

The Practice Loxford

Quality Report

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

Ratings

Overall rating for this service

Inadequate



Are services safe?

Requires improvement



Are services effective?

Good



Are services caring?

Requires improvement



Are services responsive to people's needs?

Inadequate



Are services well-led?

Inadequate



Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at The Practice Loxford on 6 November 2015. Overall the practice is rated as inadequate.

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. But local clinical staff did not have regular meetings to learn from incidents and other safety information.
- The practice did not have systems in place to manage some key risks, for example in relation to repeat prescribing.
- Patients' clinical needs were assessed and care was planned in line with national guidance. The practice had prioritised long-term care for improvement and had introduced condition-specific clinics, for example for diabetic care to improve patient outcomes.
- Patients we spoke with described doctors, nurses and reception staff as caring. However, the practice scored consistently below average in the 2015 national GP patient satisfaction survey for questions on care and patient involvement.
- The practice provided information about its services in the form of a practice leaflet and a website. Information about how to complain was available at the practice. The practice employed a complaints officer who met with patients as soon as they raised a concern and the practice had seen a reduction in complaints.
- Appointment systems were not working well. We spoke with patients who said they were queueing before 8.00am in the morning to make an appointment because of difficulty getting through on the telephone.
- The practice had suitable treatment facilities but some of the shared facilities such as the furniture and television screens in reception were damaged or not working and had been in this condition for months. The practice had raised issues with the relevant agencies but the problems had not been addressed.

Summary of findings

- Staff told us they had access to the training they needed to develop in their role. Appraisals for non-clinical staff had recently been reintroduced.
- The practice had not addressed longstanding issues with quality and safety. The practice had not acted on some of the failures identified at our previous inspection of April 2014 and had not complied with a warning notice issued at that time.

The areas where the provider must make improvements are:

- The practice must ensure that facilities, including shared facilities used by their patients, are safe and take immediate action when a safety risk has been identified.
- Fire marshals must receive appropriate training. The practice must have sight of all relevant health and safety risk assessments and obtain assurance that any recommendations have been carried out by the responsible agency.
- The practice must ensure that repeat prescriptions are processed in line with its repeat prescribing policy and patients receive medicines on time.
- The practice must make sure the service is accessible to registered patients. The telephone appointment system must be fit for purpose.
- Local management arrangements must be sufficiently robust to ensure that safety and quality concerns are addressed without undue delay.

In addition the provider should:

- Provide regular opportunities for clinical staff to meet to discuss and review their practice, including significant events, safeguarding cases, learning and improvement.
- Review and monitor clinical staffing, skill mix and systems for routing patients to the most appropriate clinician to ensure that patient needs are being met in a safe and timely way.
- Carry out staff appraisals annually and provide structured opportunities for staff to review their performance with their manager.
- Explore ways of improving the patient experience. The practice was consistently scoring below average on indicators of compassionate care as measured by the 2015 national GP patient survey.
- Increase the information and support available for carers.

I am placing this practice in special measures. Practices placed in special measures will be inspected again within six months. If insufficient improvements have been made so a rating of inadequate remains for any population group, key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The practice will be kept under review and if needed could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service. Special measures will give people who use the practice the reassurance that the care they get should improve.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

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

Requires improvement



- Staff understood their responsibilities to raise concerns, and to report incidents and near misses. Incident reports were sent to the provider's centralised management team who led any investigation. Learning was fed back to the practice at monthly management meetings at the practice, and with the staff concerned and through a staff newsletter. Administrative staff had regular meetings. However opportunities for clinical staff to meet locally to review events and learning were limited.
- The practice had systems in place to manage medicines safely and had recently invested in an in-house pharmacist. However patients and staff consistently identified repeat prescriptions as an area for improvement particularly around timeliness.
- Although most risks to patient safety were assessed and well managed, there were some gaps, for example the practice could not show us a fire safety risk assessment or a legionella risk assessment which had been carried out by the organisation responsible for managing the property and could not assure us that relevant assessments had taken place. The practice had identified lack of training for fire marshals as a risk but this had not yet been addressed.
- The practice staff were aware of their responsibility to safeguard children and vulnerable adults from the risk of abuse. Practice staff were appropriately trained and knew the procedure to raise concerns.
- The practice had a system for monitoring staffing needs and a planned approach to recruitment and the use of temporary staff. However clinical and non-clinical staff members expressed concerns about current capacity and skill mix. We were not assured that risks in relation to staffing had been addressed.
- The practice was prepared for medical emergencies. The practice was equipped with a defibrillator, emergency oxygen and emergency medicines which were regularly checked.

Are services effective?

The practice is rated as good for providing effective services.

Good



Summary of findings

- The clinical staff were up-to-date with both National Institute for Health and Care Excellence (NICE) guidelines and other locally agreed guidelines. The practice was engaging well with local specialist services to provide good quality care to patients.
- Data showed that patient outcomes were generally comparable with national averages and the practice had strategies in place to improve condition-specific outcomes, for example by offering clinics where patients could see the GP and nurse.
- The practice provided evidence of clinical audit and ongoing monitoring of data for example, patient attendances at A&E. Practice performance on these measures had improved.
- The practice worked with other health and social care professionals for example, the district nursing team; palliative care nurse; specialist consultants and attended locality meetings.
- The practice had recently restarted annual staff appraisals after a period of several years.

Are services caring?

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

- Patients we spoke with were positive about the care they received but the 2015 national GP patient survey consistently showed that patients rated the practice lower than the local and national averages for the care and concern showed by the doctors.
- Patient confidentiality and privacy was protected.
- The practice supported patients reaching the end of their life and liaised with the palliative care nurse where appropriate. The practice referred patients following bereavement for further support.
- The practice provided information for patients about the service in the practice leaflet and on their website. The practice employed a team of receptionists who could speak a range of languages reflective of the local community, for example Romanian.

Requires improvement



Are services responsive to people's needs?

The practice is rated as inadequate for providing responsive services.

- The practice reviewed the clinical needs of its local population and engaged with community and specialist health teams to provide coordinated care.

Inadequate



Summary of findings

- The practice was accessible to patients with disabilities and parents with young children although there was no hearing loop.
- Appointment systems were not working well. We spoke with patients who said they were queueing before 8.00am in the morning to make an appointment because of difficulty getting through on the telephone.
- Information about how to complain was available. The practice had recruited a complaints liaison officer and evidence showed that the practice's response to patients had improved since our last inspection in April 2014. Complaints were analysed for trends.
- However, long standing problems with the telephone appointment system and other premises issues had not been resolved which presented a safety risk. .

Are services well-led?

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

- The management team had a vision and strategy for the practice but the leadership structure was unclear and leadership capacity needed strengthening.
- The medical directors provided support to the practice manager but were less visible to other staff locally. Some staff said the practice did not encourage a culture of openness and provide enough opportunities for reflection and discussion of clinical practice at local level.
- The practice had recently carried out annual staff appraisals. The administrative staff had weekly meetings. Staff received mandatory training and there was an induction programme for new or temporary staff.
- The practice had a small but active patient reference group. The group members were positive about the service and had been involved in initiatives to improve patient awareness and feedback. However, they expressed frustration that long-standing issues they had raised had not been addressed.
- The practice had not adequately responded to relevant information about the quality of the service. Since our previous inspection in April 2014, patients had continued to experience difficulties obtaining appointments and accessing the service in a timely way.

Inadequate



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

The practice is rated as inadequate for the care of older people.

The provider was rated as good for effective care overall and this includes for this population group. The provider was rated as inadequate for responsive care and for being well-led and requires improvement for safety and caring. The concerns which led to these ratings apply to everyone using the practice, including this population group. There were, however, some examples of good practice for the care of older people.

- The practice had appointed a long-term locum GP to focus on the care of older patients. This doctor carried out weekly visits to two large local nursing homes and ran an 'Everyone Counts' clinic for older patients, calling older patients on the patient list in for a health check including dementia screening, care planning, medicines review and lifestyle advice.
- Longer appointments and home visits were available for older people when needed.
- The practice told us they identified carers and provided patients who were carers with information about available support and relevant services. However, there was little evidence of this in the electronic patient records we reviewed. The practice manager told us that this was an area the practice intended to focus on over the coming 12 months.
- The percentage of patients aged 65 or over who had received a seasonal influenza vaccination in 2013/14 was low at 56% (compared to the national average of 73%).

Inadequate



People with long term conditions

The practice is rated as inadequate for the care of people with long-term conditions.

The provider was rated as good for effective care overall and this includes for this population group. The provider was rated as inadequate for responsive care and for being well-led and requires improvement for safety and caring. The concerns which led to these ratings apply to everyone using the practice, including this population group. There were, however, some examples of good practice for the care of people with long-term conditions.

Inadequate



Summary of findings

- The practice had identified its management of long-term conditions as a priority and had improved its performance in this area as measured by the Quality and Outcomes Framework in 2014/15.
- The practice had a clinical lead GP for diabetes who had introduced a weekly diabetes clinic run with one of the nurses. The practice provided initiation of oral and insulin therapies. The practice participated in integrated care management for patients with complex and multiple health conditions. The practice developed a care plan for these patients and the plans were discussed and updated through regular multidisciplinary meetings.
- The GPs discussed the care of patients with other health and social services professionals as appropriate. The practice benefited from being located in the same centre as several community health teams.
- The practice had systems in place to call patients with long-term conditions for regular review. We spoke with two patients with a long-term condition who confirmed they had a regular review with the GP and this included a review of their medicines.
- Longer appointments and home visits were available for patients with more complex conditions when needed.

Families, children and young people

The practice is rated as inadequate for the care of families, children and young people.

The provider was rated as good for effective care overall and this includes for this population group. The provider was rated as inadequate for responsive care and for being well-led and requires improvement for safety and caring. The concerns which led to these ratings apply to everyone using the practice, including this population group. There were, however, some examples of good practice for the care of families, children and young people.

- There were systems in place 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 A&E attendances.
- Immunisation rates were good for all standard childhood immunisations.
- Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals.

Inadequate



Summary of findings

- The practice offered weekly child health surveillance clinics and routinely screened new mothers for post-natal depression.
- The practice was open before and after school hours and at the weekends for walk-in appointments. However parents told us that they had difficulty booking appointments by telephone or in person when the practice opened at 8.00am because they had to get their children ready for school at this time.
- The premises were suitable for children and babies although some of the seating in the waiting area was hazardous with deeply ripped upholstery.

Working age people (including those recently retired and students)

The practice is rated as inadequate for the care of working age people.

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

- The practice was open outside normal working hours and on the weekend for walk-in appointments. However patients who worked told us they found it difficult to access appointments. One patient who was queuing outside before the practice opened said they would be late for work and would then have to take further time out if they succeeded in making an appointment that day.
- Practice uptake rates for cervical screening (77%) were below the national average (82%).
- Breast cancer screening uptake rates (68%) were also below the national average (74%)
- The practice offered an online repeat prescription service and online appointments. Several patients told us the online appointment system was unreliable.

Inadequate



People whose circumstances may make them vulnerable

The practice is rated as inadequate for the care of people whose circumstances may make them vulnerable.

The provider was rated as good for effective care overall and this includes for this population group. The provider was rated as inadequate for responsive care and for being well-led and requires improvement for safety and caring. The concerns which led to these

Inadequate



Summary of findings

ratings apply to everyone using the practice, including this population group. There were, however, some examples of good practice for the care of people whose circumstances may make them vulnerable.

- The practice held registers of patients living in vulnerable circumstances including those with a learning disability. The practice invited patients on the learning disability register for an annual health check.
- Staff 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. The practice added 'flags' to the electronic patient records when patients were known to be at risk of abuse or were otherwise in vulnerable circumstances. The electronic records system has the facility to automatically alert staff when a patient with a 'flag' in their record contacts or attends the practice.
- The practice monitored A&E attendance and non-attendance of booked appointments.
- The practice had arrangements to allow people with no fixed address to register or be seen at the practice.
- A health advocate was located at the practice for one day a week to provide patients in vulnerable circumstances with further support.
- The practice had links with and could refer patients to 'sister' practices in the provider group providing specialist support for patients, for example, for refugees.

People experiencing poor mental health (including people with dementia)

The practice is rated as inadequate for the care of people whose circumstances may make them vulnerable.

The provider was rated as good for effective care overall and this includes for this population group. The provider was rated as inadequate for responsive care and for being well-led and requires improvement for safety and caring. The concerns which led to these ratings apply to everyone using the practice, including this population group. There were, however, some examples of good practice for the care of people whose circumstances may make them vulnerable.

- The practice held registers of patients living in vulnerable circumstances including those with a learning disability. The practice invited patients on the learning disability register for an annual health check.

Inadequate



Summary of findings

- Staff 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. The practice added 'flags' to the electronic patient records when patients were known to be at risk of abuse or were otherwise in vulnerable circumstances. The electronic records system has the facility to automatically alert staff when a patient with a 'flag' in their record contacts or attends the practice.
- The practice monitored A&E attendance and non-attendance of booked appointments.
- The practice had arrangements to allow people with no fixed address to register or be seen at the practice.
- A health advocate was located at the practice for one day a week to provide patients in vulnerable circumstances with further support.
- The practice had links with and could refer patients to 'sister' practices in the provider group providing specialist support for patients, for example, for refugees.

Summary of findings

What people who use the service say

The most recent national GP patient survey results were published on 2 July 2015. The results showed the practice was performing below average on patient experience for most aspects of care. In particular, the practice was a negative outlier in terms of patient satisfaction with GP consultations, continuity of care, access to the service and overall experience. However, the practice scored better than average for the convenience of its opening times. It also performed in line with other practices in Redbridge for the quality of nurse consultations. Questionnaires were sent to 460 registered patients and 89 were returned.

- 13% of respondents found it easy to get through to this surgery by phone compared to the Redbridge average of 53% and the national average of 73%.
- 60% found the receptionists at this surgery helpful (Redbridge average 78%, national average 87%).
- 81% said the last appointment they got was convenient (Redbridge average 68%, national average 74%).
- 29% usually waited less than 15 minutes after their appointment time to be seen (Redbridge average 50%, national average 65%).
- 74% said the last GP they saw or spoke to was good at giving them enough time (Redbridge average 82%, national average 87%).
- 62% said the last GP they saw or spoke to was good at involving them in decisions about their care (Redbridge average 75%, national average 81%).
- 85% said the last nurse they saw or spoke to was good at giving them enough time (Redbridge average 84%, national average 92%).

- 73% said the last nurse they saw or spoke to was good at involving them in decisions about their care (Redbridge average 76%, national average 85%).
- 38% would recommend the practice to someone new to the area (Redbridge average 64%, national average 78%).

Prior to our inspection we also asked for CQC comment cards to be completed by patients. We only received six comment cards, five of which criticised access to the service. The cards also included positive comments, focusing on the kindness and professionalism of individual doctors.

We spoke with eight patients and three patient members of the patient participation group during the inspection. Two of these patients had not been able to obtain a timed appointment and were waiting to be seen as 'walk-in' patients. One had been waiting for over an hour and a half and the other (with a child) had been told the likely wait would be two hours. All the patients we spoke with said they had experienced difficulty accessing the service and three patients said they were considering registering with another practice because they were so unhappy with the service.

The patient participation group members also highlighted access to appointments as a general concern but said they had seen some areas of improvement in recent months, for example in the helpfulness of reception staff.

The Practice Loxford

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC inspector and included a GP specialist advisor, a practice manager specialist advisor and a second CQC inspector.

Background to The Practice Loxford

The Practice Loxford provides services to approximately 15,000 registered patients in the surrounding areas of Redbridge from a single site. It also provides a 'walk-in' primary care service primarily aimed at members of the public not registered with the practice. The practice sees around 260 patients per week on this basis. The service is provided through an Alternative Provider Medical Services contract. The practice is accessible to people with physical disabilities although the reception area does not have an induction loop.

The practice is owned by The Practice Surgeries Limited. The practice currently employs a team of salaried GPs (six whole time equivalent). The practice also contracts with 'self employed' GPs to provide regular sessions and one of these doctors focuses on services for older patients. The practice also employs a healthcare assistant, a practice manager and a team of receptionists, senior receptionists and administrators including a complaints liaison officer. The clinical team includes male and female doctors

The practice is located in a large primary and community health centre housing a number of health services. The building is purpose-built with good disability access. The property and premises are not owned or directly managed by The Practice Surgeries Limited.

The practice is currently contracted to provide the walk-in service from 8.00am to 8.00pm, seven days a week with pre-bookable appointments for registered patients available throughout the day. The practice has introduced an electronic appointment booking system and an electronic prescription service.

Out of hours primary care is contracted to a local out of hours care provider. The practice provides patients with information in the practice leaflet, on the website and by answerphone about how to access urgent care when the practice is closed. Patients are advised to ring "111" to access the out of hours primary care service.

The registered practice population is characterised by a high proportion of young adult patients aged between 20 and 39 years and children under 14. Eleven percent of registered patients are under 4 years of age compared to six percent nationally. In 2011/12, half of the practice population had a health condition limiting daily life which is in line with the English average of 49%. The local population is mobile, and culturally and ethnically diverse.

The practice is registered to provide the following regulatory activities: family planning; maternity and midwifery services; diagnostic and screening procedures; and treatment of disease, disorder or injury.

CQC previously inspected the practice in November 2013 with follow-up visits in March and April 2014. In our report of the inspection visits in 2014, the practice was found to be non-compliant with regulations relating to respecting and involving patients and assessing and monitoring the quality of service provision.

As a result, CQC imposed a 'compliance action' highlighting the lack of information provided in the reception area in languages other than English. The practice subsequently wrote to us outlining the action it had taken to improve this. We also issued a warning notice in relation to the

Detailed findings

continued failure of the provider to monitor and improve patient access to the service. The warning notice required the provider to achieve compliance with the relevant regulation by August 2014.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme.

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

We also followed-up our previous findings of non-compliance with regulations to ensure improvements had been made. We previously inspected this service on 13 March 2014 and 8 April 2014. At that inspection we found that the practice did not have an effective system for managing appointments or monitoring patient demand for appointments. Patients were queuing from early in the morning to make an appointment and there were no pre-bookable appointments with a GP available for the following three weeks. We also found that the practice manager was not provided with effective support and training to carry out their role effectively.

How we carried out this inspection

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 6 November 2015. During our visit we:

- Spoke with the medical director and senior managers based at The Practice Surgeries Limited head office. We also spent time with the local practice manager.
- Spoke with three GPs including two salaried and one locum GP, a nurse practitioner and a practice nurse.
- We spoke with receptionists, a senior receptionist and the medical secretaries.
- Spoke with eight patients who used the service and three members of the patient participation group.
- Observed how people were greeted at reception
- Reviewed six comment cards where patients and members of the public shared their views and experiences of the service.
- Reviewed various documents to check practice policy, procedures and monitoring checks. We also reviewed a sample of 15 patient records.

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 are provided for specific groups of people and what good care looks like for them. The population groups are:

- Older people
- People with long-term conditions
- Families, children and young people
- Working age people (including those recently retired and students)
- People whose circumstances may make them vulnerable
- People experiencing poor mental health (including people with dementia)

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

Are services safe?

Our findings

Safe track record and learning

We reviewed safety records, incident reports, national patient safety alerts and minutes of meetings where these were discussed. We found there was a system in place for reporting and recording significant events.

- Significant events were recorded electronically and shared with the provider's management team who were based at a central office and collated reports from all of the surgeries including the Practice Loxford. The records included details of whether patients were attending on a booked or walk-in basis. The medical directors took the clinical lead for reviewing and investigating all significant events and feeding any findings back to the practice. Mechanisms for doing so included a written newsletter which was sent to staff by email and a weekly performance management meeting with the practice manager, regional manager and one of the medical directors.
- Staff were aware of their responsibility to report incidents and significant events and were able to show us the electronic reporting system they used.
- However we received mixed feedback about how well the practice learned from incidents and events. Completed incident forms were sent to the central team at head office for further investigation and review. Any lessons were fed back to the practice. We were told that the practice clinical staff had met, on an occasional basis, to discuss specific incidents but there was currently no routine programme of clinical meetings. Some staff members said the lack of regular discussion and reflection of practice hampered the creation of an open, 'no-blame' culture around incident reporting. Some clinical staff members described receiving individual feedback from the central team about incidents they had been directly involved with but could not recall more general learning from significant events. Some staff members said they did not always read the newsletter due to time pressures and not all staff members when asked were sure they received it.
- The practice had recorded 41 incidents over the last year including clinical, administrative and other types of events, for example members of public using the premises to take illegal drugs. These had been

documented, discussed centrally and actions noted. We saw evidence of impact, for example the premises were now monitored by a security guard on a trial basis and the police had attended to offer advice.

- Safety alerts were circulated electronically by the central team to all practices in the group including the Practice Loxford. The clinical staff confirmed to us that they received these.

Overview of safety systems and processes

The practice had systems and processes in place to keep people safe and to safeguard them from abuse. For example:

- Arrangements were in place to safeguard children and vulnerable adults from abuse that reflected relevant legislation and local requirements and 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. The GPs attended safeguarding meetings when possible and always provided reports where necessary for other agencies. Staff demonstrated they understood their responsibilities and all had received training relevant to their role. GPs were trained to Safeguarding level 3.
- Clinical staff involved in providing the walk-in service were aware of the implications for safeguarding and liaised closely with the district nursing team who were based in the same building. Walk-in patients who were not registered at another practice were asked to register at the Practice Loxford at the same visit.
- A notice in the waiting room advised patients that the practice provided a chaperone service. All staff who acted as chaperones were trained for the role and had received a disclosure and barring check (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). The practice recorded in the patient notes when a chaperone had been used.
- One of the practice nurses was the local lead for infection control. We observed the practice premises to be generally clean and tidy. We found that the staff were aware of the importance of infection control and had received training. There were appropriate handwashing

Are services safe?

facilities, clear handwashing instructions displayed in treatment rooms and sufficient supplies of personal protective equipment. The practice carried out periodic audits of infection control audit, most recently in October 2015. The practice had not identified any issues requiring action at that time.

- The practice had appropriate arrangements for managing medicines and vaccinations. Prescription pads were securely stored and there were systems in place to monitor their use. The practice carried out reviews of prescribing and monitored comparative prescribing, for example of antibiotics. One of the GPs described how they engaged patients in discussion about appropriate use of antibiotics so they understood when these were not necessary.
- The practice had recently employed a pharmacist to support the practice to improve its systems for managing medicines and 'polypharmacy' (that is, for patients who are taking multiple medicines). The pharmacist had identified several areas for focus including older patients and those in residential care and was developing a number of audit ideas.
- However several patients told us that the system for obtaining repeat prescriptions was poorly organised at the practice and prescriptions were not always ready within two working days as stated by the practice policy. This had affected five of 11 patients we spoke with. Staff we spoke with said that prescriptions were sometimes delayed because part-time doctors might not receive the prescription request until they were next on duty.
- The practice was performing in line with prescribing guidelines monitored in the QOF (Quality and Outcomes Framework), for example practice prescribing of quinolones (a class of broad spectrum antibiotics) was lower than the national average.
- Appropriate recruitment checks had been undertaken prior to employment. The practice had the support of a central Human Resources team in advertising for and recruiting new staff and locum clinicians including recruitment checks. Confidential staff records were held centrally.
- A number of appointments were blocked each day to ensure emergency or follow-up appointments were available. The receptionists and their supervisors had an understanding of clinical staff specialities but did not work from a written protocol when deciding whether to open an emergency appointment and we were told they

did not always refer to a clinician. We were concerned that there was a lack of clarity about this and non clinical supervisors were potentially "triaging" patients without a clear protocol.

Monitoring risks to patients

The practice assessed and managed some but not all risks to patients and improvement was needed.

- The practice had various health and safety policies and carried out or arranged for health and safety checks to take place. The practice did not own the premises and another organisation was directly responsible for property management, for example inspections of fire safety equipment and emergency lighting. The practice manager had not seen independent evidence confirming these had been carried out. Two members of staff on each floor were responsible for coordinating any evacuation. However, we were told that no fire marshal training had been provided by the property management agency or the local NHS bodies. This was perceived as a risk by the practice manager but had not been recorded as such. Fire alarms were tested weekly. Fire safety signage was visible throughout the practice and staff we spoke with were aware of how to exit the building and the assembly point and support patients to exit.
- All electrical equipment and clinical equipment had been checked within the last year to ensure it was working safely and reliably. The practice kept an 'asset register' of all equipment and when this had been checked. The practice also had a variety of other policies and procedures to monitor safety of the premises such as control of substances hazardous to health, safe handling of 'sharps' and infection control.
- We found that identified risks relating to premises and equipment that was not directly owned by the practice group were poorly managed. For example, some of the seating in the waiting area was severely damaged with deeply ripped upholstery and damaged frames. These problems had been identified months previously but while the practice had notified the property management agency nothing had been done to protect practice patients from injury. The state of the furniture also potentially presented an infection risk.
- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. The central team used activity

Are services safe?

data to create a monthly staffing report with projections of staff requirements which was unique to each practice in the group. The practice routinely used temporary clinical staff ('locums') to meet patient needs and these tended to be regular locums who were familiar with the practice.

- Despite these arrangements there were concerns around clinical staffing arrangements at the practice. The practice did not seem to have sufficient clinical capacity to meet patient need at the time of the inspection with patients reporting difficulty obtaining appointments. The practice had reviewed its staffing needs and skill mix and was in the process of recruiting a new nurse practitioner and had also introduced a 'duty doctor' system to respond to urgent needs. However, clinical staff expressed concerns that the system for enabling patients (booked and walk-in) to see an appropriate clinician was not yet sufficiently robust.
- The practice had arrangements in place to deal with major events, for example necessitating closure of the practice. The practice had recently had to put the major incident plan into practice when the police cordoned off the street as a crime scene following an incident.

Arrangements to deal with emergencies and major incidents

The practice had systems in place to respond to emergencies and major incidents. The practice maintained recommended emergency equipment and medicines on the premises.

- Emergency medicines were 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 fit for use. The practice stocked the full range of recommended emergency medicines for primary care services. There was a spillage kit.
- The practice had a defibrillator available on the premises and oxygen with adult and children's masks. The staff had been trained on how to use the defibrillator and on basic life support. There was also a first aid kit and accident book.
- The practice kept a list of emergency contact numbers and could call on sister practices in the provider group in the event of major incidents such as power failure.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice assessed needs and delivered care in line relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines.

- The practice had systems in place 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 peoples' needs.
- The practice monitored that guidelines were followed through checks and reviews of patient records. The practice used an electronic records system to record detailed patient notes, add relevant coding and carry out routine analyses and audit.

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). In 2013/14 the practice achieved 96% of the total number of QOF points available, with 7% exception reporting. Data from 2014/15 showed that:

- Performance for diabetes-related indicators was below the national average in relation to diabetic patients' last IFCC-HbA1c readings. Seventy percent of diabetic practice patients had a last recorded reading below 64mmol/mol compared to the national average of 78%. (This is an indicator of how well patients' blood sugar levels are being controlled). There was a similar pattern with other diabetes indicators. For example, 69% of diabetic patients' last blood pressure reading was in the normal range compared to 78% nationally. And, 84% of diabetic practice patients had been vaccinated against influenza in the previous 12 months compared to 94% nationally.
- The practice had reviewed its performance on diabetes and had recently introduced a weekly diabetes clinic. This was run by the GP lead for diabetes with one of the

nurses. The GP and nurse were positive about this approach and told us that patients were able to receive a more 'holistic' approach with more emphasis on individual needs and education.

- The percentage of patients with hypertension having regular blood pressure tests was below the national average (80% compared to 84% nationally).
- Performance for mental health related indicators was in line with the national average. For example 90% of practice patients with diagnosed psychoses had a documented care plan compared to 88% nationally. And 97% of practice patients with diagnosed psychoses had a record of their alcohol consumption in their notes compared to 90% nationally.

The practice was using clinical audit to monitor outcomes. The pharmacist had developed a prioritised plan for auditing prescribing and medicines management in the practice.

- For example, practice GPs had participated in audits of vitamin B12, benzodiazepines and thyroxine. The audit reports described actions taken in response to the findings.
- The practice had completed a two-stage clinical audit on heart health detailing sustained improvements.
- The pharmacist had developed a prioritised programme of prescribing related audits for the coming year in discussion with the practice clinicians.
- The practice participated in local commissioner-led benchmarking and reporting and was performing well, for example, in relation to emergency admissions and A&E attendances.

Effective staffing

Staff had the clinical skills, knowledge and experience to deliver effective care and treatment.

- The GPs undertook continuous professional development to ensure they were up to date with current guidance and kept a clear record of this activity as required. The GPs had undergone five-yearly professional revalidation. However, both the doctors and nurses told us they had limited time for learning and development within their working hours. At the time of the inspection there were no regular clinical meetings. Clinical staff members told us they

Are services effective?

(for example, treatment is effective)

communicated informally or on an individual basis as the need arose but some staff members said the practice would benefit from more structured clinical meeting time.

- We were told that the learning needs of non clinical staff were identified through appraisals, weekly administrative staff meetings and more informal discussions. Staff had access to appropriate training to cover the scope of their work. We found that most of the administrative staff had received an appraisal in the days leading up to the inspection. This was the first time that some staff had received an appraisal for a number of years.
- The practice manager told us that there were systems in place to manage performance although in their experience there had not been any issues of this sort. The lack of annual appraisals over the previous year however, risked delaying the identification and resolution of performance problems.
- The practice had recently recruited a regional manager and staff told us this had a positive impact on the level of support the practice received.
- Staff received training that included: safeguarding, fire procedures, basic life support, chaperoning and information governance awareness. Staff had access to and made use of e-learning training modules, in-house training and the practice took advantage of external training opportunities for example, put on by the local clinical commissioning group.

Coordinating patient care and information sharing

Essential information needed to plan and deliver patient care and treatment was available to relevant staff through the practice's electronic patient record system and paper records.

- This information included medical records and investigation and test results. Information such as NHS patient information leaflets were also available.
- The practice shared relevant information with other services, for example when referring patients to other services. The GP followed-up referrals and reviewed all discharge letters.

Staff worked with other health and social care services to understand and meet the range and complexity of people's needs. This included when people moved between services, including when they were referred, or after they are discharged from hospital.

We saw evidence that multi-disciplinary team meetings took place. For example the GP discussed complex cases every two months with the relevant consultants. The GPs also attended multi-disciplinary palliative and integrated care meetings. The practice identified the patients most at risk of unplanned admission or deterioration for review by the multidisciplinary team.

Consent to care and treatment

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

- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005.
- When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance.

Health promotion and prevention

The practice identified patients likely to need extra support on a case by case basis:

- For example, older people with complex conditions or on the palliative care list. The practice utilised a clinical team with a range of skills including a health care assistant, a pharmacist, nurse prescribers and were in the process of recruiting a nurse practitioner.
- The practice had identified diabetes as an area for improvement and had organised a weekly diabetes clinic to include more education and advice.
- Two of the patients we spoke with said they had received good advice on managing their long-term conditions. The practice was able to give us examples of signposting patients to relevant agencies.
- The practice achieved a 77% uptake for the cervical screening programme compared to the national average of 82%.
- Childhood immunisation rates were generally in line with expectations. For example in 2014/15, the practice had immunised 82% of babies in their first year with the "five-in-one" vaccination. Seventy-one percent of two year-old practice patients had received their first MMR vaccination.

We were told that patients had access to health assessments and checks. New patients were required to complete a form covering medical history and a health

Are services effective?

(for example, treatment is effective)

screening questionnaire. The practice offered smoking cessation advice and support. Patients on the practice learning disabilities register were invited for annual health checks.

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We observed that members of staff were polite and helpful to patients when they arrived at the practice.

- The practice provided information about its services with a practice leaflet and website.
- 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 and that conversations taking place in these rooms could not be overheard.
- Reception staff said they could respond when patients' wanted to discuss sensitive issues or appeared distressed they could talk to them in a quieter area of the practice to discuss their needs.

All but one of the six comment cards we received were positive about the staff. Comments described the doctors, nurses and receptionists as caring and said staff listened. However, one patient commented that they felt rushed in consultations.

We also spoke with eight patients and three members of the patient participation group. They also told us the clinical staff were very good and treated them with care. Two patients had a long-term condition and commented on receiving good continuity of care and regular reviews. Some patients made an appointment to see a specific doctor and were confident that the GP knew and understood their medical history and health needs. Patients told us they had been referred promptly for tests and specialist treatment and the GP had followed-up their care after discharge.

However, results from the national GP patient survey published in July 2015 showed that the practice performed less well than other practices on questions asking about compassion, dignity and respect, particularly for consultations with doctors. For example:

- 78% said the GP was good at listening to them compared to the Redbridge average of 85% and national average of 89%.

- 74% said the last GP they saw or spoke to was good at giving them enough time (Redbridge average 82%, national average 87%).
- 82% said they had confidence and trust in the last GP they saw (Redbridge average 93%, national average 95%).
- 66% said the last GP they spoke to was good at treating them with care and concern (Redbridge average 79%, national average 85%).
- 87% said the nurse was good at listening to them compared to the Redbridge average of 84% and national average of 91%.
- 81% said the last nurse they spoke to was good at treating them with care and concern (Redbridge average 82%, national average 90%).
- 60% said they found the receptionists at the practice helpful (Redbridge average 78%, national average 87%).

The practice manager had arranged for additional customer service training to be provided to the reception team following a number of complaints. Several patients and the patient participation group members reported that reception staff were helpful and this had noticeably improved over the last year.

Care planning and involvement in decisions about care and treatment

Patients we spoke with said that 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 on the comment cards we received also reflected these views.

However, results from the national GP patient survey again showed that the practice was scoring below average on these aspects of care and this is a concern. For example:

- 66% said the, the last GP they saw was good at explaining tests and treatments compared to the Redbridge average of 80% and national average of 86%
- 62% said the last GP they saw was good at involving them in decisions about their care (Redbridge average 75%, national average 81%)
- 78% said the, the last nurse they saw was good at explaining tests and treatments (Redbridge average 81%, national average 90%)

Are services caring?

- 73% said the last nurse they saw was good at involving them in decisions about their care (Redbridge average 76%, national average 85%).

We were told that telephone translation and interpreting services were available for patients who did not have English as a first language although this was rarely used in practice. We saw notices welcoming patients at the reception desk in a range of languages. The practice employed receptionists who between them could speak a range of languages including South East Asian and Eastern European languages. The receptionists told us that the diversity of languages spoken remained a challenge.

Patient and carer support to cope emotionally with care and treatment

There was relatively little written information on display in the waiting area telling patients and carers how to access support groups and organisations. We were told this was because the landlord did not permit poster displays on the walls.

- The practice's computer system had the facility to alert staff if a patient was also a carer. The practice told us they identified carers and provided patients who were carers with information about available support and relevant services. However, there was little evidence of this in the electronic patient records we reviewed. The practice manager told us that this was an area the practice intended to focus on over the coming 12 months. The practice was able to provide carers with written information about the various avenues of support available to them.
- Reception staff were sensitive to patients in distress.

The practice supported patients reaching the end of their life and liaised with the palliative care nurse where appropriate. The staff were aware of local specialist bereavement counselling services for adults and children and had written information they could print or hand to affected patients.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice reviewed and was responsive to the clinical needs of its population. The practice understood the socio-demographic and cultural profile of its population.

- The practice employed male and female doctors.
- Home visits were available for older patients and other patients who would benefit from these. The duty doctor had time included in their working day to carry out home visits.
- If no appointments were available, registered patients could be seen as part of the 'walk-in' service.
- The practice premises were accessible to people with disabilities although there was no hearing loop available.
- The practice had a number of patients with severe mental health problems or drug and alcohol problems and actively engaged with local specialist services to provide care in line with current guidelines.

Access to the service

The practice was open from 8.00am to 8.00pm, seven days a week. On the day of the inspection, before 8.00am, there was a queue of 27 patients waiting outside the practice. Although the clinic housed a number of different primary and community health services, most of these patients were waiting to book an appointment with the Practice Loxford. Patients we spoke with said they had been advised by the practice staff to attend at opening time to obtain an appointment; others said their experience of the online and telephone booking systems was so poor that they now always attended in person. Both patients and staff told us it was usual for patients to queue. Of the patients we saw queuing, several were older people and one person was on crutches. There was no seating or shelter outside the clinic. At our previous inspection in April 2014, we had similarly noted that patients needed to queue early in the morning to make an appointment.

Patients we spoke with were all critical of access to the service. Five of six patient comment cards received also included negative comments about obtaining an appointment. Two parents independently told us they felt disadvantaged by the appointments system because they needed to take children to school and could not attend the practice to make an appointment. One of these was, as a

consequence, using the walk-in service although she was a registered patient, and had been told to expect to wait for around two hours for her child to be seen. Three patients told us they were considering changing practice because of the difficulty obtaining an appointment.

Results from the national GP patient survey confirmed that while patients appreciated the long opening hours, patient satisfaction with access to the service was low. The practice was the worst performing practice in Redbridge for getting through to the surgery by phone and the experience of making an appointment:

- 86% were satisfied with the practice's opening hours compared to the Redbridge average of 69% and national average of 75%
- 13% of respondents found it easy to get through to this surgery by phone (Redbridge average of 53%, national average of 73%)
- 21% described their experience of making an appointment as good (Redbridge average 58%, national average 73%)
- 28% said they usually waited less than 15 minutes after their appointment time (Redbridge average 50%, national average 65%).

We spoke with three receptionists who all said there were not enough appointments to meet demand. The next available non-urgent appointment on the day of the inspection (6 November 2015) was 1 December 2015. (The bookings rota for December had just been opened). We were told this was a typical wait to book a routine appointment.

Since the last inspection, the practice had introduced a duty doctor system to ensure that 'walk-in' patients had access to a doctor if required and in response to concerns around access to the service more generally. The duty doctor could telephone patients, make home visits or see patients. The duty doctor's consultations were fully booked by 9.00am on the day of the inspection.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. The practice manager told us one of their strategic priorities over the next year was to reduce the number of complaints.

- The practice complaints policy and procedures were in line with recognised guidance and contractual

Are services responsive to people's needs?

(for example, to feedback?)

obligations for GPs in England. Since our last inspection, the practice had recruited a complaints liaison officer who was a visible presence in the waiting and reception area. The number of complaints received had reduced since this member of staff had been recruited.

- The practice collated all complaints and sent details to the central support team for review, analysis and feedback.
- Information was available in the practice leaflet and displayed at reception to help patients understand the complaints system. Patients could submit comments and suggestions on the practice website but there was little other information on the website about how to make a formal complaint.
- The patients we spoke with were unhappy with aspects of the service. One patient had complained verbally about their prescription not being ready on time. They said they were listened to and received a verbal apology. However they were not convinced, that the service was likely to improve as a result.

Four complaints had been received in September 2015. These had been managed in line with the practice policy. Clinical complaints were passed to the GP for a response

and shared with the central support team. The practice wrote to complainants with the results and with information about how to take the complaint further if they were unhappy with the result. The practice included an apology and an explanation when a complaint was upheld.

The central support team analysed complaints from all practices in the group by category and the results were shared at board level. We found that the practice's complaints systems had improved since our inspection in April 2014.

We spoke with members of the patient participation group. They were positive about the practice and said that the practice had made some improvements, for example, the practice had started holding focused, condition-specific health promotion events to publicise care for long-term conditions. However, the group told us (and this was confirmed in the minutes of their meetings) that they had repeatedly highlighted other issues, such as faults with the television screens in the reception area; the damaged furniture in reception area and problems with the telephone appointments system. None of these issues had been effectively addressed.

Are services well-led?

Inadequate 

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

Our findings

Vision and strategy

The practice presented its vision as a provider of primary care services to deliver high quality service across multiple practice sites. The medical director highlighted the importance of primary care provision to the local population which was characterised by high need, mobility and vulnerability.

The practice had identified clinical priorities for improvement around the provision of care for older patients and long-term conditions. They had employed a long-term locum GP to focus on providing care for older people and were developing condition-specific clinics including diabetes and an 'Everyone Counts' clinic for older patients. Their clinical performance as measured by the QOF had improved.

The practice provided a walk-in service which was primarily nurse-led. The practice had recently created a duty doctor system however so that patients who needed to see a doctor quickly could be referred to the duty doctor the same day.

The practice was aware of demographic changes locally, the likely business implications of these and was keen that the service adapted to meet patients' changing needs.

Governance arrangements

The practice had governance arrangements in place. A central 'support team' were responsible for governance across the group's services. Significant incidents, complaints and activity data were routinely reported to the central support team who then analysed the data and produced reports for the board. Information was fed back in the form of a newsletter and through weekly management meetings. The newsletter included positive praise for good performance and the work of individual staff members was recognised.

However local staff sometimes reported that they were not fully involved in learning and review and the clinical staff currently had limited opportunities to meet. This led to a culture where the local team did not 'own' responsibility for quality improvement and the boundary between central and local responsibilities was not always clear. For example, we were told that one of the medical directors, who provided no clinical sessions at the practice, was going

to become the named lead for all patients aged over 75. The rationale was unclear as this doctor would have no familiarity with these patients if, for example, social services asked to discuss a patient's circumstances with their named GP.

We found that:

- Staff knew how to report any concerns, incidents or raise a safeguarding alert.
- Practice policies were available to all staff and policies, such as infection control, were specifically tailored to the practice.
- The central and local management team had a good understanding of the clinical performance of the practice and had implemented changes that were improving outcomes.
- The GPs had undertaken clinical audits to monitor practice against established standards of good practice and to make improvements where necessary.
- The practice had clinical 'failsafe' systems in place to ensure for example, that patient test results and referrals were followed-up appropriately. These systems tended to be paper based and run in parallel to the electronic patient records system which already included this sort of functionality.
- The practice had an structured induction programme for new or temporary staff.

Leadership, openness and transparency

The central support team, regional manager and human resources department provided support for the local practice manager. The medical directors chaired a weekly performance management meeting with the regional and local practice managers.

- The practice had experienced a high turnover of local clinical leaders. Since our previous inspection in April 2014, two clinical leads and two nurse leads had joined and then left the practice. The practice had decided on a new clinical leadership structure whereby a small number of salaried GPs would share the lead role, each taking particular responsibilities. This was still in the planning stages.
- Staff gave us mixed feedback on whether there was an open culture within the practice. The lack of opportunities for clinicians to regularly discuss learning from events and complaints was cited as a factor.

Are services well-led?

Inadequate 

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

- Staff had confidence in the local and regional managers to varying degrees to act on concerns. One staff member gave us a positive example of raising a potential safeguarding concern with the GP safeguarding lead who acted promptly and sensitively to follow this up.

We found that the practice had not addressed all of the issues raised at our last inspection despite being issued with a warning notice at that time. At our inspection in 2014, we noted that patients experienced difficulty accessing appointments to the extent that patients queued outside. At this inspection, we found this was still occurring on a daily basis.

The practice said this was due to the telephone system being inadequate with insufficient telephone lines into the building. The practice said they had no control over this. The practice showed us written correspondence with their property management agency on this matter which had been on-going without progress. There was little acknowledgement from the management team in our discussion that there might be any additional underlying capacity issue.

We were given a similar reason for the lack of action in relation to damaged seating in the waiting area. This was not directly owned by the practice and so the manager told us they needed written permission from the property management agency before they could act. We saw from the patient reference group meeting notes dated August 2015, that the practice had been given verbal approval to remove the affected seating at that time.

We observed that reception staff faced considerable pressure from patients, particularly when the practice opened. The reception was busy throughout the day and

staff had to repeatedly explain that appointments were not available when patients wanted them. The reception staff we spoke with expressed concern that the service was not more patient-centred.

In summary, we found that despite our earlier inspection findings, the practice tolerated poor patient access despite the risks to patient health, staff morale and the practice's reputation in the local community.

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

The practice encouraged patients to feedback through the use of brief feedback forms. These were short and pictorial so enabling patients who could not read English to participate. The practice had set up a patient participation group (PPG) which was small but active. The practice held regular meetings with the group and they were involved in patient engagement and education activities such as a recent breast cancer awareness event at the practice.

The practice was aware that it was under-performing in the national GP patient survey and registered patients had difficulties accessing the service but had not made significant changes to the appointment system to address the issue. We were told that the practice was carrying out audits of telephone response and appointment waiting times to monitor the situation.

The practice obtained feedback from staff members informally or through staff meetings. Staff told us they felt comfortable to give feedback and discuss concerns but some reported a lack of confidence that concerns would be addressed.

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Treatment of disease, disorder or injury	<p>Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment</p> <p>Regulation 12 Safe care and treatment</p> <p>The registered provider assessed the risks to the health and safety of patients but had not done all that was reasonably practical to mitigate such risks.</p> <p>In particular we found the practice:</p> <ul style="list-style-type: none">· failed to provide repeat prescriptions in line with its policy, leaving patients potentially without access to their prescribed medicines· had not ensured that damaged furniture was removed, repaired or screened off despite recognising this as a risk to patients. <p>Regulation 12 (1)(2)(a)(b)</p>

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Treatment of disease, disorder or injury	<p>Regulation 17 HSCA (RA) Regulations 2014 Good governance</p> <p>Regulation 17 Good governance</p> <p>The registered provider had not improved the quality and safety of the services provided and had not mitigated the risks relating to the health, safety and</p>

Enforcement actions

welfare of service users. The registered provider had not effectively acted on feedback from patients, staff nor on previous regulatory reports and notices to improve the service.

Specifically, the registered provider was failing to provide patients with reasonable access to the service. We found no improvement to access since our last inspection in April 2014, even though the practice had been issued with a warning notice at that time. The practice tolerated poor patient access and experience despite the risks to patient health, staff morale and the practice's reputation in the local community.

Regulation 17 (1)(2)(a)(b)(e)(f)