The Willows Medical Practice

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?	Good
Are services caring?	Good
Are services responsive to people's needs?	Requires improvement
Are services well-led?	Good

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at The Willows Medical Practice on 13 October 2016 and rated the practice as requires improvement for caring and inadequate for safe, effective, responsive and well-led key questions. This led to an overall rating of inadequate and the practice was placed in special measures. Breaches of legal requirements were found and requirement notices were issued in relation to patient safety, staffing and governance. The full comprehensive report can be found by selecting the http://www.cqc.org.uk/location/1-572070226 link for The Willows Medical Practice on our website at www.cqc.org.uk.

This inspection was an announced comprehensive inspection which we undertook on 11 October 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 13 October 2016. This report covers our findings in relation to those requirements. The overall rating from this visit was requires improvement. Our key findings across all the areas we inspected were as follows:

- There was an open and transparent approach to safety and a system in place for reporting and recording significant events.
- The arrangements for managing medicines, including emergency medicines and vaccines, in the practice minimised most risks to patient safety, however the practice could not demonstrate all staff who administered vaccines had received the appropriate training.
- The practice had systems to keep all clinical staff up to date.
- Data from the Quality and Outcomes Framework showed patient outcomes were below CCG and national averages.
- Clinical audits now demonstrated quality improvement.
- Information about services and how to complain was available. Improvements were made to the quality of care as a result of complaints and concerns.

Summary of findings

- Results from the 2017 national GP patient survey showed patients felt they were treated with compassion, dignity and respect.
- Patients rated the practice below local and national averages on how they could access treatment and care.

- The practice had good facilities and was well equipped to treat patients and meet their needs.

The area where the provider must make improvement is:

- Ensure care and treatment is provided in a safe way to patients.

In addition the provider should:

- Continue to monitor its national GP patient survey results, as these showed patients satisfaction on how they could access treatment and care were below local and national averages.
- Monitor and record the usage of blank prescription forms.

I am taking this service out of special measures. This recognises the significant improvements made to the quality of care provided by the service.

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.

- Staff told us they would document and inform the practice manager of any incidents and there was a recording form which was now available on the shared drive.
- Staff demonstrated they understood their responsibilities and all had received training on safeguarding children and vulnerable adults relevant to their role.
- There were procedures for assessing, monitoring and managing risks to patient and staff safety.
- The practice could not evidence what specific or core training the HCA had undertaken to administer flu vaccines and B12 injections.
- The practice did not have systems in place for monitoring uncollected prescriptions.
- The practice had adequate arrangements to respond to emergencies and major incidents including an up to date Business Continuity Plan.

Are services effective?

Good

The practice is rated as good for providing effective services.

- Data from the Quality and Outcomes Framework showed patient outcomes were below CCG and national averages, however we found this was due to an IT glitch.
- Staff were aware of most current evidence based guidance.
- Clinical audits now demonstrated quality improvement.
- The practice had systems to keep all clinical staff up to date.
- There was evidence of appraisals and personal development plans for all staff.
- Staff had begun to work with other health care professionals including midwives and health visitors to understand and meet the range and complexity of patients' needs.
- End of life care was coordinated with other services involved.

Are services caring?

Good

The practice is rated as good for providing caring services.

- Results from the 2017 national GP patient survey showed patients felt they were treated with compassion, dignity and respect.

Summary of findings

- The practice was able to demonstrate it was more proactive in the identification of carers and that it had now increased the number of identified carers from two to 86 (over 1.5% of patient list).
- The practice now maintained registers for carers and end of life patients.
- Written information was available in the form of a carer's pack which directed carers to the various avenues of support available to them.
- 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?

Requires improvement

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

- The practice reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified, for example, patients had access to an in-house pharmacist.
- The practice took account of the needs and preferences of patients with life-limiting conditions.
- Results from the 2017 national GP patient survey showed that patients' satisfaction with how they could access care and treatment was considerably below the local CCG and national averages.
- 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 examples we reviewed showed the practice responded quickly to issues raised.

Are services well-led?

Good

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

- The practice now had a vision and that that was to strive towards a partnership between patients and health professionals, whilst providing high quality holistic care in a compassionate manner. Staff were clear about the vision and their responsibilities in relation to it.

Summary of findings

- Most staff were aware of their own roles and responsibilities, however the healthcare assistant was still administering flu vaccines and B12 injections without having received core training.
- Practice policies had been updated and were now practice specific for example, safeguarding policy contained all the relevant information and staff now had access to whistle-blowing policy.
- Staff had received inductions, annual performance reviews and attended staff meetings and training opportunities.

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 is rated as requires improvement for safe and responsive and good for effective, caring and well-led. The evidence which led to these ratings affected all patients including this population group.

- Staff were able to recognise the signs of abuse in older patients and knew how to escalate any concerns.
- The practice offered proactive, personalised care to meet the needs of the older patients in its population.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs.
- The practice identified at an early stage older patients who may need palliative care as they were approaching the end of life.
- The practice followed up on older patients discharged from hospital and ensured that their care plans were updated to reflect any extra needs.
- Annual health checks were offered to this group.
- A dedicated member of staff worked closely with the in-house pharmacist to organised blister packs for patients who needed additional support to take their medicines.

People with long term conditions

Requires improvement

The provider is rated as requires improvement for safe and responsive and good for effective, caring and well-led. The evidence which led to these ratings affected all patients including this population group.

- Performance for diabetes related indicators was comparable to CCG and national averages in some areas. For example, the percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) was 150/90 mmHg or less was 86%, compared to the CCG average of 68% and national average of 78%. This was achieved with a higher than average exception reporting rate of 24%.
- The practice followed up on patients with long-term conditions discharged from hospital and ensured their care plans were updated to reflect any additional needs.
- The practice offered a “one stop clinic” where patients had access to a phlebotomist, electrocardiogram (ECG) testing, body mass index (BMI) calculations and blood pressure checks.

Summary of findings

- 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.
- Patients at risk of developing a long-term condition were coded on the clinical system to alert staff of their vulnerability.
- Patients had their medication reviewed by the in-house pharmacist.

Families, children and young people

Requires improvement

The provider is rated as requires improvement for safe and responsive and good for effective, caring and well-led. The evidence which led to these ratings affected all patients including this population group.

- We found there were systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, where child abuse was witnessed.
- Immunisation rates were mixed for all 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.
- The practice had emergency processes for acutely ill children and young people.
- The practice's uptake for the cervical screening programme was 79%, which was comparable to CCG/national averages.

Working age people (including those recently retired and students)

Requires improvement

The provider is rated as requires improvement for safe and responsive and good for effective, caring and well-led. The evidence which led to these ratings affected all patients including this population group.

- 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 consultations were available daily and appointments with GPs and practice nurse were offered outside of normal working hours.

Summary of findings

- The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group.
- To assist patients in accessing the service, patients could use the online kiosk which was available in the reception area to book appointments.

People whose circumstances may make them vulnerable

Requires improvement

The provider is rated as requires improvement for safe and responsive and good for effective, caring and well-led. The evidence which led to these ratings affected all patients including this population group.

- The practice held a register of patients living in vulnerable circumstances including those with a learning disability.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice offered longer appointments for patients with a learning disability, carers and other vulnerable patients.
- The practice 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.

People experiencing poor mental health (including people with dementia)

Requires improvement

The provider is rated as requires improvement for safe and responsive and good for effective, caring and well-led. The evidence which led to these ratings affected all patients including this population group.

- The practice carried out advance care planning for patients living with dementia.
- Performance for dementia related indicators was comparable to CCG and national average. For example, 73% of patients

Summary of findings

diagnosed with dementia had a care plan and had been reviewed in a face-to-face setting in the preceding 12 months, compared to the CCG average of 80% and national average of 83%.

- Performance for mental health related indicators was comparable to CCG and national averages. 97% of patients with schizophrenia, bipolar affective disorder and other psychoses had their alcohol consumption recorded in the preceding 12 months. This was above the CCG average of 91% and national average of 89%.
- The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health.

Summary of findings

What people who use the service say

The national GP patient survey results were published on 6 July 2017. The results showed the practice was performing in line with or above local and national averages for most questions except for those regarding access to appointments. Two hundred and eighty three (283) survey forms were distributed and 122 were returned. This represented over 2% of the practice's patient list.

- 74% of patients described the overall experience of this GP practice as good compared with the CCG average of 74% and the national average of 85%.
- 44% of patients described their experience of making an appointment as good compared with the CCG average of 58% and the national average of 73%.
- 59% of patients said they would recommend this GP practice to someone who has just moved to the local area compared to the CCG average of 66% and 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. Twenty nine of the 37 patient Care Quality Commission comment cards we received were positive about the service experienced. Patients said they felt the practice offered a good service and staff were helpful, conscientious and treated them with kindness and respect. The other eight comment cards were mixed, patients spoke about the difficulty they faced when trying to access urgent and routine appointments.

We spoke with 10 patients and two members from the patient participation group (PPG). They told us 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.

The Willows Medical 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 advisor and a practice manager specialist advisor.

Background to The Willows Medical Practice

The Willows Medical Practice is located in Chigwell, Essex and provides primary medical services to approximately 6600 patients. The building is owned and maintained by an external organisation and is located on the ground floor in a purpose built building providing GP services. Services are provided under a General Medical Services (GMS) contract with NHS England and the practice is part of the Redbridge Clinical Commissioning Group (CCG). (GMS is one of the three contracting routes that have been available to enable commissioning of primary medical services).

The Willows Medical Practice is registered as a partnership with the Care Quality Commission (CQC) to provide the regulated activities of treatment of disease, disorder or injury, maternity and midwifery services, family planning, surgical procedures and diagnostic and screening procedures from Hainault Health Centre, Chigwell, Redbridge, IG7 4DF.

Information published by Public Health England rates the level of deprivation within the practice population group as five on a scale of one to 10. Level one represents the highest levels of deprivation and level 10 the lowest. The practice population age/sex distribution is similar to that of other practices in England. The life expectancy for males and females is 80 years and 84 years respectively.

The clinical team is made up of four GP partners (two female, two male), a salaried female GP collectively working 21 weekly sessions, a full-time female practice nurse and a female health care assistant (HCA). They are supported by a full time practice manager, secretary and various reception/administrative staff. The practice is a teaching and training practice for medical schools and takes students from Foundation Year 2 to 5. There is an onsite pharmacist who worked two days a week as part of a national pilot for clinical pharmacists in general practice.

The practice is open between 8am and 6.30pm Monday to Friday with the exception of Tuesday when the practice opens at 7.30am. Extended hours appointments are offered on Tuesday between 7.30am and 8am and Wednesday between 6.30pm and 8.00pm. Pre-bookable appointments can be booked up to four weeks in advance; urgent appointments as well as telephone consultations are also available daily. Out of hours services are delivered by another provider which is detailed in the practice leaflet, posters at reception, website and can be directly accessed by calling the practice telephone number.

The practice was inspected under the Care Quality Commission's current inspection regime in October 2016 and was found to be in breach of Regulation 12 HSCA (RA) Regulations Safe care and treatment, Regulation 18 HSCA (RA) Regulations 2014 Staffing and Regulation 17 HSCA (RA) Regulations 2014 Good Governance. This led to an overall rating of inadequate and the service placed in special measures.

Detailed findings

Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 on 13 October 2016 as part of our regulatory functions. The inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014. A breach of legal requirements was found and requirement notices were issued in relation to patient safety, good governance and staffing. As a result, we undertook a comprehensive inspection on 11 October 2017 to follow up, but not limited to, whether action had been taken to address the breaches outlined in the notice as well as to look at the overall quality of the service. The report outlined our findings on the day.

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 11 October 2017. During our visit we:

- Spoke with a range of staff including GPs, practice manager, administrative staff, practice nurse, HCA and spoke with 10 patients including two members of the PPG who used the service.
- Observed how patients were being cared for in the reception area.
- Reviewed a sample of personal care or treatment records of patients.
- Reviewed 37 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?

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 13 October 2016, we rated the practice as inadequate for providing safe services as the arrangements in respect of safeguarding, chaperoning, DBS checking, fire safety, infection control, medicines management and health and safety were not adequate. A Requirement Notice was issued in relation to these breaches.

Most arrangements had improved when we undertook a follow up inspection on 11 October 2017. The practice is now rated as requires improvement for providing safe services.

Safe track record and learning

There was a system in place for reporting and recording significant events.

- Staff told us they would document and inform the practice manager of any incidents and there was a recording form which was now available on the shared drive. 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).
- We saw evidence that when things went wrong with care and treatment, patients were informed of the incident, received reasonable support, truthful information, a written apology and were told about any actions to improve processes to reduce the likelihood of similar incidents.
- We reviewed safety records, incident reports, patient safety alerts and found that these were discussed in staff meetings.
- We saw evidence action was taken to improve safety in the practice. For example, following an incident relating to a patient who had been placed on a particular medicine despite contraindications. The investigation found that there had been an administrative error whereby the patient was incorrectly coded on the clinical system as low risk which was not the case. To reduce the likelihood of this incident happening again the practice contacted the clinical software company who created a template which merged patient's medical history as well as medication list.

Overview of safety systems and process

- At our inspection on 13 October 2016 we found there was a lack of systems, processes and practices in place to keep patients safe and safeguarded from abuse: There was insufficient attention to safeguarding. Policies and procedures were not easily accessible to staff as they were kept in the practice manager's office, which was locked in their absence. The policies were not specific to the practice, did not state who the practice lead for safeguarding was and made reference to the Primary Care Trust (PCT), an organisation dissolved in 2013. Staff we spoke with were unclear about who the practice lead was. At this inspection we found the aforementioned had improved; the practice now had an updated safeguarding policy in place and all staff we spoke with knew they could access on the shared drive. All staff we spoke with knew who the safeguarding lead was and who deputised in their absence.
- At our last inspection on 13 October 2016 the practice could not demonstrate all staff had received up to date safeguarding training as no records were kept. We looked at five staff files (one nurse and four non-clinical) and there was no evidence of any child or adult safeguarding training. GPs were last trained to child safeguarding level 3 in February 2014. At this inspection the practice was now able to demonstrate clinical and non-clinical staff had received training relevant to their roles. All staff including non-clinical had received level 3 child safeguarding training.
- The GPs and other staff attended safeguarding events and any concerns were discussed at their weekly clinical meetings. We saw evidence of multi-agency child safeguarding referrals from the practice and safeguarding and vulnerable registers were in place.
- At our previous inspection on 13 October 2016 we found not all staff who acted as chaperones were trained for this role and those who acted as chaperones had not received a Disclosure and Barring Service (DBS) check by the practice and the practice had not undertaken a risk assessment to determine why one was not

necessary. (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). At this inspection we found all staff who acted as chaperones had received formal training and DBS checks were now in place.

- We observed the premises to be clean and tidy including staff and patient toilets. There were cleaning schedules in place.
- At our previous inspection on 13 October 2016 the practice did not have systems and processes in place to ensure infection control risks were identified and mitigated. There was an infection control policy in place which made reference to the local infection prevention teams, however, there was no evidence of any joint working. No infection control audits had been completed and the healthcare assistant (HCA) who was the infection control clinical lead had not received any training for this role. The practice was unable to provide any evidence that other staff had received infection control training. At this inspection we saw evidence internal annual IPC audits were now carried out and steps were taken to remedy identified issues. An external audit undertaken on 9 March 2017 identified 12 problems and we found the practice took action to address these satisfactorily and within the recommended timeframe. We were provided with evidence which confirmed all staff had received infection control training and the practice had implemented an infection prevention and control induction checklist for all new employees to complete within four weeks of commencing employment.
- At our previous inspection on 13 October 2016 we found curtains in the consulting rooms had not been laundered or changed since November 2013 and the spillage kit was out of date. At this inspection we noted the practice were now using paper curtains which were in good condition. There was an IPC protocol in place and on the day of the inspection we observed a member of the non-clinical team using the spillage kit correctly after an incident which involved spillage of vomit.

The arrangements for managing medicines, including emergency medicines and vaccines, in the practice minimised most risks to patient safety, however the practice could not demonstrate all staff who administered vaccines had received the appropriate support and training.

- There were processes for handling repeat prescriptions which included the review of high risk medicines, however the practice did not always monitor and cleansed uncollected prescriptions in line with their policy. For example, the practice told us this process was carried out monthly; however we found 22 uncollected prescriptions dated between July and August. We reviewed patient records in relation to this and was satisfied patients had received medication through the Electronic Prescribing Service (EPS).
- The practice carried out medicines audits, with the support of the in-house pharmacist to ensure prescribing was in line with best practice guidelines for safe prescribing.
- Blank prescription forms and pads were securely stored; however the practice did not have systems in place to monitor their usage and there was no process for recording when prescriptions were used.
- At our previous inspection on 13 October 2016 we found staff only recorded the current fridge temperature and the practice did not have a second thermometer to check the accuracy of temperature readings and the one thermometer had not been calibrated. At this inspection we found this had been resolved.
- Patient Group Directions (PGDs) had been adopted by the practice to allow nurses to administer medicines in line with legislation. (PGDs are written instructions for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment).
- At our previous inspection on 13 October 2016 we noted the health care assistants (HCA) were also administering vaccines but these were not administered in accordance with a patient specific direction (PSD) from a prescriber. (PSDs are written instructions from a qualified and registered prescriber for a medicine including the dose, route and frequency or appliance to be supplied or administered to a named patient after the prescriber has assessed the patient on an individual basis). The practice were not aware of what PSDs were and had signed Patient Group Directions (PGD) for administering

flu immunisations instead. Furthermore, one HCA had not received any foundation immunisation training and neither HCA had obtained annual updates. At the inspection on 11 October 2017 we were told by the practice that the HCA had been trained and supervised by the lead GP, however no formal supervision records were kept to demonstrate the HCA competence had been assessed.

- The practice could not evidence what specific or core training the HCA had undertaken to administer flu vaccines and B12 injections. We received confirmation the HCA had enrolled to begin this core training in February 2018.
- Fifth (5th) year medical students carried out home visits where they administered flu vaccines. We saw evidence which confirmed students had received the required training, monitoring and supervision to carry out this role.
- At the inspection on 13 October 2016 the practice had failed to complete the appropriate recruitment checks for two members of staff prior to them starting work. At this inspection 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

At the previous inspection of the 13 October 2017 we found the practice did not assess, monitor or manage risks to patients and staff.

- At our previous inspection on 13 October 2016 the practice did not have a health and safety policy in place. Whilst the practice had undertaken a risk assessment for Legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings), they were unable to demonstrate risks in relation to infection control and the control of substances hazardous to health (COSHH) were appropriately monitored and managed; no COSHH risk assessment had been completed. The practice had resolved these issues at the time of our inspection on 11 October 2017; a COSHH policy was now in place and the 42 actions identified in the most recent health and safety risk assessment had been completed at the time of inspection.
- At our previous inspection on 13 October 2016 we noted staff had not received fire safety training. A fire risk assessment had been carried out in November 2015 which had a risk rating of 'moderate' based on the issues identified. We also found the risk assessment had documented several recommendations which had not been actioned. At this inspection on 11 October 2017 we saw evidence to confirm all staff had received training in fire safety and those who were nominated as fire wardens had also received specific training to carry out this role. We spoke with the building manager who showed us copies of the fire risk assessment which was completed in April 2017 and had a risk rating of "low". The competent person who undertook the risk assessment stated that "no action was required other than to maintain existing standard." Records reviewed demonstrated that fire -fighting equipment and emergency lighting were checked regularly to ensure they were in good working order. The last recorded fire drill on file was dated November 2016.
- At our previous inspection on 13 October 2016 no electrical equipment had been checked since 2014 to ensure the equipment was safe to use. At this inspection on 11 October 2017 the practice provided us with a record of portable appliance testing (PAT) and clinical equipment calibration.
- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system in place for all the different staffing groups to ensure enough staff were on duty. Locum GPs were used to provide cover during absences and annual leave. There was a detailed locum pack in place and which was accessible via the computer shared drive.

Arrangements to deal with emergencies and major incidents

At our previous inspection on 13 October 2016 we found the practice did not have sufficient arrangements in place to respond to emergencies and major incidents.

- There was an instant messaging system on the computers in all the consultation and treatment rooms

Requires improvement

Are services safe?

which alerted staff to any emergency. A first aid kit, accident book and emergency medicines were available. The emergency medicines were easily accessible to staff in a secure area and staff knew of their location. All the medicines we checked were in date.

- At our previous inspection on 13 October 2016 not all staff had received basic life support training. At this inspection the practice was now able to demonstrate all staff had received training in basic life support (BLS).
- The practice shared a defibrillator with the community services located in the building. At our previous inspection we noted the oxygen was stored in a room without suitable signage or ventilation. This had been resolved when we undertook our follow up inspection on 11 October 2017.
- The practice now had a comprehensive business continuity plan in place for major incidents such as power failure or building damage. Copies were held off site by the practice manager. The plan included emergency contact numbers for all staff and for both GP practices with whom they had reciprocal arrangements with in the event of an emergency.

Good

Are services effective?

(for example, treatment is effective)

Our findings

At our previous inspection on 13 October 2016 we found the arrangements for effective services needed improving; not all staff had received training in safeguarding, fire safety awareness, basic life support infection control and information governance. There was evidence to suggest not all staff had received annual appraisals and clinical audits did not drive improvements. At this inspection, we found the practice had addressed these issues sufficiently, therefore the practice is now rated as good for providing effective care.

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; however the practice nurse did not have access to current guidelines which underpinned cervical cytology screening. Following the inspection this was implemented.
- Staff told us they had access to guidelines from NICE and used this information to deliver care and treatment that met patients' needs.
- The practice monitored that these guidelines were followed 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 94% of the total number of points available compared with the clinical commissioning group (CCG) average of 93% and national average of 95%. This was achieved with an overall exception reporting rate of 28% which was notably higher than CCG and national averages of 10%. (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). We had concerns about the practice unusually high exception reporting rate (highest in the CCG) and spoke to them about this, but they told us they were unsure as to why the practice had such high reporting rates. We reviewed in depth 2016/17 QOF and found although there had been improvements, exception reporting rates were still higher than CCG and national averages. After interrogation of the practice's data we concluded the practice followed the exception reporting criteria for most patients; however we also found that the clinical system used by the practice included "excluded" patients in their exception reporting rates which affected the exception reporting rates for the clinical indicators. Exclusions refer to patients who are on the disease register or in the target group for the clinical area concerned, but not included in an indicator. The practice told us they would contact the clinical software company to report this, however any changes made to the system would not change the 2016/17 QOF data.

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

- Performance for diabetes related indicators was lower than the CCG and national averages in some areas. For example, the percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) was 150/90 mmHg or less was 86%, compared to the CCG average of 68% and national average of 78%. This was achieved with an exception rate of 24% which was considerably higher than the CCG average of 10% and national average of 13%.
- Performance for mental health related indicators was similar to the CCG and national averages. For example, 86% of patients with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive care plan documented in their records, in the preceding 12 months compared to the CCG average of 91% and national average of 89%. This was achieved with an exception reporting rate of 33% which was higher than CCG average of 6% and national average of 13%.

Good

Are services effective?

(for example, treatment is effective)

- Performance for dementia related indicators was 73% which was slightly below the CCG average of 82% and national average of 84%. This was achieved with an exception rate of 17% which was higher than the CCG average of 8% and national average of 7%.
- Hypertension related indicators were below the CCG and national averages. For example, the percentage of patients with hypertension in whom the last blood pressure reading was 150/90mmg or less was 67% which was below to the CCG average of 82% and national average of 83%. This was achieved with an exception rate of 17% which was higher than the CCG and national averages.

At the inspection of 13 October 2016 we found there was no ongoing programme of clinical audit to drive improvements in patient outcomes. At this inspection we found this had improved.

- There had been three clinical audits undertaken in the last two years, two of these were completed audits where the improvements made were implemented and monitored. One example was an audit of patients who had been taking bisphosphonates (type of drugs which helps to prevent bone thinning and may also be used to treat certain types of cancer) for more than five years. This audit was carried out in line with new guidance from NICE. The standard set for the audit was to review all patients who had been taking bisphosphonates medication for more than five years. The review included patients FRAX scoring (fracture risk assessment tool) with a view to being considered for a medication break depending on The National Osteoporosis Guideline Group (NOGG- management algorithm for the assessment of patients at risk of fracture). In the first cycle, 42 patients were identified from a search of medication record and each one had their notes reviewed using NICE guidance. Based on the findings, patients were contacted and nine had their medication stopped, 13 referred for dual energy X-ray apsorptiometry (DEXA scans which are used to assess a patient's risk of osteoporosis), 16 continued on the medication and four patients were incorrectly identified or needed further investigation. In the second cycle, 40 out of the 42 selected patients had their notes reviewed (two were ineligible) and 25 of those who had a high frax score, previous fracture of the femur and taking steroids continued on bisphosphonates. Further findings from the audit showed 15 patients were able to stop the medicines, four had a normal FRAX score, six had a normal cone mineral density (BMD) and two patients did not wish to continue taking the medicine. It was documented that a re-audit would be repeated in 2018.

Effective staffing

At our previous inspection on 13 October 2016 the practice did not ensure all staff had the skills, knowledge and experience to deliver effective care and treatment. At this inspection, we found evidence of staff training to demonstrate staff had the necessary skills and knowledge.

- The practice now had an up-to-date induction checklist for all newly appointed staff and we saw evidence it was used for the two newest recruits.
- The practice nurse who was recently employed had begun formal cervical cytology training and there was a system in place to ensure practice nurse received appropriate clinical supervision. The practice nurse had attended specific immunisation training as recommended by Public Health England (PHE) and Royal College of Nursing (RCN). The practice nurse told us she intended to stay up to date with changes to the immunisation programmes, for example by access to on line resources and discussion at practice meetings.
- At our last inspection on 13 October 2016 there was a lack of monitoring and oversight to ensure all staff learning needs were being identified. The practice told us the learning needs of staff were identified through a system of appraisals and reviews of practice development needs; however they did not always keep records to support this. This included ongoing support, one-to-one meetings, coaching and mentoring, clinical supervision and facilitation and support for revalidating GPs and nurses. All staff had now received an appraisal within the last 12 months.
- At our last inspection on 13 October 2016 we noted there were gaps in staff training. At this inspection, all staff had received training that included: fire safety awareness, basic life support and information governance. Staff had access to and used e-learning training modules and in-house training and there was now a training schedule in place to ensure timely completion of mandatory training.

Coordinating patient care and information sharing

Good

Are services effective?

(for example, treatment is effective)

The information needed to plan and deliver care and treatment was available to relevant staff and accessible 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.
- From the sample of documented examples we reviewed we found that the practice shared relevant information with other services, for example when referring patients to other services. The practice had effective failsafe systems in place to monitor two weeks wait referrals.

Staff told us they worked together and with other health and social care professionals to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. 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. We saw evidence meetings took place with other health care professionals which would allow for care plans to be 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

At our last inspection on 13 October 2016 we found the systems in place to ensure that staff sought patients' consent to care and treatment in line with legislation and guidance were inadequate.

- Staff we spoke with at this inspection understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005 (MCA). All clinical staff had received 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.
- The process for seeking consent was monitored through patient records audits.

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.
- A phlebotomist attended the practice twice weekly.

The practice's uptake rate for the cervical screening programme was 79%, which was comparable with the CCG average of 79% and the national average of 81%. This was achieved with an exception rate of 14% which was comparable to the CCG average of 9% and national average of 7%. There was a policy to offer telephone or written reminders for patients who did not attend for their cervical screening test. Longer appointments were available patients with a learning disability and they ensured female sample takers were available. There were no failsafe systems to ensure results were received for all samples sent for the cervical screening programme. Following the inspection the practice provided us with a copy of their failsafe policy.

The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer. Public health data showed 67% of females aged between 50 and 70 years had been screened for breast cancer in the last three years which was comparable to the local CCG average of 68% and national average of 73%.

Childhood immunisations were carried out in line with the national childhood vaccination programme. Uptake rates for the vaccines given were mixed when compared to CCG/ national averages. For example, rates for the vaccines given to under two year olds ranged from 76% to 85% and five year olds from 75% to 90%.

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 13 October 2016, we rated the practice as requires improvement for providing caring services as there was no carer's register, end of life register and some results from the National GP patient survey were below average and the practice could not demonstrate what they had done to address these.

At this inspection on 11 October 2017 we found that the practice now maintained a carer's and end of life register. In addition the practice had taken steps to address the low scores as highlighted in the GP patient survey. The practice is rated as good for providing caring services.

Kindness, dignity, respect and compassion

We observed members of staff were courteous and very helpful to patients and treated them with dignity and respect.

- Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- We noted that consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- Reception staff knew when patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.

29 of the 37 patient Care Quality Commission comment cards we received were positive about the service experienced. Patients said they felt the practice offered a good service and staff were helpful, conscientious and treated them with kindness and respect. The other eight comment cards were mixed, patients spoke about the difficulty they faced when trying to access urgent and routine appointments.

We spoke with 10 patients and two members from the patient participation group (PPG). They told us 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.

Results from the 2017 national GP patient survey showed patients felt they were treated with compassion, dignity and respect. The practice was in line with local and national satisfaction scores on consultations with GPs and nurses. For example:

- 89% of patients said the GP was good at listening to them compared to the clinical commissioning group (CCG) average of 86% and the national average of 89%.
- 84% of patients said the GP gave them enough time compared to the CCG average of 82% and the national average of 86%.
- 96% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 94% and the national average of 95%.
- 87% of patients said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 81% national average of 86%.

  92% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 83% and national average of 91%.
- 74% of patients said they found the receptionists at the practice helpful compared to the CCG average of 78% and the national average of 87%.

Care planning and involvement in decisions about care and treatment

At our previous inspection on 13 October 2016 feedback from CQC highlighted issues with staff attitude and poor communication. Patients also told us they were not listened to or involved in decisions about their care. At this inspection on 11 October 2017 the 10 patients we spoke with told us they felt involved in decision making about the care and treatment they received. They also told us they felt listened to 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 2017 national GP patient survey aligned with these views and showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. For example:

Good

Are services caring?

- 86% of patients said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 83% and the national average of 86%.
- 85% of patients said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 78% and national average of 82%.
- 87% of patients said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average of 78% and national average of 85%.

At our last inspection on 13 October 2017 we found that the facilities to help patients be involved in decisions about their care were not effective. These had improved at the inspection of 11 October 2017.

- Staff told us that translation services were available for patients who did not have English as a first language and there were now notices displayed in the reception areas informing patients this service was available.
- Information leaflets were available in easy read format.
- The NHS e-Referral Service was used with patients as appropriate. (The NHS e-Referral Service combines electronic booking 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 which had been recently updated. 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. The practice now maintained a carers register and used this information to offer annual health check and flu vaccine. As of October 2017, the practice had identified 86 patients as carers (over 1.5% of the practice list) which had improved since our visit on 13 October 2016. Carer's details were now captured on the new patient registration form and there were posters which encouraged patients to register at the reception desk. Written information was available in the form of a carer's pack which directed carers to the various avenues of support available to them. The CCG carers group met monthly within the health centre and patients were encouraged to attend.

At our previous inspection on 13 October 2016 the practice told us that they did not maintain an end of life register, however at this inspection on 11 October 2017 we saw that this was now in place. On the day of the inspection we observed good working relationship between the GPs and the Macmillan nurse who attended the practice on the last Tuesday of each month to discuss patients on the palliative register. The practice had a bereavement policy and staff told us that if families had experienced bereavement, their usual GP contacted them or sent them a condolence card. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs. Patients were referred to bereavement services on consent and information leaflets were available in the waiting area on the relevant support services available to patients.

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

At our previous inspection on 13 October 2016, we rated the practice as inadequate for providing responsive services as the system in place for handling complaints and concerns was ineffective. In addition the practice did not demonstrate what they had done to address low GP patient scores relating to how patients could access care and treatment.

At this inspection, the practice could demonstrate what they were doing to address low GPs scores; however results were still significantly lower than national averages. The practice is rated as requires improvement for providing responsive services.

Responding to and meeting people's needs

The practice reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. For example, they were a part of the joint NHS England and CCG pharmacist

project to recruit a practice based pharmacist to support the practice and provide expert advice to patients on medicines and safe prescribing. The pharmacist worked two days a week and undertook roles such as prescribing and patient reviews.

- The practice offered extended hours on a Tuesday morning at 7.30am and on a Wednesday evening until 8pm.
- The practice offered telephone triage and patients could book appointments online. Prescriptions could be ordered online and via post.
- There were longer appointments available for patients with a learning disability and carers.
- Patients with no fixed abode could register at the practice.
- 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.
- Mothers were able to breastfeed and were accommodated in a private room if requested.
- Patients were able to receive travel vaccinations available on the NHS and were signposted to other clinics for vaccines available privately, for example, yellow fever.
- There was an electronic notice board in the waiting area which kept patients informed of services.
- The building was fully wheelchair accessible.
- Patients had access to an on-site phlebotomist.
- The practice now had a hearing loop.

Access to the service

The practice was open between 8am and 6.30pm Monday to Friday with the exception of Tuesday when the practice opened at 7.30am. Extended hours appointments were offered on Tuesday between 7.30am and 8am and Wednesday between 6.30pm and 8.00pm. Pre-bookable appointments could be booked up to four weeks in advance, urgent appointments as well as telephone consultations were also available daily. Patients could book appointment online and were encouraged to as 50% were available online; at the time of our inspection 1009 patients had registered to book appointments online, of which 758 had utilised this service. Out of hours services were delivered by another provider which was detailed in the practice leaflet, posters at reception, website and could be directly accessed by calling the practice telephone number.

Results from the 2016 national GP patient survey showed that patients' satisfaction with how they could access care and treatment was lower than national averages.

- 61% of patients were satisfied with the practice's opening hours compared to the CCG average of 70% and national average of 78%.
- Results from the 2016 national GP patient survey showed 47% of patients said they could get through easily to the practice by phone; this had not improved when we undertook our follow up inspection. At 25% results were still below the CCG average of 51% and national average of 73%.

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

- 74% of patients were able to get an appointment to see or speak to someone the last time they tried compared to the CCG average of 76% and national average of 84%.

The practice told us telephone access was an ongoing issue which they were trying to resolve. We were told that the practice had six incoming telephone lines at any one point and during peak hours four members of staff manned these lines. Telephone lines in the GPs rooms were standalone so did not interfere with the main practice's line. The practice team including the chair of the PPG visited a practice that had similar issues and found they had installed a new telephone system which worked alongside the clinical system; this led to improved access within the practice. However the practice told us they were having on-going conversations and negotiations with their existing telephone provider regarding opting out of the five years fixed contract. The practice carried out a quality improvement survey in September 2017 to investigate the use of the online booking system and found that the key mode of booking appointment was via telephone and that there was a lack of awareness of the internet portal being available. The practice intervened by creating a poster which encouraged patients to book appointments online and this information was also recorded on prescriptions. The practice manager also told us there were plans to send bulk emails to inform patients of the online service.
We noted that the practice's latest in-house survey results were starting to show improvements in how patients responded to questions on how they could access treatment and care.

Listening and learning from concerns and complaints

At our last inspection on 13 October 2016 we found the practice did not have an effective system for handling complaints and concerns.

- At our inspection on 13 October 2016 we were not provided with a complaints policy and there was no evidence that the procedures were in line with recognised guidance and contractual obligations for GPs in England. At this inspection
- The practice manager was the designated responsible person who handled all complaints in the practice and we saw information on how to complain on a noticeboard in the waiting room.
- We saw that information was available in the practice leaflet, a poster at reception and on their website to help patients understand the complaints system.
- Verbal complaints were recorded and responded to.

We looked at five complaints received in the last ten months and found they were dealt with satisfactorily and in a timely manner. Lessons were learned from individual concerns and complaints and also from analysis of trends and action taken as a result to improve the quality of care. For example, one of the complaints we looked at related to incorrect information in medical notes. We saw that the complaint was investigated, evidence collated, discussed in practice meeting and written response was provided to patient as per practice policy. There was now evidence which demonstrated complaints and concerns were being discussed and learning was shared amongst staff.

Are services well-led?

Good

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

Our findings

At our previous inspection on 13 October 2016, we rated the practice as inadequate for being well-led as the practice's governance arrangements were unclear, poorly managed and did not ensure the practice was run safely and effectively.

Most of these arrangements had improved when we undertook a follow up inspection on 11 October 2017. The practice is rated as good for being well-led.

Vision and strategy

At our previous inspection on 13 October 2016 the leadership failed to demonstrate how it assured the provision of safe and high quality care and there was no clear vision, mission statement or business plans in place. At this inspection on 11 October 2017 the practice provided us with a copy of their ethos and vision which was to strive towards a partnership between patients and health professionals, whilst providing high quality holistic care in a compassionate manner.

- Staff we interviewed on the day understood the values and their responsibilities in relation to it.
- The practice did not have a business plan, but told us they regularly discussed the future of the organisation.

Governance arrangements

At our inspection on 13 October 2016 we were not assured the practice was run safely and effectively as most risks to patients and staff were not appropriately assessed or mitigated. At this inspection we saw that the practice had taken steps to improve the governance arrangements.

- At our previous inspection we noted there was no clear staffing structure. At this inspection this had been addressed. The practice had a hierarchical organisation chart which depicted individual staff functions.
- The HCA was still administering flu vaccines and B12 injections without having received core training. The practice informed us that the HCA had been booked on the core training in February 2018 and until then will no longer administer vaccines.
- Practice policies had been updated and were now practice specific for example, safeguarding policy contained all the relevant information and staff now had access to whistle-blowing policy. The policies we reviewed were fit for purpose and were accessible via shared drive and hard copy.
- Although management ensured staff had access to most current guidelines, we noted important guidelines which underpinned Cervical Screening was not available on the day of inspection, however this was provided to us after the inspection.
- The latest QOF scores showed the practice still had higher than average exception reporting rates, however we were satisfied that patients were exception reported in line with guidelines.
- The practice now had a programme of clinical audits to monitor quality and make improvements. Two of the three audits we saw were completed where the improvements made were implemented and monitored.
- The practice now had its own programme of internal infection control audits.
- The arrangements for identifying, recording and mitigating risks had improved since our visit on 13 October 2016, for example, actions identified in the latest fire and other risk assessments had been satisfactorily addressed and most staff had completed training relevant to their role with the exception of the HCA.
- The practice could demonstrate regular meetings were held and we saw evidence that important business functions such as significant events, complaints, patient and safety alerts were discussed, actioned and cascaded.

Leadership and culture

On the day of inspection, the management team demonstrated they wanted to improve the care and services they give to patients. Leadership arrangements and managerial oversight had improved. Staff told us the GPs and management team 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

Are services well-led?

Good

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

wrong with care and treatment).This included support training for all staff on communicating with patients about notifiable safety incidents. Management told us they 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.
- The practice kept written records of verbal interactions as well as written correspondence.

There was a leadership structure and staff felt supported by management.

- At our previous inspection on 13 October 2016 we were not assured meeting took place as minutes were not formalised. At this inspection we saw evidence meetings were held and minuted and learnings were shared with staff.
- Staff said they felt respected, valued and supported, particularly by the partners in the practice.

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

At our previous inspection on 13 October 2016 we found the practice had minimal engagement with people who used the service. At this inspection we found these issues had improved; The practice now encouraged and valued feedback from patients and staff which were used to improve quality care for example, changes to online appointment bookings as a result of in-house surveys.

- Patients through the patient participation group (PPG). The practice had a PPG who met regularly and submitted proposals for improvements to the practice management team. For example, they told us they had suggested a triaging system which was still being considered at the time of inspection.
- 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 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Regulation 12 HSCA (RA) Regulations 2014 Care and treatment must be provided in a safe way for service users.** How the regulation was not being met: The provider did not do all that was reasonably practicable to provide safe care and treatment. In particular: • The health care assistant (HCA) had not completed core training courses on how to administer medication via intra-muscular injection or influenza vaccine. • Uncollected prescriptions were not monitored in line with practice policy. This was in breach of regulation 12 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.