Bayswater Medical Centre

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Bayswater Medical Centre on 3 February 2016. The overall rating for the practice was requires improvement. The full comprehensive report on the 3 February 2016 inspection can be found by selecting the 'all reports' link for Bayswater Medical Centre on our website at www.cqc.org.uk.

This inspection was an announced comprehensive inspection carried out on 27 July 2017 to confirm that the practice had carried out their plan to meet the legal requirements in relation to the breaches in regulations that we identified in our previous inspection on 3 February 2016. This report covers our findings in relation to those requirements and any improvements made since our last inspection.

Overall the practice is remains rated as requires improvement.

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

- Although risks to patients were assessed, the systems to address these risks were not implemented well enough to ensure patients were kept safe. For example, we found concerns in relation to infection prevention and control, medicines management, recruitment processes, staff training and appraisals.
- There was an open and transparent approach to safety and a system in place for reporting and recording significant events.
- Staff were aware of current evidence based guidance and were trained to provide them with the skills and knowledge to deliver effective care and treatment. However, clinical protocols were not available to support the scope of responsibility undertaken by the healthcare assistants.
- Patients we spoke with told us they were treated with compassion, dignity and respect and were involved in their care and decisions about their treatment.

Summary of findings

- Information about services and how to complain was available. Improvements were made to the quality of care as a result of complaints and concerns.
- Patients we spoke with said they found it easy to make an appointment with a named GP and there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.
- The provider was aware of the requirements of the duty of candour. Examples we reviewed showed the practice complied with these requirements.

The areas where the provider must make improvement are:

- Ensure care and treatment is provided in a safe way to patients.
- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.
- 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.

The areas where the provider should make improvement are:

- Consider the infection control lead undertaking enhanced training to support them in this extended role.
- Address all actions identified in the fire, health and safety and Legionella risk assessments.
- Continue to monitor patient outcomes in relation to the childhood immunisation programme.
- Review how carers are identified and recorded on the clinical system to ensure information, advice and support is made available to them.

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?

Requires improvement

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

- Although risks to patients were assessed, the systems to address these risks were not implemented well enough to ensure patients were kept safe. For example, we found concerns in relation to infection prevention and control, medicines management and recruitment processes.
- From the sample of documented examples we reviewed, we found there was an effective system for reporting and recording significant events; lessons were shared to make sure action was taken to improve safety in the practice. When things went wrong patients were informed as soon as practicable, received reasonable support, truthful information, and a written apology. They were told about any actions to improve processes to prevent the same thing happening again.
- Staff demonstrated that they understood their responsibilities in relation to safeguarding children and vulnerable adults. However, the practice could not demonstrate that all staff had received training relevant to their role.
- The practice had adequate arrangements to respond to emergencies and major incidents.

Are services effective?

Requires improvement

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

- Data from the Quality and Outcomes Framework (QOF) showed patient outcomes were comparable to the clinical commissioning group (CCG) and the national average.
- Staff were aware of current evidence based guidance and had the skills and knowledge to deliver effective care and treatment. However, clinical protocols were not available to support the scope of responsibility undertaken by healthcare assistants.
- Clinical audits demonstrated quality improvement.
- There was evidence of appraisals for non-clinical staff and the healthcare assistants but the practice did not have an appraisal system for its substantive GPs.
- Staff worked with other health care professionals to understand and meet the range and complexity of patients' needs.
- End of life care was coordinated with other services involved.

Summary of findings

Are services caring?

Good

The practice is rated as good for providing caring services.

- Data from the national GP patient survey showed patients rated the practice comparable to others for several aspects of care.
- Survey information we reviewed showed that patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment which was echoed by patients we spoke with on the day.
- Information for patients about the services available was accessible.
- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services.

- The practice understood its population profile and had used this understanding to meet the needs of its population.
- The practice took account of the needs and preferences of patients with life-limiting conditions, including patients with a condition other than cancer and patients living with dementia.
- Patients we spoke with said they found it easy to make an appointment with a named GP and there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- Information about how to complain was available and evidence from two examples reviewed showed the practice responded quickly to issues raised.

Are services well-led?

Requires improvement

The practice is rated as requires improvement for being well-led.

- The practice told us they had a vision to deliver high quality care and promote good outcomes for patients. However, there was no written strategy or supporting business plan that detailed the short and long-term development objectives that the practice wanted to achieve.
- Although risks to patients were assessed, the systems to address these risks were not implemented well enough to ensure patients were kept safe.
- The practice proactively sought feedback from staff and patients and we saw examples where feedback had been acted on. The practice engaged with the patient participation group.
- There was a leadership structure and staff told us they felt supported by management.

Summary of findings

- The provider was aware of the requirements of the duty of candour. In examples we reviewed we saw evidence the practice complied with these requirements.
- The partners encouraged a culture of openness and honesty.

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

Requires improvement

The provider was rated as requires improvement for safe, effective and well-led. The issues identified as requiring improvement overall affected all patients including this population group. However, there was evidence of some good practice.

- Staff were able to recognise the signs of abuse in older patients and knew how to escalate any concerns.
- The practice offered proactive, personalised care to meet the needs of the older patients in its population.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs.
- The practice identified at an early stage older patients who may need palliative care as they were approaching the end of life. It involved older patients in planning and making decisions about their care, including their end of life care.
- The practice followed up on older patients discharged from hospital and ensured that their care plans were updated to reflect any extra needs.
- Older patients were provided with health promotional advice and support to help them to maintain their health and independence for as long as possible. In addition, patients requiring additional support could be referred to a Primary Care Navigator who helped signpost patients to health, social care and voluntary sector services.

People with long term conditions

Requires improvement

The provider was rated as requires improvement for safe, effective and well-led. The issues identified as requiring improvement overall affected all patients including this population group. However, there was evidence of some good practice.

- Clinical staff had lead roles in long-term disease management and patients at risk of hospital admission were identified as a priority.
- Performance for diabetes related indicators was comparable to the CCG and national averages. For example, the percentage of patients with diabetes, on the register, in whom the last HbA1c was 64 mmol/mol or less in the preceding 12 months was 69% (CCG average 74%; national average 78%) and the percentage

Summary of findings

of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less was 79% (CCG average 76%; national average 78%).
- The practice followed up on patients with long-term conditions discharged from hospital and ensured that their care plans were updated to reflect any additional needs.
- All these patients had a named GP and there was a system to recall patients for a structured annual review to check their health and medicines needs were being met. For those patients with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Requires improvement

The provider was rated as requires improvement for safe, effective and well-led. The issues identified as requiring improvement overall affected all patients including this population group. However, there was evidence of some good practice.

- There were systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances.
- Immunisation rates were below target for standard childhood immunisations.
- Appointments were available outside of school hours and the premises were suitable for children and babies.
- The practice worked with midwives, health visitors and school nurses to support this population group. For example, in the provision of ante-natal, post-natal and child health surveillance clinics.
- 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 was 76% which was comparable to the CCG average of 77% and the national average of 76%.
- The practice's uptake for the cervical screening programme was 88%, which was comparable to the CCG average of 75% and the national average of 81%.
- The practice promoted chlamydia testing for the 15-24 year old cohort.

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Working age people (including those recently retired and students)

Requires improvement

The provider was rated as requires improvement for safe, effective and well-led. The issues identified as requiring improvement overall affected all patients including this population group. However, there was evidence of some good practice.

- The needs of these populations had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care, for example, telephone appointments and extended opening hours on Tuesday and Wednesday from 6.30pm to 8pm and on Saturday from 9am to 1pm.
- The practice offered on online services which included appointment booking, repeat medication requests and access to Summary Care Record (an electronic summary of key clinical information such as medicines, allergies and adverse reactions about a patient sourced from the GP record).

People whose circumstances may make them vulnerable

Requires improvement

The provider was rated as requires improvement for safe, effective and well-led. The issues identified as requiring improvement overall affected all patients including this population group. However, there was evidence of some good practice.

- The practice held a register of patients living in vulnerable circumstances including those with a learning disability.
- The practice offered longer appointments for patients with a learning disability.
- Clinical and non-clinical staff had undertaken learning disabilities awareness training.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice regularly worked with other health care professionals in the case management of vulnerable patients.
- The practice had information available for vulnerable patients about how to access various support groups and voluntary organisations.
- Staff interviewed knew how to recognise signs of abuse in children, young people and adults whose circumstances may make them vulnerable. They were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

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People experiencing poor mental health (including people with dementia)

Requires improvement

The provider was rated as requires improvement for safe, effective and well-led. The issues identified as requiring improvement overall affected all patients including this population group. However, there was evidence of some good practice.

- The practice carried out advance care planning for patients living with dementia.
- Patients at risk of dementia were identified and offered an assessment.
- The percentage of patients diagnosed with dementia who had had their care reviewed in a face-to-face meeting in the last 12 months was 93% based on 28 patients which was comparable to the CCG average of 85% and the national average of 84%.
- Performance for mental health related indicators was comparable to the CCG and national averages. For example, 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 was 86% (CCG average 91%; national average of 89%) and the percentage of patients with schizophrenia, bipolar affective disorder and other psychoses whose alcohol consumption has been recorded in the preceding 12 months was 95% (CCG average 89%; national average 89%.)
- The practice had a system for monitoring repeat prescribing for patients receiving medicines for mental health needs.
- The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those living with dementia.
- The practice had information available for patients experiencing poor mental health about how they could access various support groups and voluntary organisations.
- Staff interviewed had a good understanding of how to support patients with mental health needs and dementia and we saw staff had undertaken dementia awareness training.

Summary of findings

What people who use the service say

The national GP patient survey results were published in July 2017 for the most recent data. Three hundred and ninety survey forms were distributed and 73 were returned. This represented 1% of the practice's patient list and a completion rate of 19%.

- 72% of patients described the overall experience of this GP practice as good compared with the clinical commissioning group (CCG) average of 85% and the national average of 85%.
- 73% of patients described their experience of making an appointment as good compared with the CCG average of 77% and the national average of 73%.
- 71% of patients said they would recommend this GP practice to someone who has just moved to the local area as compared with the CCG average of 81% and the national average of 77%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 34 comment cards of which 32 were positive about the standard of care received. Patients said they felt the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect.

We spoke with six patients during the inspection all of whom said they were highly satisfied with the care they received and told us they felt the practice offered an excellent service. They told us they thought the practice staff were approachable, committed and caring.

The practice had undertaken its own internal survey in June 2017 to supplement the national GP survey. One hundred and thirty seven surveys were returned. The outcome of the survey showed:

- 96% of patients described the opening hours of the practice to be excellent or very good.
- 85% of patients described the quality of care by the doctor during the consultation to be excellent or very good.
- 84% of patients described the quality of care by the nurse during the consultation to be excellent or very good.
- 79% of patients described the helpfulness of receptionists to be excellent or very good.
- 98% of patients said they would definitely recommend the surgery to friends and family.

Areas for improvement

Action the service MUST take to improve

- Ensure care and treatment is provided in a safe way to patients.
- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.
- 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.

Action the service SHOULD take to improve

- Consider the infection control lead undertaking enhanced training to support them in this extended role.
- Address all actions identified in the fire, health and safety and Legionella risk assessments.
- Continue to monitor patient outcomes in relation to the childhood immunisation programme.
- Review how carers are identified and recorded on the clinical system to ensure information, advice and support is made available to them.

Bayswater Medical Centre

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.

Background to Bayswater Medical Centre

Bayswater Medical Centre operates from 46 Craven Road, London W2 3QA. The practice has access to six consulting room, three are located on the ground floor and three in the basement. The basement is accessible by stairs.

The practice provides NHS primary care services to approximately 7,200 patients and operates under a Personal Medical Services (PMS) contract (an alternative to the standard GMS contract used when services are agreed locally with a practice which may include additional services beyond the standard contract). The practice is part of NHS West London Clinical Commissioning Group (CCG).

The practice is registered as a partnership with the Care Quality Commission (CQC) to provide the regulated activities of diagnostic and screening procedures, treatment of disease, disorder or injury, maternity and midwifery services, family planning and surgical procedures.

The practice staff comprises of a principal GP (eight sessions per week) and two male and one female salaried GP (totalling 14 sessions per week). The clinical team is supported by two healthcare assistants and a locum practice nurse one day a week. There is a full-time practice manager who is a non-clinical partner and five administration/reception staff.

The practice is open between 8am and 6:30pm Monday to Friday. Extended hours appointments are available on Tuesday and Wednesday from 6.30pm to 8pm and Saturday from 9am to 1pm. Appointments are available on Mondays, Thursdays and Fridays from 8am to 1pm and 2pm to 6:30pm and on Tuesday and Wednesday from 8am to 1pm and 2pm to 8pm.

Why we carried out this inspection

We undertook an announced comprehensive inspection at Bayswater Medical Centre on 3 February 2016 under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The overall rating for the practice was requires improvement. The full comprehensive report on the 3 February 2016 inspection can be found by selecting the 'all reports' link for Bayswater Medical Centre on our website at www.cqc.org.uk.

We undertook a follow-up announced comprehensive inspection of Bayswater Medical Centre on 27 July 2017. This inspection was carried out to review in detail the actions taken by the practice to improve the quality of care and to confirm that the practice was now meeting legal requirements.

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 27 July 2017. During our visit we:

Detailed findings

- Spoke with a range of staff which included the principal GP, salaried GPs, healthcare assistant, practice manager and reception and administration staff.
- 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.
- Spoke with patients who used the service and reviewed comment cards where patients and members of the public shared their views and experiences of the service.
- Inspected the facilities, equipment and premises.
- Reviewed a wide range of documentary evidence including policies, written protocols and guidelines, recruitment and training records, safeguarding referrals, significant events, patient survey results, complaints, meeting minutes and performance data.

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.

Requires improvement

Are services safe?

Our findings

At our previous inspection on 3 February 2016, we rated the practice as requires improvement for providing safe services as the arrangements in respect of medicines management required improvement.

Although the practice had addressed the findings of our previous inspection in relation to medicines management, we found additional concerns in relation to infection prevention and control, medicines management and recruitment processes on our inspection on 27 July 2017. The practice remains rated as requires improvement for providing safe services.

Safe track record and learning

There was a system for reporting and recording significant events.

- There was a lead for significant events and staff had access to an operational policy. 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).
- Staff told us that significant events were discussed in practice meetings and we saw evidence of minutes of meetings where these had been discussed.
- The practice had recorded 18 significant events for the past 12 months. From a sample we reviewed we found that when things went wrong with care and treatment, patients were informed of the incident as soon as reasonably practicable, received reasonable support, truthful information, a written apology and were told about any actions to improve processes to prevent the same thing happening again.
- We saw evidence that lessons were shared and action was taken to improve safety in the practice. For example, the practice had reviewed its patient identification process and reinforced the need to check at least three identification parameters, for example, name, date of birth and NHS number following an error with the identification of a patient.

The practice had a system in place for the receipt and dissemination of patient safety alerts and MHRA (Medicines and Healthcare Regulatory Agency) alerts. We saw that the practice maintained a log of alerts received and action taken. We reviewed minutes of meetings where alerts had been discussed.

Overview of safety systems and processes

The practice had systems, processes and practices in place to minimise risks to patient safety.

- Arrangements for safeguarding reflected relevant legislation and local requirements. Policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. There was a lead member of staff for safeguarding and staff we spoke with knew who this was. The GPs told us they attended safeguarding meetings when possible or provided reports where necessary for other agencies.
- Staff interviewed demonstrated they understood their responsibilities regarding safeguarding and had received training on safeguarding children and vulnerable adults. GPs were trained to child safeguarding level three and administration staff to level one. It was noted that the practice had only provided level one safeguarding children training for a healthcare assistant. The guidelines 'Safeguarding Children and Young People: roles and competencies for health care staff' sets out competencies all health staff must have, and the minimum training requirements necessary, to recognise child maltreatment and take effective action as appropriate to their role. The minimum level required for healthcare assistants is safeguarding level two.
- We observed safeguarding key contact details and referral flowcharts displayed in consultation and treatment rooms.
- There was a chaperone policy and guidance available to staff. Notices were visible around the practice to advise patients that chaperones were available if required, which included access to male and female chaperones. All staff who acted as chaperones 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). We saw that all staff who regularly acted as a chaperone had been trained and understood their role and responsibilities when chaperoning.

Although the practice had processes in place to maintain standards of cleanliness and hygiene these required improvement.

- The practice engaged an external cleaning contractor and we saw cleaning schedules were in place. However, we found evidence of low level dust in some of the consulting rooms. There was a dedicated cleaning store cupboard situated in a patient accessible area which was cluttered and unlocked and there was inadequate storage and segregation of cleaning mops which posed a risk of cross-contamination. Furthermore, we found some mops and buckets used for cleaning were stored at the bottom of an external dirty stairwell.
- Clinical waste, awaiting collection, was stored in an approved clinical waste wheelie bin located in a patient accessible area. We observed on the day of the inspection that this was unlocked.
- We observed that each consulting room had information displayed on good handwashing techniques, how to deal with a sharps injury and was well equipped with personal protective equipment and waste disposal facilities. All staff we spoke with knew the location of the bodily fluid spill kits and had access to appropriate personal protective equipment when handling specimens at the reception desk.
- The practice had nominated one of the healthcare assistants as infection prevention and control (IPC) clinical lead supported by the principal GP and the practice manager. There was an IPC protocol in place and separate protocols for waste management and the safe handling of sharps and spillages. We saw that these were accessible to staff.
- We saw evidence that all staff had undertaken on-line IPC training. However, the lead for IPC had not undertaken any enhanced training to support the responsibilities of the role.
- An IPC audit had been undertaken in July 2017 by the healthcare assistant. The audit did not include an action plan to evidence that action had been taken to address the improvements identified. We noted that although the IPC audit reviewed clinical waste procedures it had not alerted the practice to the fact that clinical staff did not have access to all the appropriate colour-coded sharps containers required for the range of medicines administered. Furthermore, the audit had not recorded that some of the consulting rooms floors were damaged and some work surfaces chipped which posed an infection control risk. We saw that some consultation rooms had fabric chairs which were visibly stained and dirty.
- The practice could not provide an up-to-date immunisation record for its clinical staff in direct patient contact, for example, hepatitis B, measles, mumps and rubella.

Although there were arrangements in place for managing medicines, including emergency medicines and vaccines to minimise risks to patient safety (including obtaining, prescribing, recording, handling, storing, security and disposal) these required improvement.

- Although there were processes in place for handling repeat prescriptions, there was no formal process in place for the management of high risk medicines such as warfarin, methotrexate and other disease-modifying anti-rheumatic drugs (DMARDs) in line with guidance. For example, the practice did not have a mechanism in place to check patients had up-to-date blood tests before repeat prescriptions were issued.
- Patient Group Directions had been adopted by the practice to allow the locum practice nurse to administer medicines in line with legislation and we saw that these had been signed. Healthcare assistants had been trained to administer some vaccines and medicines. However, there were no Patient Specific Directions (PSDs) in place. A PSD is a specific, written order by a qualified prescriber who retains responsibility for the safe administration of the vaccine.
- The practice carried out regular medicines audits, with the support of the local clinical commissioning group pharmacy teams, to ensure prescribing was in line with best practice guidelines for safe prescribing.
- Blank prescription forms and pads were securely stored and there were systems to monitor their use.
- There were dedicated vaccine storage refrigerators with built-in thermometer and we saw evidence that the minimum, maximum and actual temperatures were recorded daily. However, the practice were not aware of Public Health England's Protocol for ordering, storing and handling vaccines (March 2014) which states all vaccine fridges should ideally have two thermometers, one of which is a maximum and minimum thermometer

independent of mains power. If only one thermometer is used, then a monthly check should be considered to confirm that the calibration is accurate. The practice had not considered this recommendation and could not demonstrate regular calibration. During our previous inspection on 3 February 2016 we found some boxes of vaccines within the fridge had exceeded their expiry date. At the time of our inspection we found all medicines stored within the fridge were within their expiry date.

We reviewed five personnel files of substantive staff 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. However, we noted that one of the healthcare assistants only had a standard DBS check and not an enhanced DBS check in line with practice policy. Furthermore, the practice had not carried out appropriate recruitment checks for a locum GP.

Monitoring risks to patients

There were procedures for assessing, monitoring and managing risks to patient and staff safety.

- There was a health and safety policy available and a health and safety poster.
- We saw that the practice had engaged an external organisation the week before our inspection to undertake risk assessments for health and safety, disability access, fire and Legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings). Each assessment identified an action plan to be undertaken within a risk rated timeframe. For example, low risk to be completed within six months, moderate risk to be completed within one month and high risk to be completed immediately. The practice told us they were currently addressing each of the recommendations made in each assessment.
- There was a fire alarm warning system and firefighting equipment in place and these were regularly maintained by an external contractor. There was a fire policy in place and the practice had identified fire marshals. We saw that staff had undertaken on-line fire awareness training and all staff we spoke with knew who the fire marshals were and the location of the fire evacuation assembly point. However, staff told us that there had not been a test fire evacuation drill for more than a year. We observed that this was a recommendation of the fire risk assessment.
- Each clinical room was appropriately equipped and we saw evidence that the equipment was maintained. This included checks of electrical equipment and equipment used for patient examinations. We saw evidence of calibration of equipment used by staff was undertaken annually and was tested in June 2017 and that portable electrical appliances had also been checked in June 2017. The practice could not provide evidence of recent electrical wire testing. We noted that this was a recommendation of the fire risk assessment. The boiler was maintained on an annual basis and had been last serviced in May 2017.
- There were arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. At the time of our inspection two salaried GPs were leaving the practice. The practice told us they would utilise locum GPs until they were able to recruit substantive staff.

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. All staff we spoke with knew how to activate and respond to this.
- The practice had a defibrillator available on the premises and oxygen with adult and children's masks. All staff had received basic life support training.
- A first aid kit and accident book were available.
- 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.
- The practice had a comprehensive business continuity plan for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff. The practice had established a 'buddy' system with a neighbouring practice.

Requires improvement

Are services effective?

(for example, treatment is effective)

Our findings

At our previous inspection on 3 February 2016, we rated the practice as requires improvement for providing effective services as some patient outcome data required improvement.

Although the practice had made improvements in its patient outcome data, we found additional concerns when we undertook a follow up inspection on 27 July 2017 in relation to staff training, GP appraisals and clinical protocols. The practice remains rated as requires improvement for providing effective services.

Effective needs assessment

Clinicians were aware of relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines.

- The practice had systems to keep all clinical staff up to date. Staff had access to guidelines from NICE and used this information to deliver care and treatment that met patients' needs.
- The practice did not have a system in place to monitor that these guidelines were followed. For example, through risk assessments, audits and random sample checks of patient records.

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 recent published results were 96% of the total number of points available (CCG 91%; national 95%) with 7.5% overall exception reporting (CCG 6%; national average 6%). (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).

This practice was not an outlier for any QOF (or other national) clinical targets. Data from 2015/16 showed:

At our previous inspection on 3 February 2016 we found that performance for diabetes-related indicators was below local and national averages. At our inspection on 27 July 2017 we found performance for diabetes-related indicators was statistically comparable to the CCG and national averages. For example:

- The percentage of patients with diabetes, on the register, in whom the last HbA1c was 64 mmol/mol or less in the preceding 12 months was 69% (CCG average 74%; national average 78%) with a practice exception reporting of 8% (CCG average 12%; national 12%);
- The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less was 79% (CCG average 76%; national average 78%) with a practice exception reporting of 8% (CCG average 10%; national average 9%);
- The percentage of patients with diabetes, on the register, whose last measured total cholesterol (measured within the preceding 12 months) is 5 mmol/l or less was 75% (CCG average 76%; national average 80%) with a practice exception reporting of 6% (CCG average 11%; national average 13%).

At our previous inspection on 3 February 2016 we found that performance for mental health related indicators was below local and national averages. At our inspection on 27 July 2017 we found performance for mental health-related indicators was statistically comparable to the CCG and national averages. For example:

- 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 was 86% based on 64 patients (CCG average 91%; national average of 89%) with a low practice exception reporting of 2% (CCG average 9%; national average 13%);
- The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses whose alcohol consumption has been recorded in the preceding 12 months was 95% (CCG average 89%; national average 89%) with a low practice exception reporting of 2% (CCG average 7%; national average 10%);
- The percentage of patients diagnosed with dementia who had had their care reviewed in a face-to-face meeting in the last 12 months was 93% based on 28 patients (CCG average 85%; national average 84%) with a practice exception reporting of 4% (CCG average 7%; national average 7%).

Requires improvement

Are services effective?

(for example, treatment is effective)

Performance for respiratory-related indicators was statistically comparable to the CCG and national averages. For example:

- 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 was 76% (CCG average 77%; national average 76%) with a practice exception reporting of 4% (CCG average 4%; national average 8%);
- The percentage of patients with chronic obstructive pulmonary disease (COPD) who had a review undertaken including an assessment of breathlessness was 92% (CCG average 89%; national average 90%) with a practice exception reporting of 5% (CCG average 11%; national average 12%);
- The percentage of patients with physical and/or mental health conditions whose notes record smoking status in the preceding 12 months was 96% (CCG average 95%; national average 95%) with a practice exception reporting of 0.7% (CCG average 1.2%; national average 0.8%).

There was evidence of quality improvement including clinical audit:

- There had been four clinical audits commenced in the last two years, all of which were completed audits where the improvements made were implemented and monitored.
- Findings were used by the practice to improve services. For example, an audit was undertaken on patients with atrial fibrillation (an irregular and often very fast heart rate) to ensure there was a recorded assessment of stroke and bleeding risk in their clinical records in line with guidance. The first cycle of the audit found 51% of patients surveyed had an assessment of bleeding risk and 52% of patients had an assessment of stroke risk recorded in their clinical records. The second cycle audit showed an improvement with 97% of patients surveyed had an assessment of bleeding risk and 100% of patients had an assessment of stroke risk recorded in their clinical records.

Effective staffing

Although we found that staff had the skills and knowledge to deliver effective care and treatment this required improvement.

- The practice had an induction programme for all newly appointed substantive staff and locum GPs. This covered such topics as significant event procedure, fire safety, emergency procedures, health and safety and confidentiality.
- The practice could demonstrate how they ensured role-specific training and updating for relevant staff and we saw that healthcare assistants had been trained to undertake services under an out of hospital initiative, such as electrocardiograms (ECGs) wound care, ambulatory blood pressure monitoring and spirometry. However, although staff told us that patients would be referred to the doctor if there were any concerns, there were no clinical protocols available outlining the framework for the management of specific clinical situations or definition of circumstances where patients should be referred to a GP for further assessment.
- Staff administering vaccines and taking samples for the cervical screening programme had received specific training which had included an assessment of competence.
- The learning needs of staff were identified through a system of appraisals. Staff had access to appropriate training to meet their learning needs and to cover the scope of their work. All non-clinical staff and the healthcare assistants had received an appraisal within the last 12 months. However, the practice did not have an appraisal system in place for its substantive GPs.
- Staff had access to and made use of e-learning training modules and in-house training.

Although the majority of substantive staff had received training which included safeguarding, fire safety awareness, basic life support and information governance we found the practice could not demonstrate any training undertaken for one substantive GP and a locum GP. We found that one of the healthcare assistants had not been trained to the appropriate level for safeguarding children.

Coordinating patient care and information sharing

The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practice's patient record system and their intranet system.

- This included care and risk assessments, care plans, medical records and investigation and test results.

Requires improvement

Are services effective?

(for example, treatment is effective)

- From the sample of documented examples we reviewed we found that the practice shared relevant information with other services in a timely way, for example when referring patients to other services.
- The practice used an IT interface system which enabled patients' electronic health records to be transferred directly and securely between GP practices. This improved patient care as GPs would have full and detailed medical records available to them for a new patient's first consultation.
- The practice maintained a register of its two-week wait referrals and had a system in place to verify that the referral had been received by the hospital. However, there was no system in place to ensure that the patient had received an appointment or had attended for an appointment. Two-week wait referral data showed that the percentage of new cancer cases (among patients registered at the practice) who were referred using the urgent two-week wait referral pathway was 71% which was above the CCG average of 46% and the national average of 49%. This gives an estimation of the practice's detection rate, by showing how many cases of cancer for people registered at a practice were detected by that practice and referred via the two-week wait pathway. Practices with high detection rates will improve early diagnosis and timely treatment of patients which may positively impact survival rates.

Staff worked together and with other health and social care professionals to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. This included when patients moved between services, including when they were referred, or after they were discharged from hospital. Information was shared between services, with patients' consent, using a shared care record. Meetings took place with other health care professionals when care plans were routinely reviewed and updated for patients with complex needs.

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

Consent to care and treatment

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

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

Supporting patients to live healthier lives

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

- Patients receiving end of life care, carers, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation were signposted to the relevant service.
- A Primary Care Navigator was attached to the practice and could help signpost patients to health, social care and voluntary sector services.

At our inspection on 3 February 2016 we found that the practice's uptake for the cervical screening programme was 72% which was below the national average of 82%, At our inspection on 27 July 2017 we found the practice had improved its uptake to 88% (CCG average 75%; national average 81%). There was a policy to offer telephone and text reminders for patients who did not attend for their cervical screening test. There were failsafe systems to ensure results were received for all samples sent for the cervical screening programme and the practice followed up women who were referred as a result of abnormal results. The practice encouraged its patients to attend national screening programmes for bowel and breast cancer.

Childhood immunisations were carried out in line with the national childhood vaccination programme. Data for childhood immunisation rates for the vaccinations given to the under two year olds for the period 1 April 2015 to 31 March 2016 were below the target of 90% and ranged from 65% to 75%. Immunisation rates for five year olds ranged from 69% to 81% (CCG average from 62% to 83% and national average from 88% to 94%). The practice

Requires improvement

Are services effective?

(for example, treatment is effective)

recognised that this was an area for improvement and were working to improve these rates and had engaged a locum practice nurse and utilised a text appointment reminder service.

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.

Good

Are services caring?

Our findings

At our previous inspection on 3 February 2016, we rated the practice as good for providing caring services. At our follow up inspection on 27 July 2017 we also found the practice was good for providing caring services.

Kindness, dignity, respect and compassion

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

- At our previous inspection curtains were not provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments. The practice had applied for an improvement grant to install curtains rails within the consultation rooms and we saw evidence that these were due to be installed after our inspection. In the meantime, the practice were using portable screens to maintain privacy and dignity.
- We noted 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.
- Patients could be treated by a clinician of the same gender and there were male and female chaperones available.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 34 comment cards of which 32 were positive about the standard of care received. Patients said they felt the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect. The negative comments included getting an appointment to see a GP and perceived rudeness of reception staff.

We spoke with six patients including six members of the patient participation group (PPG) which included the chair and they told us they were highly satisfied with the care provided by the practice and told us they felt the practice offered an excellent service. They told us they thought the practice staff were approachable, committed and caring and said their dignity and privacy was respected at all times. Comments highlighted that staff responded compassionately when they needed help and provided support when required.

Results from the national GP patient survey showed patients felt they were treated with compassion, dignity and respect. The practice was statistically comparable for its satisfaction scores on consultations with GPs and nurses. For example:

- 89% of patients said the GP was good at listening to them compared with the clinical commissioning group (CCG) average of 89% and the national average of 89%.
- 78% of patients said the GP gave them enough time compared to the CCG average of 84% and the national average of 87%.
- 93% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 95% and the national average of 95%.
- 72% of patients said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 86% and the national average of 86%.
- 79% of patients said the nurse was good at listening to them compared with the CCG average of 86% and the national average of 91%.
- 84% of patients said the nurse gave them enough time compared with the CCG average of 88% and the national average of 92%.
- 90% 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 97%.
- 81% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 87% and the national average of 91%.
- 82% of patients said they found the receptionists at the practice helpful compared with the CCG average of 88% 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 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.

Good

Are services caring?

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

- 81% of patients said the last GP they saw was good at explaining tests and treatments compared with the CCG average of 87% and the national average of 86%.
- 71% of patients said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 83% and the national average of 82%.
- 82% of patients said the last nurse they saw was good at explaining tests and treatments compared with the CCG average of 84% and the national average of 90%.
- 71% of patients said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average of 80% and the national average of 85%.

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

- Staff told us that interpretation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patients this service was available. Patients were also told about multi-lingual staff who might be able to support them.
- The practice website had the functionality to translate to other languages and the patient check-in screen was available in other languages aligned to the practice demographic.
- Information leaflets were available in easy read format.
- The Choose and Book service was used with patients as appropriate. (Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital.

Patient and carer support to cope emotionally with care and treatment

Patient information leaflets and notices were available in the patient waiting area which told patients how to access a number of support groups and organisations. Information about support groups was also available on the practice website.

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 49 patients as carers (0.7% 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 experienced bereavement, their usual GP contacted them or sent a letter. This would be 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.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

At our previous inspection on 3 February 2016, we rated the practice as good for providing responsive services. At our follow up inspection on 27 July 2017 we also found the practice was good for providing responsive services.

Responding to and meeting people's needs

The practice understood its population profile and had used this understanding to meet the needs of its population:

- The practice offered extended hours on Tuesday and Wednesday from 6.30pm to 8pm and on Saturday from 9am to 1pm for working patients who could not attend during normal opening hours.
- There were longer appointments available for patients with a learning disability, those requiring an interpreter and those with complex medical needs.
- Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice.
- Same day appointments were available for children and those patients with medical problems that require same day consultation.
- The practice sent text message reminders of appointments.
- Patients were able to receive travel vaccines available on the NHS as well as those only available privately.
- There were accessible facilities, which included a hearing loop, and interpretation services available.
- The waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for access to consultation rooms and was visible from reception. There was enough seating for the number of patients who attended on the day of inspection.
- Patients had access to baby changing and breast feeding facilities.
- A Primary Care Navigator was attached to the practice and could help signpost patients to health, social care and voluntary sector services.

Access to the service

The practice was open between 8am and 6:30pm Monday to Friday. Appointments were available on Mondays, Thursdays and Fridays from 8am to 1pm and 2pm to 6:30pm and on Tuesday and Wednesday from 8am to 1pm and 2pm to 8pm. Extended hours appointments are available on Tuesday and Wednesday from 6.30pm to 8pm and on Saturday from 9am to 1pm.

The practice offered online services which included appointment booking, repeat medication requests and access to Summary Care Record (an electronic summary of key clinical information such as medicines, allergies and adverse reactions about a patient sourced from the GP record).

Results from the national GP patient survey showed that patient's satisfaction with how they could access care and treatment was comparable to local and national averages.

- 83% of patients were satisfied with the practice's opening hours compared with the clinical commissioning group (CCG) average of 79% and the national average of 76%.
- 86% of patients said they could get through easily to the practice by phone compared to CCG average of 84% and the national average of 71%.
- 78% of patients said that the last time they wanted to speak to a GP or nurse they were able to get an appointment compared with the CCG average of 84% and the national average of 84%.
- 76% of patients said their last appointment was convenient compared with the CCG average of 81% and the national average of 81%.
- 73% of patients described their experience of making an appointment as good compared with the CCG average of 77% and the national average of 73%.
- 54% of patients said they don't normally have to wait too long to be seen compared with the CCG average of 59% and the national average of 58%.

Patients told us on the day of the inspection that they were able to get appointments when they needed them.

The practice had a system to assess:

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

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

Listening and learning from concerns and complaints

Good

Are services responsive to people's needs?

(for example, to feedback?)

The practice had a system for handling complaints and concerns.

- 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 staff had received on-line complaints training.
- We saw that information was available to help patients understand the complaints system. For example, a poster in the waiting room and a complaint leaflet and form.

The practice had recorded six complaints in the past 12 months. We found that these had been handled satisfactorily and in a timely manner. We saw evidence of apology letters to patients which included further guidance on how to escalate their concern if they were not happy with the response.

Are services well-led?

Requires improvement

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

Our findings

At our previous inspection on 3 February 2016, we rated the practice as good for providing well-led services. At our follow up inspection on 27 July 2017 we found that the overarching governance framework was not implemented well enough to ensure patients were kept safe.

The practice is now rated as requires improvement for providing well-led services.

Vision and strategy

The practice told us they had a vision to deliver high quality care and promote good outcomes for patients. However, there was no written strategy or supporting business plan that detailed the short and long-term development objectives that the practice wanted to achieve. This had also been a finding of our previous inspection on 3 February 2016.

Governance arrangements

Although the practice had an overarching governance framework which supported the delivery of good quality care, we found some arrangements were not implemented well enough to ensure patients were kept safe. For example:

- Arrangements in relation to infection control did not mitigate the risk of spread of infection.
- There was no effective safety-netting procedure in place to monitor two-week wait referrals.
- There were no effective systems in place to monitor patients on high risk medicines in line with guidance.
- Clinical protocols were not available to support the scope of responsibility undertaken by the healthcare assistants.
- Patient Specific Directions (PSDs) were not in place for healthcare assistants administering vaccines.
- There was no appraisal system in place for general practitioners.
- The practice could not demonstrate that all staff, including locum staff, had received training.
- There was no effective recruitment system in place for locum staff to ensure only fit and proper persons were employed.

However, we found:

- There was a clear staffing structure and that staff were aware of their own roles and responsibilities. GPs and nurses had lead roles in key areas.
- Practice specific policies were implemented and were available to all staff. These were updated and reviewed regularly.
- A comprehensive understanding of the performance of the practice was maintained and we saw improvement on patient outcomes through the Quality and Outcomes Framework (QOF) since our previous inspection on 3 February 2016.
- Clinical audit was used to monitor quality and to make improvements.
- We saw evidence from minutes of a meetings structure that allowed for lessons to be learned and shared following significant events and complaints.

Leadership and culture

The principal GP and practice manager told us they prioritised safe, high quality and compassionate care. Staff told us GPs and the manager were approachable and always took the time to listen to all members of staff.

The provider was aware of and had systems 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). The practice encouraged a culture of openness and honesty. From the sample of documented examples 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.

There was a clear leadership structure and staff we spoke with on the day told us they felt supported by management.

- The practice held a range of multi-disciplinary meetings including meetings with district nurses and social workers to monitor vulnerable patients. GPs, where required, met with health visitors to monitor vulnerable families and safeguarding concerns.
- Staff told us the practice held regular practice meetings and we saw evidence of minutes.

Are services well-led?

Requires improvement

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

- Staff told us there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and felt confident and supported in doing so.
- Staff we spoke with on the day told us they felt respected, valued and supported.

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

The practice encouraged and valued feedback from patients and staff. It proactively sought feedback from:

- The NHS Friends and Family test, complaints, compliments, internal surveys and NHS Choices.
- The patient participation group (PPG) which was active and met quarterly. The PPG members we spoke with told us 10 members were in the group. The agenda was set by the PPG chair and the practice manager and attended by the principal GP and administration staff.
- Staff through appraisals and staff meetings. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management.

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 Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider was failing to ensure that care and treatment was provided in a safe way for patients: • Arrangements in relation to infection control did not mitigate the risk of spread of infection. • Clinical protocols were not available to support the scope of responsibility undertaken by the healthcare assistants. • Patient Specific Directions (PSDs) were not in place for healthcare assistants administering vaccines. 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 Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider was failing to ensure systems and processes are operated effectively to improve the quality and safety of services: • There was no effective safety-netting procedure in place to monitor two-week wait referrals. • There were no effective systems in place to monitor patients on high risk medicines in line with guidance. • There was no effective recruitment system in place for locum staff to ensure only fit and proper persons were employed. • There was no written strategy or supporting business plan that detailed the short and long-term development objectives.

This section is primarily information for the provider

Requirement notices

Regulation 17 (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 Surgical procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing The provider was failing to ensure persons employed in the provision of the regulated activity had received the appropriate support, training, professional development, supervision and appraisal necessary to enable them to carry out the duties. • There was no appraisal system in place for general practitioners. • The practice could not demonstrate that all staff, including locum staff, had received training. This was in breach of regulation 18(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.