explanation for the apparent oversights. The learning points recorded were limited.

Overview of safety systems and processes

The practice had various protocols and procedures to keep patients safeguarded from abuse. We found that arrangements reflected relevant legislation and local requirements. Policies relating to safeguarding vulnerable adults and child protection had been reviewed in April 2016 and 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 Provider attended safeguarding meetings when possible – we saw evidence of

meetings held at the practice - and always provided reports where necessary for other agencies. Staff demonstrated they understood their responsibilities. The provider was trained to safeguarding level three, the practice nurse to level two and the administrative staff to level one.

Notices in the waiting area and treatment rooms advised patients that chaperones were available if required. The chaperoning policy had last been reviewed in November 2015. The practice nurse and the administrative staff performed chaperoning duties. We saw evidence that they had received appropriate training and had undergone a Disclosure and Barring Service (DBS) check. DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable.

Cleanliness and infection control

The practice did not maintain appropriate standards of cleanliness and hygiene. We observed the premises to be generally clean, but the reception area floor was dirty, particularly around the edges and some walls were grubby. Work surfaces in the nurse's room were cluttered, preventing effective cleaning. The cleaner was directly employed and worked to a simple chart, which staff checked and ticked to confirm the cleaning had been carried out. The chart had not been completed for the two days prior to our inspection. There was no detailed plan recording, for example, how the cleaning was to be done, such as stipulating mopping, vacuuming or disinfecting, as appropriate. There was no mention of when deep-cleaning should be undertaken.

The practice nurse (who was absent on the day of our inspection) and practice manager jointly led on infection prevention and control matters and all staff had received appropriate training in the last 12 months. The practice had an infection control protocol, but it had not been fully implemented. For example, it stated that the practice nurse and practice manager would undertake an "inspection" every two months using a written checklist, but there were no records to confirm these inspections were carried out. The practice manager told us the checklist was not used. Nor was there evidence to confirm that regular infection control audits were conducted. The practice manager told us, "nothing has been written down this year". There was no evidence of a suitable risk assessment in relation to legionella being carried out. Legionella is a term for a particular bacterium which can contaminate water systems in buildings.

Couches in the consultation rooms were covered in disposable paper roll, changed after each use, and the privacy curtains, which appeared in good condition, were changed at least every six months in accordance with their date labels. The practice manager told us there were arrangements in place for the removal of clinical waste by a licenced contractor on a weekly basis. We found there were no sharps bins in the treatment room being used by the locum GP on the day of our inspection. Staff had no explanation for this. There were three sharps bins in the provider's consultation room, but we saw that all were incorrectly assembled and did not have a label stating when they had been brought into use. There were no purple bins used for disposal of medicines containing hormones. We noted that in the nurse's room there were two posters, one dated 2009, offering conflicting guidance on dealing with sharps injuries.

The practice did not maintain records of staff members' Hepatitis B immunisation status. The practice manager was unable to demonstrate how this was monitored.

Medicines management

The practice had arrangements for managing medicines, including emergency medicines and vaccines, but these were not applied well enough to keep patients safe.

We saw the practice's repeat prescribing protocol, which had been drafted in 2015 and had hand written annotations stating it had been reviewed and amended in September and November 2016. The protocol was generic and made no specific reference to high risk drugs, such as Methotrexate, Warfarin and Lithium.

Blank prescription forms and pads were securely stored, but there was no system in place for recording reference numbers to monitor missing or lost forms, in accordance with the NHS prescription form security guidance.

The practice used Patient Group Directions (PGDs) to allow nurses to administer medicines in line with legislation. PGDs are written instructions for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment. However, the locum nurse working on the day of

the inspection had no PGDs in place. We looked at the PGD file for the practice nurse and found a number of forms had not been completed correctly and were therefore invalid. They included those for shingles; measles, mumps and rubella; polio, whooping cough, diphtheria, tetanus and Haemophilus influenzae b; rotarix; revaxis; meningococcal ACWY; influenza; and Haemophilus influenzae type b (Hib) and meningitis C, which did not having the name of the practice recorded on the form. Some others were out of date and in addition, the forms for shingles; influenza; and Haemophilus influenzae type b (Hib) and meningitis C had not been adopted and authorised for use by NHS London.

Recruitment procedures

We reviewed the personnel files of the five staff members and found appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Criminal Records Bureau or later by the Disclosure and Barring Service.

Monitoring risks to patients

Risks to patients were not appropriately assessed and managed. All staff had undertaken recent training in fire safety and all but the provider had had recent general health and safety training. We were told that responsibility for health and safety had been delegated to a person not employed by the practice and there was no evidence available to confirm that the person had the appropriate training or relevant experience to carry out the role. The practice's health and safety policy was reviewed in June 2016, but the practice was not able to provide evidence of any general health and safety risk assessments being carried out to monitor and manage risks to patients and staff.

One member of staff was trained as a fire marshal, but there was nobody to cover their absence. A fire drill had been carried out in May 2016 and the fire alarm was tested on a weekly basis. Fire extinguishers had been checked and certified in November 2015. The practice's fire safety policy was overdue a review. Although our report of last year's inspection mentions a fire risk assessment being done in 2014, staff members were not able to produce evidence of a risk assessment being conducted more recently than 2012. All items of electrical equipment had been inspected and tested in August 2016, together with medical equipment such as nebulisers and monitors being inspected and calibrated.

Arrangements to deal with emergencies and major incidents

The practice did not have adequate arrangements in place to respond to emergencies and major incidents. We saw evidence that the provider and administrative staff had received annual basic life support training in 2016 and the practice nurse in April 2015. There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency. The practice had a supply of emergency medicines available. The practice manager told us they were checked monthly, but there were no records to confirm they had been checked more recently than August 2016.

The practice did not have a defibrillator - a device used to restart a person's heart in an emergency - and had not carried out a suitable assessment of the risk of not having one. There was an oxygen cylinder, but it was still wrapped in film and not ready for use. We noted that there was an adult mask and airway available, but these had been unwrapped and were seen to be dusty, putting patients at risk of infection if required during an emergency. The mask for children's use was still wrapped, however it had expired in 2013.

The practice had a business continuity plan, but it had not been put to full use during a recent incident which led to the temporary closure of the premises.

Inadequate

Are services effective?

(for example, treatment is effective)

Our findings

At our inspection in March 2015, we had rated the practice as requires improvement in relation to providing effective services. Data showed patient outcomes were at or below average for the locality. Rates for health checks of patients on the diabetes register and mental health register were low, as was the number of patients with learning disabilities receiving annual follow ups.

Although a system of clinical audits had been introduced, no audit cycles had been completed to drive improvement in performance and to improve patient outcomes. Staff had generally received training appropriate to their roles. However, there was a need for continuing appropriate training to be provided to make full and effective use of the practice's clinical computer system, to ensure that basic care and treatment needs were met.

Effective needs assessment

At this inspection, we found that people's care and treatment did not always reflect current evidence-based guidance, standards and practice.

The practice had access to relevant and current evidence-based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines. The practice manager told us they received NICE guidelines and distributed them to the provider and the practice nurse. The guidelines were saved on the shared computer drive. They showed us recent examples such as Diabetes (type 1 and type 2) in children and young people: diagnosis and management, from August 2016 and Mental health problems in people with learning disabilities: prevention, assessment and management, from September. However, there was no formal process for guidance to be reviewed and discussed at staff meetings to ensure that patients' needs were assessed and that care was delivered in line with guidance and standards. For example, we asked the provider about his use of NICE guidelines and others issued from time to time by the CCG relating to prescribing. He told us he was aware of the guidelines, but usually referred to the British National Formulary for guidance. When we asked the provider about asthma management, he said he was aware of the guidelines. However, he did not follow them - for example, he was not familiar with the latest combination inhalers, only prescribing them if recommended by consultants.

Management, monitoring and improving outcomes for people

There was limited monitoring of people's outcomes of care and treatment. People's outcomes were significantly worse than expected when compared with similar services. Necessary action was not taken to improve people's outcomes.

At the last inspection, in March 2015, we had noted that the practice had started undertaking clinical audits to identify where improvements could be made and to monitor them over time. It had not done so previously with any consistency. At this inspection the practice offered us evidence of six audits carried out over the past two years. These included an annual audit of cervical screening and a completed-cycle audit relating to Warfarin prescribing. Two other audits, relating to patient referrals for dermatology tests and of patients discharged from hospital, had been done in 2015 but not repeated. Both had been organised by the CCG and involved a review of records. The practice's recorded reflection on the audits, including identifying any learning points, was limited. The remaining two audits, of diabetic foot screening and repeat prescribing, had been carried out in 2016, with recorded plans for them to be repeated in early 2017. At our inspection, in March 2015, we were told that a vaccinations audit was planned for June 2015, but evidence of it having been done was not produced.

The practice participated in the Quality and Outcomes Framework (QOF), a voluntary system intended to improve the quality of general practice and reward good practice and performance. The most recently published results were for the year 2015/16, when the practice achieved 68.4% of the total number of points available. This was 19.5% below both the local and national averages. The practice's clinical exception rate was 6.8%, being 3.1% and 3% below the local and national rates respectively. Exception rate reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines that cannot be prescribed because of side effects.

Data from 2015/16 showed:

Inadequate

Are services effective?

(for example, treatment is effective)

- Performance for chronic obstructive pulmonary disease related indicators was 48.9%, being 33% below the CCG average and 47% below the national average.
- Performance for diabetes mellitus related indicators was 51.8%, being 27.9% below the CCG average and 38.1% below the national average.
- Performance for heart failure related indicators was 69%, being 20.8% below the CCG average and 29.1% below the national average.
- Performance for mental health related indicators was 45.9%, being 39.3% below the CCG average and 46.9% below the national average.
- Performance for stroke and transient ischaemic attack related indicators was 69%, being 21.5% below the CCG average and 28.2% below the national average.

The results had not improved since our last inspection in 2015 and we discussed them with the provider. Last year we had been told that the low results were due mostly to administrative issues. At the time, the practice had recently changed its computer records system and staff were unused to the new one. In addition, it had previously been the responsibility of the practice nurse to process QOF information, but the nurse had left some time before our last inspection and remaining staff had found it difficult to cover her duties collating, monitoring and managing the QOF data. We were told that a new nurse was appointed just after our inspection in 2015 and worked only part time. The provider told us that most of the QOF reviews were done by the nurse. Due to pressure of work, the provider found it necessary to concentrate on patients with acute health issues and only occasionally, and usually opportunistically, was he able to carry out reviews. The practice did not have any viable plans on how to improve performance.

The practice told us last year that further training on the new computer system was to be provided by the local CCG. At this inspection we were told that the training had consisted of two hours per month for four months for each staff member. Staff we spoke with were still having problems making effective use of the clinical computer system. For example, we asked the provider to demonstrate how he used the system to conduct records searches of patients prescribed particular medications and he had difficulty doing so.

Effective staffing

At the last inspection, the practice staff included the provider, a healthcare assistant, practice manager and five administrative staff. A part-time nurse was appointed shortly after our inspection. We were told at this inspection that the practice nurse had given notice of leaving at the end of the year. A further recruitment process was underway.

At our inspection last year, the provider told us he had been in discussion with another doctor with a view to them joining the practice making it a partnership. However, at this inspection we saw that no progress had been made. It was also apparent that there was insufficient administrative staff at the practice. The team consisted of the practice manager, deputy practice manager and the head of reception; a reception / administrative post was vacant. On the day of the inspection, the deputy practice manager was absent and the reception and phone duties were covered by the head of reception all day. The practice manager had to leave our feedback session in the evening to take over the duties when the head of reception's hours were completed.

We were told that the learning needs of staff were monitored at annual appraisals. Having identified a need for better records keeping at the last inspection, we found the staff records to have improved. We reviewed the training records of all staff and saw that most were up to date with their mandatory training requirements. These topics included Health and Safety Awareness, Fire Safety, Basic Life Support, Infection Prevention and Control, Safeguarding, Equality and Diversity and Information Governance. Staff performing chaperoning duties had received appropriate training. We noted that the practice nurse was overdue refresher training on Information Governance. We were not shown evidence that the provider had received training in Information Governance or Health and Safety Awareness. Staff had received additional training relevant to their role. For example, the provider had undertaken recent training on diabetes, cardiology and dementia care; the practice nurse on spirometry, asthma and atrial fibrillation; and the administrative staff had had training in customer service. The practice manager was due to attend a leadership course in December 2016.

Inadequate

Are services effective?

(for example, treatment is effective)

The lack of familiarity with, and training on using, the clinical computer system was preventing staff from making full and effective use of it to manage, monitor and improve patient outcomes.

Coordinating patient care and information sharing

Staff told us that they 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. The information needed to plan and deliver care and treatment was available to relevant staff. The provider told us he made little use of templates and care plans for patient care, but we did see some evidence of information sharing, for example in minutes of Multi-disciplinary team meetings, when patients' care was reviewed and future care planned. However, these minutes were consistently brief and did not confirm the patients' agreement to the planned care. The provider told us that patients' unplanned admission to hospital was not routinely monitored and patients' discharged from hospital were followed up opportunistically.

Consent to care and treatment

Staff generally sought patients' consent to care and treatment in line with legislation and guidance. However, as few care plans were used, patients' consent was not always recorded.

- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005.
- 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 provider or practice nurse assessed the patient's capacity and, recorded the outcome of the assessment.
- Although there was a process for seeking consent, this had not yet been monitored by any regular patients' records audits.

Supporting patients to live healthier lives

There was no focus on prevention and early identification of health needs. Staff were reactive rather than proactive in supporting people to live healthier lives. The provider told us he found it necessary to concentrate on patients with acute healthcare issues because of pressure of work.

The practice's uptake for the cervical screening programme was significantly low at 52.94%, compared with the CCG average of 72.99% and the national average of 81.43%. The practice policy was to send three reminders, including by text message or email, to patients who had not attended for their cervical screening test after the initial invitation. Patients not wishing to have their tests carried out at the practice, due to a lack of female staff, were referred to a nearby family planning and sexual health clinic as an alternative. The practice achieved comparable scores, encouraging its patients to attend national screening programmes for bowel cancer screening (practice uptake rate 40.9%; CCG average 41%) and breast cancer screening (practice uptake rate 59.2%; CCG average 56.9%).

The practice's 2015/16 take-up rates for standard childhood immunisations were significantly below average. Vaccinations given to under two year olds ranged from 60% to 72%, missing all four targets and achieving a score of 6.5 out of 10, compared with the national average of 9.1 out of 10. For five year olds, the provision of measles, mumps and rubella (MMR) doses 1 and 2 was 54% and 72%, compared with the CCG average range of 62% and 79% and the national average of 87% and 93%.

Requires improvement

Are services caring?

Our findings

At our inspection in March 2015, we rated the practice as good in relation to providing caring services. However, at this inspection evidence from the GP patient survey indicated a decline in patients' satisfaction and in most cases showed the practice was performing below average.

Kindness, dignity, respect and compassion

We observed members of staff were courteous and 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.
- We noted that consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- Reception staff knew when patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.

We received 46 patient comment cards and all but one were positive about the caring aspects of the service. Patients we spoke with said they felt the practice staff were helpful and caring and treated them with dignity and respect. Two of the patients mentioned that staff were caring and helpful despite being under a lot of pressure.

We spoke with seven patients during the visit and their views reflected the positive feedback in the comments cards. They also told us they were satisfied with the care provided by the practice and said their dignity and privacy were respected. The patients and the comments cards highlighted that staff responded compassionately when they needed help and provided support when required.

However, results from the national GP patient survey in relation to consultations with GPs and nurses were varied, generally below average, and in a number of cases showed a reduction in patient satisfaction since last year. For example:

- 83% of patients said the last GP they saw or spoke to was good at giving them enough time, compared to the local average of 81% and the national average of 87%
- 83% of patients said the last GP they saw or spoke to was good at listening to them, compared to the local average of 85% and the national average of 89%
- 72% of patients (previously 86%) said the last GP they saw or spoke to was good at treating them with care and concern, compared to the local average of 81% and the national average of 85%
- 90% of patients (previously 94%) had confidence and trust in the last GP they saw or spoke to, compared to the local average of 94% and the national average of 95%
- 87% of patients (previously 88%) said the last nurse they saw or spoke to was good at giving them enough time, compared to the local average of 88% and the national average of 92%
- 89% of patients said the last nurse they saw or spoke to was good at listening to them, compared to the local average of 87% and the national average of 91%
- 78% of patients (previously 83%) said the last nurse they saw or spoke to was good at treating them with care and concern, compared to the local average of 87% and the national average of 91%
- 91% of patients had confidence and trust in the last nurse they saw or spoke to, compared to the local average of 95% and the national average of 97%
- 81% of patients (previously 87%) found the receptionists at this surgery helpful, compared to the local average of 84% and the national average of 87%

Care planning and involvement in decisions about care and treatment

Patients told us they felt involved in decision making about their care and treatment. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them.

This differed from evidence provided by the national GP patient survey. Results regarding patients' involvement in planning and making decisions about their care and treatment were below the local and national averages and indicated a reduction since last year's results. For example:

- 62% of patients (previously 84%) said the last GP they saw was good at explaining tests and treatments, compared to the CCG average of 82% and the national average of 86%.

Requires improvement

Are services caring?

- 72% of patients (previously 77%) said the last GP they saw was good at involving them in decisions about their care, compared to the CCG average of 78% and the national average of 82%.
- 79% said the last nurse they saw or spoke to was good at explaining tests and treatments, compared to the CCG average of 86% and the national average of 90%
- 64% of patients (previously 80%) said the last nurse they saw was good at involving them in decisions about their care, compared to the CCG average of 81% and the national average of 85%.

One of the comments cards was less positive than others about this aspect of care; the patient being unhappy with the clinician's manner during their consultation. They also questioned the recorded message patients hear when calling the practice, which they described as "overlong and a little insulting".

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

- Staff told us that interpreting services were available for patients who did not have English as a first language. We were told that this amounted to approximately 40% of the patients. However, we did not see any information about the interpreting services in the reception area or on the practice website.
- Various healthcare information leaflets were available and there was also information on healthcare issues and services available to patients the practice website. There was no information on the website in languages other than English. The site did allow access to a "translate page" facility providing a limited translation function.

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.

The practice's computer system alerted staff when a patient was also a carer. The practice had identified 41 patients as carers (1.36% of the practice list). Written information was available to direct carers to the various avenues of support available to them.

Staff told us that if families had suffered bereavement, the GP contacted them or sent them a sympathy card. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service.

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

At our inspection in March 2015, we had rated the practice as good in relation to providing responsive services. However, although the practice had reviewed the needs of its local population, it had not put in place a plan to secure improvements for all of the areas identified. Patients had raised concerns regarding the lack of a female GP at the practice and this had an impact on outcomes, with some female patients being referred to other services to meet their health care needs.

Responding to and meeting people's needs

At this inspection we established that some patients found the appointments system difficult to use. There was a lack of clear information available. The website contained a notice regarding the provider's working hours changing in May 2016, which stated, "All patients are encouraged to make appointments, particularly as they are freely available, so as to curtail on those attending surgery waiting for an available slot. Try to desist adopting this style, particularly as the doctor and his entire staff are very busy, with heavy work commitments.[sic]"

Access to the service

- Appointments with the provider were available until 6.30 pm on Monday, Tuesday, Thursday and Friday. This was extended on Wednesday until 8.00 pm for working patients who could not attend during normal opening hours.
- Standard appointments were 10 minutes long, but double appointments could be booked if patients had more than one issue to discuss.
- A number of daily slots were kept free for emergency appointments.
- 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 meant it was difficult for them to attend the surgery.
- Patients who had previously registered for the service could book appointments and order repeat prescriptions online.
- The premises were suitable for patients with mobility issues, with ramp access for wheelchair users and patients with prams. There was a disabled toilet and baby-changing facilities.

The practice's morning opening hours were between 8.00 am and 1.00 pm, Monday to Friday. The afternoon hours were 2.00 pm to 6.30 pm on Monday, Tuesday, Thursday and Friday; and 5.00 pm to 8.00 pm on Wednesday. The provider's consulting hours were between 9.00 am and 12.00 noon on Monday, Tuesday, Wednesday and Thursday; and from 8.00 am to 12.00 noon on Friday. Afternoon sessions were between 3.00 pm and 6.30 pm on Monday, Tuesday and Friday; 5.30 pm to 8.00 pm on Wednesday; and 5.30 pm to 6.30 pm on Thursday. Appointments with the practice nurse, who worked on Monday, Tuesday and Wednesday, began at 8.30 am.

The practice had previously operated a walk-in service during the morning, but this had been withdrawn in May 2016 and some patients seemed unaware of this.

The practice closed at weekends. It had opted out of providing an out-of-hours service. Patients calling the practice when it is closed are connected with the local out-of-hours service provider. There was information given about the out-of-hours provider and the NHS 111 service on the practice website.

Results from the national GP patient survey showed that patient's satisfaction with how they could access care and treatment were mixed in relation CCG and national averages and indicated a fall in performance since last year -

- 73% of patients (previously 75%) were satisfied with the surgery's opening hours, compared with the local average of 73% and the national average of 76%
- 91% of patients found it easy to get through to this surgery by phone, compared to the local average of 82% and the national average of 73%
- 74% of patients (previously 83%) were able to get an appointment to see or speak to someone the last time they tried, compared with the local average of 82% and the national average of 85%
- 75% of patients (previously 83%) described the overall experience of this GP practice as good, compared to the local average of 81% and the national average of 85%.
- 69% of patients (previously 79%) said they would recommend this GP practice to someone who has just moved to the local area, compared to the local average of 75% and the national average of 78%.

Four of the comments cards also mentioned delays in getting appointments and those patients we spoke with

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

said they usually waited a week for a routine appointment with the provider. However, a number mentioned they had occasionally attended same day emergency appointments. One patient said there was no provision for emergency appointments and another told us the walk in service could be used in an emergency. This suggested that patients were not clear about the appointment system.

The provider told us that due to pressure of work he found it necessary to concentrate on patients with acute healthcare issues, leaving the management of patients with long term conditions to the part-time practice nurse. The workload meant it was difficult for the practice to be fully responsive to patients' needs.

The premises were generally compliant with requirements for disabled patients, being accessible by a ramp, with all the rooms on one floor. However, we noted that it did not have an induction loop to assist patients with a hearing impairment. Staff told us they had to raise their voice when speaking with the patient, possibly compromising confidentiality.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. There was information on the practice website and in the practice leaflet regarding the procedure, but we had to ask the receptionist for a complaints form, as none were displayed in the waiting area. The complaints policy and procedure was in line with recognised guidance and contractual obligations for GPs in England. The website gave the contact details for the local Patient Advice and Liaison Service, which offers advice and support to patients with complaints about healthcare services. The practice invited comments and suggestions, with a feedback box on the reception counter.

Staff told us that verbal complaints would be recorded, but there had been no verbal or written complaints by patients in the last 12 months. Three complaints had been made in the year prior to that, which we had noted were dealt with appropriately, in a timely way, with openness and transparency. None of the patients we spoke with, or any of those who completed comments cards, had had cause to complain.

Are services well-led?

Inadequate

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

Our findings

At our inspection in March 2015 we had rated the practice as requires improvement in relation to providing well-led services. The practice had a number of policies and procedures to govern activity, but some of these were overdue a review. Staff told us that they received regular appraisals, but there was no evidence to confirm this.

At this inspection, we found that the delivery of high-quality care was not assured by the leadership, governance or culture in place.

Vision and strategy

We noted that the practice's statement of purpose was in need of review and amendment. It referred to a healthcare assistant being employed, not mentioning the practice nurse. It also made reference to the morning walk in clinic, which had been discontinued in May 2016. The statement contained the practice's aims and objectives, but there were no detailed or realistic plans to achieve them.

The practice manager had been appointed just before our last inspection, having previously worked at the practice in a more junior role. We were told they would be given guidance and formal mentoring by a manager at a nearby practice. The provider told us that the practice manager had been relieved of some duties, including responsibility for health and safety and some elements of recruitment and training, as they had a heavy workload. The day after the inspection, the provider sought the assistance of the local medical committee for further mentoring support for the practice manager.

Governance arrangements

The practice had minimal structures and procedures to support an overarching governance framework. Protocols and procedures had been reviewed and updated since our last inspection, but a number were again overdue a review. These included the information governance policy, confidentiality agreement, occupational health, access to medical reports and the carer protocol.

The practice had a business continuity plan, intended for use in major incidents such as power failure or building damage. However, the plan had not been followed in a recent incident of flooding from the flats above the premises. The plan included the telephone numbers for utilities providers and emergency contacts, as well as staff.

We noted it made several references to a nearby practice with which there was an agreement for "mutual aid" and "risk sharing". We saw minutes of a staff meeting in September to review the incident. The practice had been closed for 18 hours over two days. Patients with booked appointments were contacted and asked to rearrange for the following week. Those who could not wait were visited at home by the provider. The minutes stated that the practice had been able to function partially, producing prescriptions, answering phone calls, and the practice nurse saw patients through the emergency entrance. Patients were directed by a notice in the window to a walk-in clinic, not to the nearby practice mentioned in the business continuity plan. There was no recorded explanation for this.

The system and programme for clinical and internal audit was not sufficiently robust to monitor quality and to make improvements. There was little or no evidence of arrangements for identifying, recording and managing risks and implementing mitigating actions, for example, relating to general health and safety, fire safety, infection control and legionella.

We reviewed with the provider the action plan submitted by the practice following our inspection last year and established that a significant number of the actions had not been implemented. For example -

- The plan included training being provided to ensure staff were proficient in using the new computer system to identify patients at risk. The training had been very limited and staff were not confident with the system; when asked to demonstrate its use, staff were not able to run effective searches.
- NICE guidelines were to be reviewed and discussed at recorded staff meetings, but there was no evidence of this happening.
- Infection prevention and control records were to be maintained as evidence of effective procedures, but we were told that no written records had been made.
- Arrangements were to be made to deal with emergencies and these were to be "checked continuously". However, the oxygen cylinder was not ready for use, the adult mask was unwrapped and dusty and the child's mask was out of date. There was no defibrillator on the premises and an assessment had not been made of the risk of not having one.

Leadership and culture

Are services well-led?

Inadequate

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

The provider was visible in the practice and staff told us they enjoyed working there. However, there was a lack of awareness of individual roles and responsibilities. Staff felt supported by the provider, but some were vague with their responses to questions about the apparent lack of management capacity which had an impact on the governance systems.

We saw evidence of annual staff appraisals being carried out, with provision for staff to comment on issues that concerned them. We noted that there were several references to a heavy workload, pressure and stress, and in our discussions with the provider he had mentioned his own heavy workload.

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

The practice encouraged feedback from patients, the public and staff. The practice's patient participation group (PPG) had been set up shortly after our inspection last year. There had been three meetings in 2015 and the plans were for there to be two per year henceforward. We saw there were fifteen or so members of the PPG, with most attending the meetings, together with a number of the practice staff members. We had noted, however, that one issue raised by the PPG, early last year, relating to female practitioners being employed, remained to be addressed.

The practice had gathered feedback from staff meetings and general ad hoc discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management.

Continuous improvement

There was no evidence of innovation or service development. There was minimal evidence of learning and reflective practice.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing (1) We found that the registered person had failed to ensure that sufficient numbers of suitably qualified, competent, skilled and experienced persons be deployed in order to meet the requirements of this Part, and to provide a safe, effective and responsive service. (2) We found that the registered person had failed to ensure that persons employed in the provision of the regulated activities received such appropriate support, training and supervision as is necessary to enable them to carry out the duties they are employed to perform. Staff were not sufficiently trained to make full and effective use of the practice's clinical computer system, to provide safe and effective care, or to monitor and improve service performance. This was in breach of regulation 18 (1) and (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment We found the registered person had failed to ensure that care and treatment was provided in a safe way for service users. The registered person had failed to (a) assess the risks to the health and safety of service users of receiving the care or treatment; (b) do all that is reasonably practicable to mitigate any such risks; (c) ensure that persons providing care or treatment to service users have the qualifications, competence, skills and experience to do so safely; (e) ensure that the equipment used by the service provider for providing care or treatment to a service user is safe for such use and is used in a safe way; (g) ensure the proper and safe management of medicines; (h) assess the risk of, and preventing, detecting and controlling the spread of, infections, including those that are health care associated. 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 Family planning services Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance We found the registered person had failed to establish systems or processes and operate them effectively to ensure compliance with the requirements in this Part.

This section is primarily information for the provider

Enforcement actions

The registered person had failed to establish processes to enable the registered person, in particular, to -

(a) assess, monitor and improve the quality and safety of the services;

(b) assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others;

(c) maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided;

(d) maintain securely such other records as are necessary to be kept in relation to--

(ii) the management of the regulated activity;

(e) seek and act on feedback from relevant persons and other persons on the services provided in the carrying on of the regulated activity, for the purposes of continually evaluating and improving such services;

(f) evaluate and improve their practice in respect of the processing of the information referred to in sub-paragraphs (a) to (e).

This was in breach of regulation 17 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.