The Staunton Group Practice

Quality Report

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Date of inspection visit: 26 July 2017 and 1 August 2017
Date of publication: 19/10/2017

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?	Inadequate
Are services well-led?	Inadequate

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out a comprehensive inspection of the practice in August 2015, when we rated it as requires improvement overall and specifically relating to the key questions of safe and responsive services. We carried out a focussed follow up inspection in May 2016, when we found that the practice had taken appropriate action to address the safety concerns. We revised the rating for providing safe services to good, which brought the practice's overall rating to good. However, although some action had been taken to address the concerns regarding responsive services, there remained problems over access. Accordingly, we did not revise the rating for that key question.

We carried out this announced comprehensive inspection of the Staunton Group Practice on 26 July 2017, but were unable to complete the inspection on the day due to time constraints and returned on 1 August 2017. Overall the practice is rated as inadequate.

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

- The system for reporting and recording significant events was not sufficiently robust to ensure that events were investigated fully and learning was shared appropriately.
- The system for reviewing and actioning safety alerts did not effectively ensure that patients were protected from risks.
- There was insufficient evidence that all staff had received mandatory training in areas such as safeguarding, infection prevention and control and fire safety.
- There had been no infection prevention and control audit since January 2016. Some infection control issues, relating to waste management, hygiene and legionella had not been addressed.
- There was not an effective process to ensure that care was provided in accordance with relevant and current evidence based guidance and standards.
- We found a large volume of papers and correspondence that was waiting scanning onto patients' records and others waiting to be read and actioned by GPs.
- Monitoring of patients' two week referrals had lapsed.

Summary of findings

- Staff could not provide evidence that information was appropriately shared with other healthcare professionals, such as the local out-of-hours care provider.
- Although problems with the practice's telephone system had been identified in the past as adversely impacting on patients' access, the issues had not been resolved.
- Patient feedback and survey data highlighted significant dissatisfaction over the availability of appointments and continuity of care.
- Issues identified from an analysis of complaints had not been addressed.
- Staff morale was very low. Changes intended to improve performance and governance had been introduced without sufficient consultation, or planning and training being provided. Administrative staff members were not fully aware of their own roles and responsibilities and their annual appraisals were overdue by three months.

The areas where the provider must make improvements are:

- Ensure the care and treatment of patients is appropriate, meets their needs and reflects their preferences.
- Ensure care and treatment is provided in a safe way to patients.
- Maintain appropriate standards of hygiene for premises and equipment.
- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.
- Ensure sufficient numbers of suitably qualified, competent, skilled and experienced persons are deployed to meet the fundamental standards of care and treatment.
- Ensure persons employed in the provision of the regulated activity receive the appropriate support, training, professional development, supervision and appraisal necessary to enable them to carry out the duties.
- Ensure that patients' records are maintained securely and are not accessible to unauthorised persons.

The areas where the provider should make improvement are:

- Ensure that patients' uncollected prescriptions are monitored on a regular basis.
- Ensure that blank prescription pads and forms are kept securely.
- Continue with work to identify patients who are carers, so that they may be provided with appropriate ongoing support.

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.

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

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Inadequate

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

- Staff were not clear about reporting significant events and concerns. Although the practice carried out investigations when significant events took place, lessons learned were not communicated effectively and so safety was not improved.
- Patients were at risk of harm because systems and processes had weaknesses.
- The system for reviewing and actioning safety alerts did not effectively ensure that patients were protected from risks.
- There was insufficient evidence that all staff had received mandatory training. There had been no infection prevention and control audit since January 2016.

Are services effective?

Inadequate

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

- There was not an effective process to ensure that care was provided in accordance with relevant and current evidence based guidance and standards.
- Administrative staff had not been sufficiently trained in new ways of working for them to carry out their responsibilities effectively.
- We found a large volume of papers and correspondence that was waiting scanning onto patients' records and others waiting to be read and actioned by various GPs.
- Monitoring of patients' two week referrals had lapsed.
- Staff could not provide evidence that information was appropriately shared with other healthcare professionals, such as the local out-of-hours care provider.
- Data from the Quality and Outcomes Framework showed most patient outcomes were comparable with local and national averages.

Are services caring?

Requires improvement

The practice is rated as requires improvement for providing caring services.

Summary of findings

- Results from the national GP patient survey were mixed. They showed patients' satisfaction with GP consultations was lower than local and national averages; results for nurse consultations were generally comparable with, or above, local and national averages.
- Survey results regarding patients' satisfaction with receptionists, as well as regarding continuity of care, were significantly lower than averages and had fallen since last year.
- Some patient feedback during our inspection was negative.
- The practice had identified 58 patients as carers (0.4% of the practice list).

Are services responsive to people's needs?

Inadequate

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

- Although problems with the practice's telephone system had been identified over two years ago as adversely impacting on patients' access, the issues had still not been resolved.
- Patient feedback and survey data highlighted significant dissatisfaction over the availability of routine appointments. However, patients did tell us that urgent appointments were usually available the same day.
- Information about how to complain was available and evidence showed the practice responded quickly to issues raised. But there was limited evidence that learning from complaints was actioned appropriately.
- The practice had good facilities and was well equipped to treat patients and meet their needs.

Are services well-led?

Inadequate

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

- Although the need for improvements in some areas of practice had been identified, there were no detailed or realistic plans to achieve these.
- Staff morale was low. Changes intended to improve performance and governance had been introduced without sufficient consultation, planning and training being provided.
- Although staff told us they were able to raise concerns and suggestions regarding possible improvements, they did not feel confident that they would be acted upon.

Summary of findings

The six population groups and what we found

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

Older people

Inadequate

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

- Staff were able to recognise the signs of abuse in older patients and knew how to escalate any concerns.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs.
- Older patients were provided with health promotional advice and support to help them to maintain their health and independence for as long as possible.

People with long term conditions

Inadequate

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

- Data showed patient outcomes were mixed. In some instances, the practice's results were low compared to the local and national averages.
- The percentage of patients with COPD who had a review undertaken including an assessment of breathlessness using the Medical Research Council dyspnoea scale in the preceding 12 months (01/04/2015 to 31/03/2016) was 59.02%, compared with the local average of 89.01% and the national average of 89.59%.
- In those patients with atrial fibrillation with a record of a CHA2DS2-VASc score of 2 or more, the percentage of patients who are currently treated with anti-coagulation drug therapy. (01/04/2015 to 31/03/2016) was 72.41%, compared with the local average of 81.46% and the national average of 86.69%.
- The percentage of patients with asthma, on the register, who have had an asthma review in the preceding 12 months that includes an assessment of asthma control using the 3 RCP questions. (01/04/2015 to 31/03/2016) was 69.83%, compared with the local average of 75.24% and the national average of 75.55%.

Summary of findings

Families, children and young people

Inadequate

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

- Immunisation rates were mixed for the standard childhood immunisations. The practice achieved two of four targets for under-2 year olds; its rates for 5 year olds were above local and national averages.
- Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals.
- Appointments were available outside of school hours and the premises were suitable for children and babies.

Working age people (including those recently retired and students)

Inadequate

The provider was rated as inadequate for safe, effective, responsive and well led services and requires improvement for caring 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).

- The practice had adjusted the services it offered to make them accessible and flexible, for example, by operating extended hours each weekday evening
- The practice offered online access and a 24-hour automated appointments system, as well as a full range of health promotion and screening that reflects the needs for this age group.
- The percentage of women aged 25-64 whose notes record that a cervical screening test has been performed in the preceding 5 years (01/04/2015 to 31/03/2016) was 80.46%, compared with the local average of 78.72% and the national average of 81.43%

People whose circumstances may make them vulnerable

Inadequate

The provider was rated as inadequate for safe, effective, responsive and well led services and requires improvement for caring 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 those with a learning disability.

Summary of findings

- The practice offered longer appointments for patients with a learning disability. Annual follow ups had been conducted for 56 patients (97%) on the learning disability register.
- 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.

People experiencing poor mental health (including people with dementia)

Inadequate

The provider was rated as inadequate for safe, effective, responsive and well led services and requires improvement for caring 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).

- The percentage of patients diagnosed with dementia whose care plan has been reviewed in a face-to-face review in the preceding 12 months was 75.61%, compared with the CCG average of 88.34% and the national average of 83.77%.
- The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive, agreed care plan documented in the record, in the preceding 12 months (01/04/2015 to 31/03/2016) was 82.58%, compared with the local average of 83.46% and the national average of 88.77%.
- The practice had information available for patients experiencing poor mental health about how they could access various support groups and voluntary organisations.

Summary of findings

What people who use the service say

The national GP Patient survey results were published July 2017 and related to the period January - March 2017. Some of the results had improved since the last figures were published in 2016, whilst others had fallen. Generally they indicated that the practice was performing below CCG and national averages. Three hundred and sixty-six survey forms were distributed and 112 were returned. This represented approximately 0.75% of the practice's patient list.

- 60% of patients described the overall experience of this GP practice as good compared with the CCG average of 79% and the national average of 85%. (A drop from 63% in the 2016 results)
- 47% of patients described their experience of making an appointment as good compared with the CCG average of 69% and the national average of 73%. (Up from 40%)
- 42% 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 72% and to the national average of 77%. (Down from 52%)

We saw the practice's results for the Friends and Family Test over the past 12 months, which were more positive. There had been 826 responses, of which 538 (approx. 65%) would recommend the practice, whilst 187 (approx. 23%) would not.

We spoke with 20 patients, most of whom were generally happy with their consultations saying they were satisfied with the care provided by the practice and that their dignity and privacy was respected. They thought staff were approachable, committed and caring, but six of the patients we spoke with had concerns over telephone access and seven said they had difficulty getting an appointment when they needed one. Seven patients told us they did not get to see the GP of their choice; eight mentioned delays of between 15 and 30 minutes waiting to be seen by a GP.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 23 comments cards, which evidenced mixed views on the practice. Sixteen of the cards were positive regarding the service patients experienced. However, four cards expressed dissatisfaction with the service, stating that some staff members were intimidating, that the patient felt rushed, that the availability of female clinicians was sometimes limited and that there was no continuity of care. Five of the cards stated that getting appointments was difficult.

Areas for improvement

Action the service MUST take to improve

- Ensure the care and treatment of patients is appropriate, meets their needs and reflects their preferences.
- Ensure care and treatment is provided in a safe way to patients.
- Maintain appropriate standards of hygiene for premises and equipment.
- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.
- Ensure sufficient numbers of suitably qualified, competent, skilled and experienced persons are deployed to meet the fundamental standards of care and treatment.
- Ensure persons employed in the provision of the regulated activity receive the appropriate support, training, professional development, supervision and appraisal necessary to enable them to carry out the duties.
- Ensure that patients' records are maintained securely and are not accessible to unauthorised persons.

Summary of findings

Action the service SHOULD take to improve

- Ensure that patients' uncollected prescriptions are monitored on a regular basis.
- Ensure that blank prescription pads and forms are kept securely.
- Continue with work to identify patients who are carers, so that they may be provided with appropriate ongoing support.

The Staunton Group Practice

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 GP specialist adviser, a practice nurse specialist adviser and an Expert by Experience.

Background to The Staunton Group Practice

The Staunton Group Practice (the practice) operates at Morum House Medical Centre, 3-5 Bounds Green Road, Wood Green, London N22 8HE. It shares the premises with other healthcare services.

The practice provides NHS primary medical services through a General Medical Services (GMS) contract to approximately 14,500 patients. The practice is part of the NHS Haringey Clinical Commissioning Group (CCG) which is made up of 51 general practices. The practice is registered with the CQC to provide the following regulated activities - Diagnostic and screening procedures, Family planning, Maternity and midwifery services, Surgical procedures, Treatment of disease, disorder or injury. The patient profile for the practice indicates a population of more working age people than the national average, with a high proportion of younger adults in the 20 to 40 age range. There is a lower proportion of older people in the area compared with the national average.

The clinical team is made up of four partner GPs and four salaried GPs. Four of the GPs are female and four male. The partner GPs work between six and nine clinical sessions per week; the salaried GPs between four and nine sessions. The practice uses two regular locum GPs. There is a nurse practitioner, who works six sessions; three nurses, working between two and eight sessions. The practice has one healthcare assistant. It is a training practice, with two doctors in training and a trainee nurse being attached for the coming year. The administrative team comprises a practice manager, an administrative manager, a reception manager and a project manager. There are 15 other staff in the administrative / reception team.

The practice is open between 8.30 am and 6.30 pm, Monday to Friday and is closed at weekends. Phones are operated between 8.00 am and 6.30 pm, but the practice asks patients to restrict calls between 8.00 am and 11.00 am to urgent calls only.

The practice 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.

Why we carried out this inspection

We carried out a comprehensive inspection of the practice 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 practice 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 practice under the Care Act 2014.

We had previously undertaken a comprehensive inspection of the practice in August 2015, when we rated it as requires improvement overall and specifically relating to the key questions of safe and responsive services. There was insufficient evidence that all staff had undergone necessary pre-employment checks. Not all staff had received appropriate training in safeguarding and infection prevention and control. There was limited evidence that

regular infection prevention and control audits were being carried out. The results of the GP patients survey, together with patients' comment cards and those patients we spoke with highlighted problems with telephone access and the availability of appointments.

We carried out a focussed follow up inspection in May 2016, when we found that the practice had taken appropriate action to address the safety concerns. We revised the rating for providing safe services to good, which brought the practice's overall rating to good. However, although some action had been taken to address the concerns regarding responsive services, there remained problems over telephones and access. Accordingly, we did not revise the rating for that key question.

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice. We carried out an announced visit on 26 July 2017 and completed the inspection on 1 August 2017.

During our visit we:

- Spoke with a range of staff, including partner GPs, practice nurses, the practice manager and project manager, together with a number of administrative team. We also spoke with patients who used the service and a member of the patient participation group.
- Observed how patients were being cared for in the reception area and talked with carers and/or family members
- 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.
- Looked at information the practice used to deliver care and treatment plans.

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

We had previously carried out a comprehensive inspection of the practice in August 2015, when we rated it as requires improvement for providing safe services. There was insufficient evidence that all staff had undergone necessary pre-employment checks or received appropriate training in safeguarding and infection prevention and control, and regular infection prevention and control audits were not being carried out. We carried out a focussed follow up inspection in May 2016, when we found that the practice had taken appropriate action to address the safety concerns. We revised the rating for safe services to good.

At this inspection, there was limited assurance about safety. Systems, processes and policies were not always reliable or appropriate to keep people safe. We had a number of concerns, including how significant incidents were managed; how safety alerts were reviewed and disseminated amongst staff; that not all staff had completed appropriate training in specific issues, such as safeguarding, fire safety and infection prevention and control, and more generally following the introduction of a new clinical computer system and changes in administrative functions.

Safe track record and learning

Staff told us they would inform the practice manager of any incidents and there was a recording form available on the practice's computer system. The incident recording form supported the recording of notifiable incidents under the duty of candour. The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment. However, the system for reporting and recording significant events was not sufficiently robust to ensure that events were investigated fully and learning was shared appropriately. The practice had sent us summary records of five significant events that had occurred in the preceding 12 months, which we reviewed with the partner GPs. The summaries varied in the amount of detail recorded and three did not mention when they should be reviewed or by whom. Partner GPs told us that meetings involving the partners and salaried GPs were held to discuss each significant event. We saw that two significant events had been discussed at a clinical meeting in January 2017. Administrative staff told us they were not routinely involved in any discussion, even if they had raised the concern in the first instance. There was no formal system for learning from significant events to be passed on. The partner GPs we spoke with could not recall two of the significant events the practice had informed us of. Staff told us they did not routinely record new cancer diagnoses as significant events.

Staff told us that one of the partner GPs was responsible for reviewing safety alerts that had come into the practice and actioning as necessary. In their absence, alerts were passed to the duty GP. We saw two examples of recent safety alerts issued by the Medicines and Healthcare products Regulatory Agency (MHRA). One of the alerts concerned issues relating to secondary care and was accordingly filed without action. The other alert, dated May 2017, related to possible faults with a particular type of defibrillator. Although actions had been identified the person responsible for carrying them out had not been informed.

Overview of safety systems and processes

Although the practice had systems and processes to minimise risks to patient safety, for example relating to safeguarding vulnerable adults and child protection, these were not implemented sufficiently well to ensure patient safety was maintained.

One of the partner GPs was the lead for safeguarding children and another was lead for adult safeguarding. Staff we interviewed demonstrated they understood their responsibilities regarding safeguarding. However, records were not able to confirm that all staff, including the clinical leads for safeguarding, had up to date training appropriate to the appropriate level.

The practice had a written policy, which had last been reviewed in June 2017, and guidance on safeguarding, which were accessible to all staff. The guidance outlined who to contact for further guidance if staff had concerns about a patient's welfare. We asked staff to demonstrate the clinical system to highlight cases where there were safeguarding concerns, but staff members were not able to show us that appropriate coding was used or whether pop up alerts would notify staff of any ongoing concerns. The GPs attended safeguarding meetings when possible or provided reports where necessary for other agencies. Monthly Multi-Disciplinary Team (MDT) meetings were held with health visitors to review cases of concern. The practice maintained a child protection register and a child in need register.

Inadequate

Are services safe?

A notice in the waiting area and in the consultation rooms advised patients that chaperones were available if required. Six staff members had been trained to act as chaperones and had received a Disclosure and Barring Service (DBS) check. DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable.

Cleaning was done in accordance with written schedules and logs. We found that the common areas were generally clean and tidy, but some work surfaces in treatment rooms were cluttered, possibly making cleaning more difficult. In one consultation room, we found an unsealed sharps bin, used for disposing needles, was filled over the recommended half-way level and was not signed and dated to record when it was set up. In another room, we saw another unsigned and undated sharps bin. Curtains in consultation rooms were dated when they were put up. We found one that had been dated September 2016, which ought to have been changed after six months, in accordance with infection prevention and control guidance. Staff we spoke with told us they thought the curtains should be changed after 12 months. A record of staff members' Hepatitis B immunisation status was maintained and monitored.

One of the partner GPs was the clinical lead for infection prevention and control, working with one of the practice nurses. We noted that there had been no infection prevention and control audit carried out since January 2016, but were sent evidence that one had been completed on 4 August 2017, after our inspection. We saw training records that indicated 12 members of the clinical team and six members of the administrative team had not received up to date infection prevention and control training.

There were arrangements for managing medicines, including emergency medicines and vaccines, in the practice to minimise risks to patient safety, including obtaining, prescribing, recording, handling, storing, security and disposal, but these were not sufficiently robust to ensure patient safety was maintained. 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. However, there was no process for monitoring prescriptions left uncollected by patients. We also noted that some prescription pads and forms were not kept securely in accordance with good practice guidelines, some being accessible in unlocked consultation rooms. Patient Group Directions had been adopted by the practice to allow nurses to administer medicines in line with legislation.

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 employments in the form of references, qualifications, registration with the appropriate professional body and the appropriate checks through the DBS.

Monitoring risks to patients

There were procedures for assessing, monitoring and managing risks to patient and staff safety, but these were not implemented sufficiently well to ensure safety was maintained.

- A fire risk assessment was carried out by a consultant on 1 August 2017, the second day of our inspection. Firefighting equipment had been inspected in December 2016 and the emergency lighting in March 2017. Fire alarms were tested weekly and fire drills were carried out. However, most staff members had no record of receiving fire safety training.
- All electrical and clinical equipment was checked and calibrated to ensure it was safe to use and was in good working order. The most recent testing had been done in July 2017; fixed wiring had been inspected and certified in May 2016.
- The practice had a variety of other risk assessments to monitor safety of the premises such as control of substances hazardous to health and one relating to legionella, which had been carried out in April 2016. Legionella is a term for a particular bacterium which can contaminate water systems in buildings. The legionella risk assessment contained a risk management plan with a list of monitoring tasks to be carried out by the consultant. However, the log was not complete and there was no evidence that the tasks had been done.
- During the inspection we found several unoccupied consultation rooms were left unlocked and noted that staff had left their smartcards inserted in the computer terminals. This might allow unauthorised persons to access patients' medical records.

Inadequate

Are services safe?

- There were arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system designed to ensure enough staff were on duty to meet the needs of patients.

Arrangements to deal with emergencies and major incidents

The practice had adequate arrangements to respond to 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.
- Records confirmed staff had received annual basic life support training in December 2016. The practice had a defibrillator available on the premises and oxygen with adult and children's masks. The equipment was monitored and logged.
- 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. A first aid kit and an accident book were available.
- The practice had a business continuity plan for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff contractors and utilities providers. There were arrangements in place with a nearby buddy practice for the service to relocate in the event the premises were unusable.

Inadequate

Are services effective?

(for example, treatment is effective)

Our findings

At our previous comprehensive inspection in August 2015, we had found that the practice was providing an effective service and rated this key question as good.

At this inspection, we found that people were at risk of not receiving effective care or treatment. The was insufficient evidence that guidance, such as that issued by the National Institute for Health and Care Excellence (NICE), were being used to ensure that appropriate care was being delivered. Staff told us that administrative changes had been introduced without effective training being provided. We found there was a significant backlog of documents waiting to be scanned on patients' records, many of which had no note of having been reviewed previously and actioned. We also found a backlog of electronic correspondence waiting to be read and actioned. There was no system operating to monitor patients' two-week referrals for secondary care.

Effective needs assessment

There was not an effective process to ensure that clinicians were aware of relevant and current evidence based guidance and standards, including NICE best practice guidelines. Staff told us that one of the partner GPs was responsible for reviewing new guidance and disseminating it to colleagues. However, the process was described as "hit and miss" by one of the partner GPs we spoke with. We noted that one of the significant event analysis forms had an action to review NICE guidelines on Pain Management and Controlled Drug and provide feedback to the clinical team. In its action plan, submitted after our inspection, the practice set out the steps it intended to take, including running regular searches of guidance and alerts and reviewing any which were relevant to the service at weekly meetings. The practice also advised subsequent to the inspection that it had regular learning events, including case-based discussions and reviews of significant clinical events. The practice stated that these events were sometimes attended by invited guest speakers and referred to recent examples where discussions had included diabetes care, pain management, acute kidney injury and domestic violence.

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). The most recently published results for the practice, relating to 2015/16, showed it achieved 90.4% of the total number of points available, being 1.4% below the CCG Average and 4.9% below the national average. The practice's overall clinical exception rate was 11.7%, being 1.2% above the CCG Average, and 1.9% above the national average. Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects. Results from 2015/16 showed the practice's performance was mixed, for example –

- Performance for diabetes related indicators was 73.7%, being 7.8% below the CCG average and 16.1% below the national average. The exception reporting rate for the practice was 15.4%, compared with the CCG average of 12.8% and the national average of 11.6%
- Performance for hypertension related indicators was 99.7%, being 5.4% above the CCG average and 2.4% above the national average. The exception reporting rate for the practice was 4.7%, compared to the CCG average of 5.3% and the national average of 3.9%
- Performance for mental health related indicators was 78.2%, being 11.3% below the CCG average and 14.6% below the national average. The exception reporting rate for the practice was 4.5%, compared with the CCG average of 7% and the national average of 11.3%
- Performance for asthma related indicators was 99.7%, being 4.3% above the CCG average and 2.3% above the national average. The exception reporting rate for the practice was 2.6%, compared with the CCG average of 4.1% and the national average of 7.0%

We reviewed the practice's QOF results for 2016/17, which were yet to be published. These indicated a slight improvement in overall performance to 92.5%. The figure for mental health related indicators had increased from 78% in 2015/16 to 85% in 2016/17. But we noted the figure for diabetes remained around 74%. We discussed the results with staff who told us that QOF performance was monitored with partner GPs having identified areas of responsibility. Improvements had been made regarding patient recall systems and practice nurses had been given an increased role in chronic disease management. The practice had carried out an audit of care provided to a sample of its patients with diabetes which highlighted an

Inadequate

Are services effective?

(for example, treatment is effective)

improvement in patient outcomes. The practice provided us with the current QOF figures for the first four months of 2017/18. These showed that it had to date achieved 70% of the points available for diabetes related indicators and 65% of the points available for mental health related indicators.

The practice told us that five clinical audits had been carried out in the last two years. Three of these were prescribing audits; the others related to diabetes care, which included prescribing and advice, and infections following minor surgery. Two were completed cycle audits. We looked at the audit relating to diabetes care, which reviewed a sample of 65 patients, and showed an improvement in outcomes for 48 (74%) patients following reviews and changes to prescribed medication and motivational advice being given regarding diet and lifestyle. The improvements included a reduction in patients' HbA1c (glycated haemoglobin) levels and their blood pressure.

Effective staffing

The practice had a structured induction programme for all newly appointed staff, lasting two weeks. This covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality. New staff members were subject to a six month probation period.

The practice had access to an e-learning system to identify the learning needs of staff according to their role and responsibility and there was a detailed protocol setting out mandatory training requirements. Although staff generally had the skills and knowledge to deliver effective care and treatment, we found that the practice's protocol was not being consistently implemented. Some elements of training, including overdue refresher courses, had not been undertaken since our last inspection in May 2016. We noted examples such as training in infection prevention and control, safeguarding, fire safety and capacity to consent to treatment. In addition, staff told us that training in new ways of working, introduced following the reorganisation of administrative functions in October 2016, had not been sufficient to enable them to carry out their new responsibilities effectively.

We were not assured that administrative staff were being effectively deployed given the concerns we noted and which are recorded elsewhere in this report. For example, training being overdue, the backlog of papers to be scanned, there being no monitoring of two-week referrals or of uncollected prescriptions, together with delays in handling telephone calls and reported long queues at reception.

Learning requirements were further identified through a system of appraisals. Annual appraisals in respect of the clinical team had been completed and clinical staff were given ongoing support, one-to-one meetings, coaching and mentoring, clinical supervision and facilitation and support for revalidating GPs and nurses. However, the annual appraisals for non-clinical staff were overdue by three months.

Co-ordinating patient care and information sharing

We found a large volume of papers, correspondence and test results that we were told was waiting scanning onto patients' records. These numbered approximately 5,000 and dated between 2015 and October 2016, when the practice had started using a new clinical computer system. Although many of the documents were annotated as having been checked by GPs and actioned, a significant number contained no evidence of having been reviewed. We discussed the issue with partner GPs, who stated that pressure of work had prevented the papers from being scanned onto records, but assured us that all had been looked at and actioned when received. We saw internal correspondence dating from November 2016 regarding plans for staff to work at weekends to deal with the scanning backlog, but agreement of the arrangements was reached too late for many staff to attend. The partner GP undertook to review all the documents, with most of the process being completed by the second day of our inspection. The partner GPs told us that many of the documents had been downloaded directly onto patients' records - for example, those from hospitals with electronic communications links - and many others had been scanned by staff into records already. They told us that in cases where patients needed onward referral, this had been actioned at the time the documents were received. The practice subsequently informed us that the review exercise had been completed by two of the partner GPs by 7 August 2017. Four cases where patients had not attended appointments had been identified as needing follow up contact; one of whom had been booked to see the GP that week. We saw two letters that had been sent out on the second day of our visit; one to a patient who had not attended a referral and another to a hospital regarding a

Inadequate

Are services effective?

(for example, treatment is effective)

"lost follow up". The practice included in its action plan, submitted after the inspection, the reinforced procedure for all incoming letters and documents to be date stamped and scanned onto patients' records on the day of receipt. This process had been a previous aim, but had not been consistently achieved. Subsequent to the inspection the practice told us that its review of the documentation had shown that about 600 letters had not been seen by clinicians. The practice also told us that staff had been working at weekends to clear the backlog of correspondence.

We also found a total of 1,779 documents, including test results, in various GPs' Docman Workflow systems, used to transmit documents electronically, which had not been marked as read. We discussed this with partner GPs, who stated that each staff member might receive 200-300 documents via the system each week. We asked the practice to review all the unread documents; it had reviewed two-thirds of these by the second day of our inspection and completed the review by 7 August 2017. We were advised that no significant issues had been recorded.

The practice had carried out a re-organisation of its administration staff in October 2016, setting up a number of small teams each working to a number of GPs. Before then, the practice had maintained a central log of patients referred for two-week secondary consultations to investigate possible cancer symptoms. The log had been managed by a named staff member, but following the staff reorganisation the responsibility for monitoring the referrals was to be shared between the various teams. However, administration staff told us that the monitoring was not being done, as training had not been provided.

There was some 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. We saw an example of a meeting with the local palliative care team, but staff we spoke with were not aware of whether information was shared with the local out-of-hours care provider.

Consent to care and treatment

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

- Staff we spoke with understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005. We noted that 11 members of the clinical team were overdue training relating to mental capacity and consent.
- 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.

The practice's uptake for the cervical screening programme was 80.46%, which was comparable with the CCG average of 78.72% and the national average of 81.43%. 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. However, we found there was no failsafe system operating to ensure the practice followed up women who were referred as a result of abnormal results.

The practice also encouraged its patients to attend national screening programmes for breast and bowel cancer. For example, the practice's take up rate for female patients aged 50-70, who had been screened for breast cancer in last 36 months was 60.9%, compared with the CCG average of 63%. The rate for patients aged 60-69, screened for bowel cancer in last 30 months was 46.4% compared with the CCG average of 48.5%

Childhood immunisations were carried out in line with the national childhood vaccination programme. Target uptake rates for the vaccines given to children aged under-2 were exceeded for two of the sub-indicators, ranging from 93.6%

Inadequate

Are services effective?

(for example, treatment is effective)

to 94.26%, but were below standard for the remaining two, ranging from 85.6% to 89.5%. For five year olds, the take up rate ranged from 83.5% to 88.6%, being higher than the CCG average.

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

At our previous comprehensive inspection in August 2015, we had found that the practice was providing a caring service and rated this key question as good.

At this inspection, we saw from survey data and feedback we received that there are times when people do not feel well supported or cared for. Some people who use the service have concerns about the way staff treat people. Patient satisfaction over continuity of care was significantly lower than local and national averages and had fallen since last year.

Kindness, dignity, respect and compassion

During our inspection we observed that 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.
- 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.

Of the 23 comments cards we received, 16 were positive regarding the service patients experienced. However, four cards expressed dissatisfaction with the service, stating that some staff were intimidating, that the patient felt rushed, that the availability of female clinicians was sometimes limited and that there was no continuity of care. The remainder did not address the key question of caring.

We spoke with 20 patients, including two members of the patient participation group. Most of whom were generally happy with their consultations and with the reception staff, saying they were satisfied with the care provided by the practice and said their dignity and privacy was respected. Comments highlighted that staff responded compassionately when they needed help and provided support when required. A number of patients mentioned that staff were at times very busy, which sometimes had an adverse effect on the service.

Results from the 2017 national GP patient survey showed patients felt they were treated with compassion, dignity and respect. The practice's satisfaction scores on consultations with GPs were below CCG and national averages, whilst for nurse consultations results were comparable with CCG averages. For example: -

- 81% of patients said the GP was good at listening to them, compared with the CCG average of 85% and the national average of 89%. (The figure had gone down from 83% in 2016)
- 73% of patients said the GP gave them enough time, compared with the CCG average of 81% and the national average of 86%. (Down from 81%)
- 93% of patients said they had confidence and trust in the last GP they saw, compared with the CCG average of 94% and the national average of 95%. (Up from 89%)
- 78% of patients said the last GP they spoke to was good at treating them with care and concern, compared with the CCG average of 81% and the national average of 86%. (Up from 75%)
- 32% of patients usually get to see or speak to their preferred GP, compared with the CCG average of 49% and the national average of 56%. (Down from 41%)
- 84% of patients said the nurse was good at listening to them, compared with the CCG average of 85% and the national average of 91%. (Same as 2016)
- 91% of patients said the nurse gave them enough time, compared with the CCG average of 86% and the national average of 92%. (Up from 78%)
- 93% of patients said they had confidence and trust in the last nurse they saw, compared with the CCG average of 94% and the national average of 95%. (Up from 89%)
- 81% of patients said the last nurse they spoke to was good at treating them with care and concern, compared with the CCG average of 83% and to the national average of 91%. (Up from 78%)
- 68% of patients said they found the receptionists at the practice helpful, compared with the CCG average of 83% and the national average of 87%. (Down from 78%)

We discussed these figures with the practice. It was aware that some patients' perception of the receptionists had been poor for some time. The practice was in the process of identifying customer care training, but it had not yet been provided. One of the comments cards we received stated that the receptionists' approach had improved.

Care planning and involvement in decisions about care and treatment

Requires improvement

Are services caring?

Patients told us they felt involved in decision making about the care and treatment they received. 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. Patient feedback from the comment cards we received was also positive and aligned with these views.

Results from the national GP patient survey showed patients responded relatively positively to questions about their involvement in planning and making decisions about their care and treatment. Results were generally comparable with local and national averages. For example:

- 80% of patients said the last GP they saw was good at explaining tests and treatments, compared with the CCG average of 83% and the national average of 86%. (Down from 81%)
- 76% of patients said the last GP they saw was good at involving them in decisions about their care, compared with the CCG average of 77% and the national average of 82%. (Down from 77%)
- 82% of patients said the last nurse they saw was good at explaining tests and treatments, compared with the CCG average of 83% and the national average of 90%. (Up from 78%)
- 78% of patients said the last nurse they saw was good at involving them in decisions about their care, compared with the CCG average of 79% and the national average of 85%. (Up from 76%)

The practice provided 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 saw notices in the reception areas informing patients this service was available. There was also a number of multi-lingual staff who might be able to support patients.
- The NHS e-Referral Service, formerly called Choose and Book, was used with patients as appropriate. This service 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 alerted GPs if a patient was also a carer. However, the practice had identified only 58 patients as carers (0.4% of the practice list). The practice should work to identify more. Written information was available to direct carers to the various avenues of support available. Carers were offered timely and appropriate support, such as flu vaccinations at the beginning of winter.

Staff told us that if families had experienced bereavement, their usual 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.

Inadequate

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

At our comprehensive inspection of the practice in August 2015, we rated it requires improvement in respect of the key question responsive services. Patient survey data and feedback had highlighted problems with telephone access and the availability of appointments. At our focussed inspection in May 2016, we saw that there were ongoing technical problems with the new telephone system, which the practice was working to resolve with the system provider. We found that although some action had been taken to address the concerns over telephone access and appointments, the problems had not been resolved. Accordingly, we did not revise the rating for providing responsive services.

At this inspection, we again found that services do not always meet patients' needs. Patients found the appointments system problematic; telephone access was difficult and patients told us there were frequent delays at reception and whilst waiting to see clinicians.

Responding to and meeting people's needs

- Feedback from patients indicated that problems with the telephone system and access to appointments were yet to be resolved.
- The practice offered extended hours, with appointments available up to 7.00 pm on Monday, Tuesday and Friday; and up to 8.15 pm on Wednesday and Thursday.
- 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 sent text message reminders of appointments and test results and of other issues related to the practice.
- Online services, such as booking appointments and requesting repeat prescriptions, were available.
- There were accessible facilities, which included step-free access. Telephone and face-to-face interpreting services available.

Access to the service

The practice opened between 8.30 am and 6.30 pm, Monday to Friday. It closed at weekends. Phones were operated between 8.00 am and 6.30 pm, but the practice asked patients to restrict calls between 8.00 am and 11.00 am to urgent calls only. Appointments were 10 minutes long and were available throughout the day, including an extended hours service between 6.30 pm and 6.45 pm. Appointments could be booked up to four weeks in advance. Home visits were available for house-bound patients and telephone consultations could be booked. In addition, further extended hours appointments were available at two sites within the borough, up to 8.30 pm each weekday and between 8.00 am and 8.00 pm on Saturday and Sunday. Patients who had previously registered to use the service could book appointments and order repeat prescriptions online. There was also a 24-hours automated telephone booking system accessible via the practice's main telephone number.

The practice had opted out of providing an out of hours service. Patients calling the practice when it is closed were connected with the local out of hours service provider.

The practice occupied space on the ground and first floor of the Morum House Medical Centre, which it shares with other healthcare services. There was step-free access from the street, a lift and disabled parking spaces were available. The reception and waiting area was shared with the other healthcare services. The practice had use of 24 GPs' consultation rooms and three nurses' treatment rooms, including an isolation room; all were accessible on the ground floor.

Five of the 23 patients' comments cards we received stated that getting appointments was difficult. Six of the 20 patients we spoke with had concerns over telephone access and seven mentioned difficulty in getting appointments. Seven also said they did not get to see the GP of their choice; and eight told us that they had experienced delays of between 15 and 30 minutes to see a GP. Their comments were borne out by the results from the national GP patient survey. These showed that patients' satisfaction with how they could access care and treatment was significantly lower than local and national averages. For example –

- 61% of patients were satisfied with the practice's opening hours, compared with the CCG average of 76% and the national average of 76%. (Down from 67% in 2016)
- 32% of patients said they could get through easily to the practice by phone, compared to the CCG average of 69% and the national average of 71%. (Up from 31%)

Inadequate

Are services responsive to people's needs?

(for example, to feedback?)

- 66% of patients were able to get an appointment to see or speak to someone the last time they tried, compared with the CCG average of 81% and the national average of 84%. (Down from 71%)
- 63% of patients said their last appointment was convenient, compared with the CCG average of 76% and the national average of 81%. (Down from 82%)
- 47% of patients described their experience of making an appointment as good, compared with the CCG average of 69% and the national average of 73%. (Up from 40%)
- 33% of patients said they don't normally have to wait too long to be seen, compared with the CCG average of 51% and the national average of 58%. (Up from 31%)
- 38% of patients said they usually wait 15 minutes or less after their appointment time to be seen, compared with the CCG average of 55% and the national average of 64%. (Down from 41%)

The practice showed us two sets of its results from the Friends and Family Test (FFT). The first, covering the period July 2016 – June 2017, were collated from 104 response cards patients had completed. These indicated that 67 patients would recommend the service, while 22 would not. The second set of figures involved a larger sample of 722 patients, who had responded to the FFT by text between March and July 2017. These presented similar overall results, with 471 (approx. 65%) patients stating they would recommend the service, and 165 (approx. 23%) saying they would not. This second data set showed that in March 2017 around 27% of patients would recommend the service; this rose to 70% in April and 80% in May, before falling again to around 40% in June and July. Seventy-four patients responding to the FFT also submitted comments; 46 were positive regarding the service, particularly about some of the GPs. But 28 mentioned problems with the phone system, such as waiting for an average of 15-20, sometimes 30, minutes to speak with a staff member; long queues at reception, often waiting 25 minutes; appointment delays of up to 45 minutes; and taking up to four weeks to get an appointment.

Listening and learning from concerns and complaints

The practice had a system for handling complaints and concerns, but evidence showed it had not consistently implemented changes as a result of concerns and complaints submitted.

- Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England.
- There was a designated responsible person who handled all complaints in the practice.
- We saw that information was available to help patients understand the complaints system. For example posters were displayed in the reception area, together with leaflets and information was provided on the practice website.

We saw data that had been submitted by the practice to NHS England in June 2017. This showed that 31 complaints, some with multiple issues, had been received in the last 12 months. Of these, 21 had been identified as relating to communications issues. The practice had done a separate analysis of complaints, which showed that five related to communications; six were regarding problems getting appointments and 14 were over "staff attitude / behaviour / values". Although, as a consequence of monitoring complaints and other feedback, the need for additional staff training had been identified by the practice, it had not yet been provided.

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 previous comprehensive inspection in August 2015, we had found that the practice was providing a well-led service and rated this key question as good.

At this inspection, we found that the delivery of high-quality care was not assured by the leadership, governance or culture in place. Significant issues that threaten the delivery of safe and effective care were not identified or adequately managed. There were low levels of staff satisfaction. There was poor collaboration or co-operation between teams.

Vision and strategy

The practice had a written mission statement, as follows, but there were no detailed or realistic plans to achieve this -

- Provide a service which puts patient welfare first.
- Work within the framework of NHS Primary Care Services to provide professional medical, nursing and other services which meet the identified needs of patients.
- Promote best practice through utilizing specialist expertise within the practice team and externally and encouraging the continuous professional development of all members of the practice team.
- Nurture a culture which is innovative, forward looking and adaptable.
- Take into account the evidence provided by scientific and medical research in our treatment.

Governance arrangements

The practice did not have an effective governance framework which supported the delivery of the strategy and good quality care.

- Partner GPs had lead roles in key areas, such clinical governance, safeguarding, etc. But following a re-organisation of the administrative structure, staff members were not fully aware of their own roles and responsibilities. This had led, for example, to the practice's monitoring process of patients' two-week referrals to lapse.
- The practice had specific governance policies, which were reviewed on a regular basis and were available to all staff. However, we found that these were not implemented consistently. For example, the practice's training protocol set out various mandatory training areas for staff, but evidence showed not all the training was completed. Arrangements for actioning safety alerts and implementing relevant guidance were not effective. Appropriate standards of practice such as reviewing, actioning and recording correspondence and documentation in a timely manner were not maintained.

Leadership and culture

Several staff members we spoke with said that staff morale was very low. Changes intended to improve performance and governance had been introduced without sufficient consultation, planning and training being provided. Staff told us that factions had developed. Relations, collaboration and co-operation between the teams were poor. This was conceded by partner GPs, who told us that efforts were continuing to improve staff relations and working practices. A consultancy had been engaged to work with the practice to help bring about improvement. We saw that initial "fact finding" meetings had taken place in March 2017, but there seemed to have been little progress since. The practice had also obtained support from a human resources advisory company during 2016 / 17. The practice told us after the inspection that this process is on-going.

Staff were aware of the need to ensure compliance with the requirements of the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment). From the five significant events records we reviewed, we found that the practice had systems to ensure that when things went wrong with care and treatment:

- The practice gave affected people reasonable support, truthful information and a verbal and written apology.
- The practice kept written records of verbal interactions as well as written correspondence.

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

There was an active patient participation group, which met once a month, with generally between six and eight patients attending. We spoke with two members of the PPG, who were positive regarding the practice's engagement with the group. They told us the practice was open and honest with the group, sharing information regarding learning from complaints. They told us the

Are services well-led?

Inadequate

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

complaint process was both accessible and effective. But we noted that the need for staff training identified from a review of complaints had not yet been addressed. The PPG members told that the renewal of the phone system in 2015 had come about in part due to suggestions the group had made and that the group had been involved in discussions regarding choosing the new system.

Although staff told us they were able to raise concerns and suggestions regarding possible improvements, they did not feel confident that they would be acted upon effectively.

Continuous improvement

We saw little evidence of innovation or service development. There was minimal evidence of learning and reflective practice.

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 Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **The registered persons had not done all that was reasonably practicable to identify and mitigate risks to the health and safety of service users receiving care and treatment. In particular -** • The registered persons did not ensure there was a system in place to identify and support vulnerable children and adults and ensure safeguards were in place. For example, staff were not able demonstrate that all vulnerable patients could be identified on the clinical system to ensure that staff at the practice were able to carry out safeguarding responsibilities. Staff could not demonstrate that information was shared appropriately. • There was insufficient evidence that all staff had received appropriate training in safeguarding, mental capacity and consent, infection prevention and control and fire safety. • There had been no infection prevention and control audit since January 2016 • There were inadequate arrangements to ensure the proper and safe management of medicines. For example, there was no process for monitoring prescriptions left uncollected by patients. • Insecure working practices increased the possibility of allowing unauthorised persons to access patients' medical records. **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	Regulation 17 HSCA (RA) Regulations 2014 Good governance

This section is primarily information for the provider

Enforcement actions

Maternity and midwifery services

Surgical procedures

Treatment of disease, disorder or injury

There were inadequate systems or processes to enable the registered persons to assess, monitor and improve the quality and safety of the services being provided. For example -

- There was not an effective process to ensure that clinicians were aware of relevant and current evidence-based guidance and standards. Arrangements for actioning safety alerts and implementing relevant guidance were not effective. There was no monitoring of patients referred for two-week secondary consultations. Appropriate standards of practice such as reviewing, actioning and recording correspondence and documentation in a timely manner were not maintained.
- Published data from the GP patient survey showed that patient satisfaction with access to the service was significantly below average. There had been no improvement made since our inspection in August 2015 and there were no detailed or realistic plans to achieve improvement.

There were inadequate systems or processes to enable the registered persons to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk. For example –

- The practice's training protocol was not being followed. Examples of overdue training included infection prevention and control, safeguarding, fire safety and capacity to consent to treatment. Staff had not been sufficiently trained in new ways of working. Annual appraisals for non-clinical staff were overdue by three months.

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