The Family 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	Inadequate
Are services safe?	Inadequate
Are services effective?	Inadequate
Are services caring?	Requires improvement
Are services responsive to people's needs?	Requires improvement
Are services well-led?	Inadequate

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at The Family Practice on 6/7/2016. Overall the practice is rated as inadequate.

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

- Staff were aware of how to report incidents and concerns. We saw that incidents were investigated and learning disseminated. However, near misses were not documented so learning was not always maximised.
- Patients were at risk of harm because systems and processes were not in place to keep them safe. For example appropriate recruitment checks on staff had not been undertaken prior to their employment.
- There was no evidence that staff were up to date in training to administer vaccines. Appropriate patient specific directions were not in place to ensure vaccinations were administered in line with legislation.
- Patient outcomes were hard to identify as little or no reference was made to audits or quality improvement and there was no evidence that the practice was comparing its performance to others; either locally or nationally.
- Patients were positive about their interactions with staff and said they were treated with compassion and dignity. However, patients also felt frustrated by the lack of continuity of care available.
- The practice had insufficient leadership and inadequate governance arrangements.

The areas where the provider must make improvements are:

- Ensure recruitment arrangements include all necessary employment checks for all staff.
- Ensure a quality improvement programme is implemented which may include clinical audits to ensure improvements to care and treatment have been achieved.

Summary of findings

- Implement formal governance arrangements including systems for assessing and monitoring risks and the quality of the service provision.
- Provide staff with policies and guidance to carry out their roles in a safe and effective manner which are reflective of the requirements of the practice.
- Ensure there is leadership to deliver all improvements.
- Ensure infection prevention and control is appropriately monitored.
- Ensure staff training is undertaken and appropriately managed to ensure all staff have the skills and qualifications to carry out their roles.
- Ensure an appropriate complaints process is implemented and that complainants receive appropriate guidance about how to escalate their concerns should they wish. Measures should be put in place to ensure learning from complaints is maximised and disseminated appropriately amongst staff.
- Ensure measures are taken to gain feedback from patients.

The areas where the provider should make improvement are:

- Consider lowering the threshold for formal analysis of significant events and near misses in order to maximise learning outcomes.
- A systematic approach should be applied to documenting the management of safety alerts within the practice to ensure a clear audit trail of whom they have been disseminated to and any actions taken as a result.

I am placing this service in special measures. Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate for any population group, key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

The service will be kept under review and if needed could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service by adopting our proposal to remove this location or cancel the provider's registration.

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

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Inadequate

The practice is rated as inadequate for providing safe services.

- Staff understood their responsibilities to raise concerns, and to report incidents and near misses. However, we noted that near misses were not formally documented to maximise learning.
- Risks to patients were inconsistently assessed and the systems and processes to address these risks were not implemented well enough to ensure patients were kept safe.
- Appropriate recruitment checks had not been completed, for example references being sought. While we were told DBS checks had been completed for all staff, we only saw documentation relating to the practice nurse to appropriately evidence this.
- Relevant infection control audits had not been appropriately completed as the audit tool used did not relate to activities undertaken by the practice.
- The infection prevention and control lead had not received training in order to carry out this role. There was also a lack of evidence of infection control training for other clinical staff.
- Clinical staff were administering vaccines without appropriate patient specific directions being in place to ensure this was being done in line with legislation.
- There was no system in place to audit the dissemination and resulting action following receipt of safety alerts into the practice.

Are services effective?

Inadequate

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

- The lead GP was unable to articulate or demonstrate that a systematic approach had been undertaken in assessing the needs of the patient population and putting measures in place to address these needs upon taking over the practice.
- Patient outcomes were difficult for us to identify as there was no evidence of completed, full cycle audits and only limited evidence of quality improvement. There was no evidence that the practice was comparing its performance to others; either locally or nationally.

Summary of findings

- There was limited recognition of the benefit of an appraisal process for staff. No appraisals had been completed and documented. Processes were not in place to identify and support any additional training that may be required.
- Staff training was not appropriately managed and this resulted in key gaps. For example the practice was unable to evidence that clinical staff had attended appropriate update training in order to administer vaccines.
- While the lead GP was aware of issues around patient consent, there was no consent policy available for staff.
- The practice QOF results were generally high, and it was able to demonstrate some improvements in how QOF performance was being managed. However, the overall exception reporting for the practice was high compared to local and national averages.
- The practice told us that the current uptake for the cervical screening programme was 69% for the present QOF year.

Are services caring?

Requires improvement

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

- Data from the national GP patient survey showed patients rated the practice lower than others for most aspects of care.
- Some patients felt that a lack of continuity of care due to high GP turnover was impacting on the quality of care received.

However:

- Information for patients about the services available was easy to understand and accessible.
- We saw that staff treated patients with kindness and respect, and maintained patient and information confidentiality. The staff we spoke with were passionate about providing a caring service for their patients.

Are services responsive to people's needs?

Requires improvement

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

- There was no evidence that the practice had reviewed the needs of its local population.
- Feedback from patients reported that access to a named GP and continuity of care was not always available quickly, although urgent appointments were usually available the same day.

Summary of findings

- Patients could get some information about how to complain in a format they could understand. However, there was no evidence that learning from complaints had been documented or shared with staff.

Are services well-led?

Inadequate

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

- The practice did not have a clear vision and strategy.
- While there was a leadership structure in place and staff told us they felt supported by management, the leadership team lacked experience and capacity to manage an organisation that the provider themselves acknowledged had historically struggled to perform.
- The practice had a number of policies and procedures to govern activity, but these were inadequate. They were not dated to indicate a review process had been undertaken and many contained out of date information, or details not relevant to the practice. There were also gaps in policies, for example there were no consent or chaperone policies available.
- While staff meetings were held, the meeting minutes lacked sufficient detail to provide an adequate audit trail of what information had been given to whom.
- The practice had not proactively sought feedback from staff or patients and did not have a patient participation group.
- Staff told us they had not received regular performance reviews and did not have clear objectives.

Summary of findings

The six population groups and what we found

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

Older people

Inadequate

The practice is rated as inadequate for providing a safe, effective and well led service and requires improvement for providing a caring and responsive service. The issues identified affect all patients including this population group. There were, however, examples of good practice.

- The practice offered proactive, personalised care to meet the needs of the older people in its population.
- The practice was responsive to the needs of older people, and offered home visits and urgent appointments for those with enhanced needs.
- The GP engaged in multidisciplinary meetings where the needs of people requiring end of life care were discussed in order that they received the most appropriate care and treatment.

People with long term conditions

Inadequate

The practice is rated as inadequate for providing a safe, effective and well led service and requires improvement for providing a caring and responsive service. The issues identified affect all patients including this population group. There were, however, examples of good practice.

- Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority.
- Indicators for diabetes were higher than the national average, although exception reporting in these areas was also higher.
- Longer appointments and home visits were available when needed.
- These patients had a structured annual review to check their health and medicines needs were being met. However, not all had a named GP. For those patients with the most complex needs, the GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Inadequate

The practice is rated as inadequate for providing a safe, effective and well led service and requires improvement for providing a caring and responsive service. The issues identified affect all patients including this population group. There were, however, examples of good practice.

Summary of findings

- 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 relatively low for many standard childhood immunisations.
- Cervical screening rates had previously been in line with local and national averages. However, current rates had dropped.
- Appointments were available outside of school hours and the premises were suitable for children and babies.
- The practice ran regular mother and baby clinics.

Working age people (including those recently retired and students)

Inadequate

The practice is rated as inadequate for providing a safe, effective and well led service and requires improvement for providing a caring and responsive service. The issues identified affect all patients including this population group. There were, however, examples of good practice.

- The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible and flexible.
- 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.

People whose circumstances may make them vulnerable

Inadequate

The practice is rated as inadequate for providing a safe, effective and well led service and requires improvement for providing a caring and responsive service. The issues identified affect all patients including this population group. There were, however, examples of good practice.

- The practice held a register of patients living in vulnerable circumstances including those with a learning disability.
- The practice offered longer appointments for patients with a learning disability.
- The practice regularly worked with other health care professionals in the case management of vulnerable patients.
- The practice informed vulnerable patients about how to access various support groups and voluntary organisations.

Summary of findings

- Staff knew how to recognise signs of abuse in vulnerable adults and children. 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.
- A substance misuse support worker ran weekly clinics at the practice.

People experiencing poor mental health (including people with dementia)

Inadequate

The practice is rated as inadequate for providing a safe, effective and well led service and requires improvement for providing a caring and responsive service. The issues identified affect all patients including this population group. There were, however, examples of good practice.

- The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those with dementia.
- The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations.
- The practice had a system in place to follow up patients who had attended accident and emergency where they may have been experiencing poor mental health.
- Staff had an understanding of how to support patients with mental health needs and dementia.

Summary of findings

What people who use the service say

The national GP patient survey results were published in January 2016. The results showed the practice was performing below local and national averages for patient satisfaction. A total of 328 survey forms were distributed and 91 were returned. This represented a response rate of 28% and approximately 3% of the practice's patient list.

- 65% of patients found it easy to get through to this practice by phone compared to the national average of 73%.
- 67% of patients were able to get an appointment to see or speak to someone the last time they tried compared to the national average of 76%.
- 77% of patients described the overall experience of this GP practice as good compared to the national average of 85%.
- 61% of patients said they would recommend this GP practice to someone who had just moved to the local area compared to the national average of 79%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 38 comment cards which all made positive remarks about the standard of care received. Many of the cards made reference to how caring the staff at the practice were. However, as well as making positive comments, three of the cards also expressed frustration at the lack of continuity of care due to the high turnover of GP staff. Three cards also contained comments expressing frustration about how difficult it was to get through to the practice by telephone and therefore access to services offered.

We spoke with two patients during the inspection. Both patients expressed concerns about the care they received. One patient was extremely frustrated that their appointment was running 40 minutes late and was upset that practice staff had not apologised or offered an explanation as to why this was the case. The lead GP had assured the inspection team previously that GP cover had not been impacted by the inspection visit. The other patient felt they did not receive a satisfactory service during their appointment as they saw a new GP who was not familiar with their background or what services were available locally to support their needs. This patient was unhappy about the lack of continuity of care offered by the practice and felt that they had to see a different GP each time they attended for an appointment.

Areas for improvement

Action the service MUST take to improve

The areas where the provider must make improvements are:

- Ensure recruitment arrangements include all necessary employment checks for all staff.
- Ensure a quality improvement programme is implemented which may include clinical audits to ensure improvements to care and treatment have been achieved.
- Implement formal governance arrangements including systems for assessing and monitoring risks and the quality of the service provision.
- Provide staff with policies and guidance to carry out their roles in a safe and effective manner which are reflective of the requirements of the practice.
- Ensure there is leadership to deliver all improvements.
- Ensure infection prevention and control is appropriately monitored.
- Ensure staff training is undertaken and appropriately managed to ensure all staff have the skills and qualifications to carry out their roles.
- Ensure an appropriate complaints process is implemented and that complainants receive appropriate guidance about how to escalate their

Summary of findings

concerns should they wish. Measures should be put in place to ensure learning from complaints is maximised and disseminated appropriately amongst staff.

- Ensure measures are taken to gain feedback from patients.

Action the service SHOULD take to improve

The areas where the provider should make improvement are:

- Consider lowering the threshold for formal analysis of significant events and near misses in order to maximise learning outcomes.
- A systematic approach should be applied to documenting the management of safety alerts within the practice to ensure a clear audit trail of whom they have been disseminated to and any actions taken as a result.

The Family 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 and a second CQC inspector.

Background to The Family Practice

The Family Practice is a registered location under the single handed provider Dr Issak Bhojani and is situated along with a number of other GP practices and healthcare providers in a large purpose built health centre close to the centre of Blackburn. The provider took over this practice in June 2015 and has two additional registered locations in Lancashire, one in Preston and one in Fleetwood.

The Family Practice delivers primary medical services to approximately 2900 patients through a general medical services (GMS) contract with NHS England, and is part of the NHS Blackburn with Darwen Clinical Commissioning Group (CCG).

The average life expectancy of the practice population is below national but in line with CCG averages for both females and males (76 years for males, compared to CCG average of 76 and national average of 79. For females; 81 years compared to CCG average of 80 and national average of 83). The age distribution of the practice's patient demographic closely aligns with the national averages, except for a slightly higher proportion of people aged between 10 and 29 years. A slightly higher proportion of the practice's patients are in full time education or paid work; 62% compared to the CCG average of 57% and national average of 61.5%. The practice caters for a slightly lower proportion of patients with a long standing health condition (53.6% compared to the CCG average of 55.6% and national average of 54%).

Information published by Public Health England rates the level of deprivation within the practice population group as two on a scale of one to ten. Level one represents the highest levels of deprivation and level ten the lowest.

The practice is staffed by the lead GP (male), two long term, part time locum GPs (both female), a practice nurse and healthcare assistant. The clinical staff are supported by two non-clinical partners, a managing director, a medicines coordinator as well as administration and reception staff. There was a degree of ambiguity around the management structure. Prior to the inspection, documentation referred to there being a practice manager in post. Staff on the day of the visit referred to a practice manager. However, the management team discussed the structure as containing a managing director role, who had managerial oversight across the three separate practice locations. The management team told us there was currently a vacant operations manager role specific to the practice.

The practice is open from 8am until 6:30pm Monday to Friday, with appointments with the GP available between 9:30am and 12 noon each morning and between 3:00 and 5:00pm each afternoon. Extended hours appointments are also available between 7:30 and 8am each Wednesday morning.

Outside normal surgery hours, patients are advised to contact the out of hour's service, offered locally by the provider East Lancashire Medical Services.

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 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.

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 6 July 2016. During our visit we:

- Spoke with a range of staff including lead GP, long term locum GP, managing director, non-clinical partners, practice nurse as well as non clinical administrative staff and spoke with patients who used the service.
- Reviewed documents held by the practice such as staff personnel files and policys and procedures.
- Observed how patients were interacted with and talked with carers and/or family members
- Reviewed an anonymised sample of the personal care or treatment records of patients.
- Reviewed comment cards where patients and members of the public shared their views and experiences of the service.

To get to the heart of patients' experiences of care and treatment, we always ask the following five questions:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

We also looked at how well services were provided for specific groups of people and what good care looked like for them. The population groups are:

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

Please note that when referring to information throughout this report, for example any reference to the Quality and Outcomes Framework data, this relates to the most recent information available to the CQC at that time. In this case, the most recent results were from the 2014/15 year; a time when the practice was being run by the previous provider.

Inadequate

Are services safe?

Our findings

Safe track record and learning

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

- Staff told us they would inform the managing director of any incidents and there was a recording form available on the practice's computer system.
- We saw evidence that when things went wrong with care and treatment, attempts were made to inform the patient. However, a written apology was not provided nor was there evidence that the patient had been informed of any actions to improve processes to prevent the same thing happening again.
- The practice carried out an analysis of the significant events.

The practice informed us that there had been two significant events documented in the previous 12 months; one relating to a breach of contract where the practice had failed to submit an information return to NHS England on time, and another relating to a breach of confidentiality where patient documentation was given to the wrong person. We saw that these had been written up using the significant event template, and were shown meeting minutes where learning from the confidentiality breach was shared with staff. It was noted that there was a discrepancy between the attendees listed on the staff meeting minutes and those listed on the significant event meeting write-up (both were dated the same). There was no clear audit trail and no evidence to show information and lerning from significant events was shared with all staff. The staff we spoke with on the day of inspection were aware of the need to confirm a patient's identity, for example via date of birth and address, before giving out confidential information.

Staff told us of another incident where a pharmacy had complained to the practice about a prescription not being ready in an appropriate time scale. Staff told us how this was managed at the time and how the error was found to have been with the pharmacy. However, there was no evidence to demonstrate this incident had been documented as a significant event in order to maximise the learning opportunity.

We were told that safety alerts were received by email. We were also told that when they were received by email they would be distributed amongst practice staff as appropriate. However, there was no system in place to maintain records providing an audit trail of what information had been passed to whom and documenting that appropriate actions had been taken as a result of any safety alerts received. Other staff we spoke to were unable to articulate how safety alerts were managed and disseminated within the practice.

Overview of safety systems and processes

The practice had some systems, processes and practices in place to keep patients safe and safeguarded from abuse. However, there were gaps in some of these systems.

- Arrangements were in place to safeguard children and vulnerable adults from abuse. These arrangements reflected relevant legislation and local requirements. Policies were accessible to all staff. However, different safeguarding adult and children policy documents were shared with the inspection team prior to the visit to those that were on site on the day of inspection, suggesting that the policies were not embedded into practice. The policies viewed before and during the inspection visit failed to outline who to contact for further guidance if staff had concerns about a patient's welfare, although we saw on the day of inspection that appropriate contact details were displayed on the noticeboards in consulting rooms. The lead GP was the nominated lead for safeguarding. Staff demonstrated they understood their responsibilities and we were told that all had received training on safeguarding children and vulnerable adults relevant to their role, although no training certificates were available to demonstrate the health care assistant (HCA) or practice nurse had received such training. GPs were trained to child protection or child safeguarding level 3, and we saw training certificates to verify this. We also saw evidence that other non-clinical staff had completed appropriate training around safeguarding.
- Staff told us that chaperones were made available to patients if they were requested. However, there were no notices displayed in the waiting room or consultation rooms to advise patients that this facility was available if required. All staff who acted as chaperones were trained for the role. Management staff told us that all staff had received a Disclosure and Barring Service (DBS) check (DBS checks identify whether a person has a criminal record or is on an official list of people barred from

working in roles where they may have contact with children or adults who may be vulnerable). However, these checks were not documented appropriately to verify that they had been carried out; for example we saw in two staff files, one clinical and one non clinical, that a paper slip had been signed by practice management stating that a DBS certificate had been seen. The DBS certificate number was not recorded. They were both dated as having been viewed before the current provider took over the practice. This indicated that the current provider had not sought appropriate assurance to mitigate risks associated with the duties these staff members were being asked to carry out.

- The practice maintained appropriate standards of cleanliness and hygiene. We observed the premises to be clean and tidy. The practice nurse was the infection control clinical lead. However, there was no evidence of any infection prevention and control (IPC) training undertaken by the practice nurse. The practice was also unable to show us training records to demonstrate the HCA had undertaken IPC training. We saw that other non-clinical staff had accessed IPC eLearning modules. There was an infection control protocol available, however this was not specific to the practice, nor did it cover the scope of work undertaken. The document stated that it related to a mental health trust and related only to the management of sharps and sharps injuries. The occupational health contact numbers contained in the document related to the area local to the trust rather than being local numbers. Other aspects of infection prevention and control, such as handling of specimens and the management of bodily fluid spillages were not covered. The practice had not undertaken an appropriate infection prevention and control audit in the previous 12 months. We saw that an audit feedback template form from Lancashire Care NHS Trust had been completed on 11 April 2016. This document related to areas not relevant to general practice, such as catheter insertion and enteral feeding. Sections relating to hand washing and sharps had been completed, but insufficient detail was contained on the form to ascertain exactly what had been audited in relation to these areas. We noted during the visit that sharps bins were not all signed to denote the date their use was commenced or ceased. One sharps bin in a consulting room was over full.
- The arrangements for managing medicines, including emergency medicines and vaccines, in the practice kept patients safe (including obtaining, prescribing, recording, handling, storing, security and disposal). Processes were in place for handling repeat prescriptions which included the review of high risk medicines. The practice carried out regular medicines audits, with the support of the local CCG pharmacy teams, to ensure prescribing was in line with best practice guidelines for safe prescribing. Blank prescription forms and pads were securely stored and there were systems in place to monitor their use. Patient Group Directions (PGDs) had been adopted by the practice to allow the nurse to administer medicines in line with legislation. Staff told us that the Health Care Assistant administered flu vaccinations. However, during the inspection practice management were unable to confirm whether she had been trained to carry out this task, nor were they able to show the inspection team the Patient Specific Directions (PSDs) in place to ensure the vaccinations had been administered in line with legislation (PGDs and PSDs are written instructions for the administration of medicines to either groups of patients or individual patients). Two days after the inspection visit, the practice provided the inspection team with a copy of a training certificate confirming the HCA had attended training to administer flu vaccines in August 2014. No evidence that any update training had been attended by the HCA since this date was provided. Annual updates would be required in order to ensure these vaccines were administered safely.
- We reviewed six personnel files as well as the pre-employment checks completed for locum GPs and found appropriate recruitment checks had not been undertaken prior to employment in all cases. For example, three files we reviewed were for staff who commenced employment at the practice after the current provider took over the organisation in June 2015. None of these files contained application forms, interview notes, proof of identification, references or evidence of qualifications. Appropriate evidence of a check through the Disclosure and Barring Service (DBS) was contained in one file. None of the other files included appropriate documentation to confirm that a DBS check had been carried out. It was also noted that there was no DBS check for one of the long term locum GPs. We saw that a DBS check had been applied for this locum two days prior to the inspection. The practice had sought documentation from their locum agency regarding the suitability of a locum GP being used on

the day of inspection for the first time. The documents provided by the agency indicated that the locum's indemnity insurance cover expired the week prior to the inspection. There was no evidence on the day of inspection that the locum GP had appropriate cover in place, and this only came to light when the inspection team reviewed the documents. Following the inspection the practice provided further documentation that evidenced that appropriate indemnity cover had been in place for the locum GP. On the day of inspection, the practice was unable to provide evidence that the nurse was covered by appropriate indemnity insurance. Two days after the visit, we were provided with documents demonstrating that cover had commenced for the nurse the day before the inspection.

Monitoring risks to patients

Risks to patients were assessed and managed.

- There were procedures in place for monitoring and managing risks to patient and staff safety. There was a health and safety policy available with a poster in the reception office, although this did not identify local health and safety representatives. The practice had up to date fire risk assessments and carried out regular fire drills. All electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly. The practice had a variety of other risk assessments in place to monitor safety of the premises such as control of substances hazardous to health and legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings). Risks such as fire safety and legionella were managed centrally for the building by the building's management, rather than by the practice.
- 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, and staff worked to a 'buddy' system to ensure they had the skills required to cover for colleagues during times of absence.

Arrangements to deal with emergencies and major incidents

The practice had adequate 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 which alerted staff to any emergency.
- All staff received annual basic life support training and there were emergency medicines available in one of the consultation rooms.
- The practice had a defibrillator available on the premises and oxygen with adult and children's masks. A first aid kit and accident book were available.
- 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 stored securely.
- The practice had a comprehensive business continuity plan in place for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff and contractors as well as identifying an alternate GP practice premises from which services could be offered should the building become unusable. However, the plan did not fully reflect the operation of the practice, as it referenced services such as minor surgery that the practice no longer provided and referred to extended hours appointments being offered between 6:30 and 7:30pm on a Monday and Tuesday evening.

Inadequate

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Staff had access to guidelines from NICE and used this information to deliver care and treatment in order to meet patients' needs. The locum GPs told us they would access NICE guidance via the internet.

Management, monitoring and improving outcomes for people

The lead GP was unable to articulate or demonstrate that a systematic or coordinated approach had been undertaken in assessing the needs of the patient population and putting measures in place to address these needs upon taking over the practice.

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 98.7% of the total number of points available, with 13.9% exception reporting across the clinical domains (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 noted that in particular, while high QOF achievement was reported, exception reporting rates had been high for COPD indicators. For example:

- 100% of patients with COPD (diagnosed on or after 1 April 2011) had had the diagnosis confirmed by post bronchodilator spirometry between 3 months before and 12 months after entering on to the register (55% exception reporting rate; 46% above CCG average and 45% above national average).
- 97% of patients with COPD had a review, undertaken by a healthcare professional, including an assessment of breathlessness using the Medical Research Council dyspnoea scale in the preceding 12 months (28% exception reporting rate; 17% above the CCG average and 16% above the national average).
- 93% of patients with COPD had a record of FEV1 in the preceding 12 months (41% exception reporting rate; 17% above the CCG average and 26% above the national average).

The practice demonstrated that it was aware of the high exception reporting rate under the previous provider and discussed with the inspection team that appropriate steps had been taken to address the issue. The practice showed us current figures (that were not yet independently verified) which demonstrated that exception reporting around COPD had significantly reduced, while achievement against the QOF domains remained high.

Other QOF data from 2014/15 showed:

- Performance for diabetes related indicators was above the national average, although in many cases the exception reporting rate was also higher. For example:
  - The percentage of patients with diabetes on the register in whom the last IFCC-HbA1c was 64mmol/mol or less in the preceding 12 months was 85% compared to the national average of 78% (Exception reporting 29%; 14% higher than the CCG average and 16% higher than the national average).
  - The percentage of patients with diabetes on the register in whom the last blood pressure reading (measured in the last year) was 140/80 mmHg or less was 91%, compared to the national average of 78% (exception reporting 10%, in line with local and national averages).
  - The percentage of patients with diabetes on the register whose last measured total cholesterol (measured in the preceding 12 months) was five mmol/l or less was 92% compared to the national average of 81% (exception reporting 20%; 7% higher than the CCG average and 8% higher than the national average).
  - The percentage of patients with diabetes on the register who had had influenza immunisation in the preceding 1 August to 31 March was 98% compared to the national average of 94% (exception reporting 28%; 8% above the CCG average and 10% above the national average).
  - The percentage of patients on the diabetes register with a record of a foot examination and risk classification within the last 12 months was 98% compared to the national average of 88% (exception reporting 22%; 11% above the CCG average and 14% above the national average).

Inadequate

Are services effective?

(for example, treatment is effective)

- Performance for mental health related indicators was also above the national average (with exception reporting lower than national averages for all the below indicators). For example:
  - The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who had a comprehensive, agreed care plan documented in the record in the preceding 12 months is 95% compared to the national average of 88%.
  - The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses whose alcohol consumption had been recorded in the preceding 12 months was 100% compared to the national average of 90%.
  - The percentage of patients diagnosed with dementia whose care had been reviewed in a face to face review in the preceding 12 months was 100% compared to the national average of 84%.
- The percentage of patients with hypertension in whom the last blood pressure reading measured in the preceding 12 months was 150/90mmHg or less was 93% compared to the national average of 84%.
- The percentage of patients with asthma on the register who had an asthma review in the preceding 12 months that included an appropriate assessment of asthma control was 76%, compared to the national average of 75%.

There was little evidence of quality improvement including clinical audit.

- There had been two clinical audits carried out, neither of which were completed audits so did not provide evidence that improvements made were implemented and monitored. One audit examined antibiotic prescribing for sore throats. This had been documented on a Public Health England / Royal College of General Practitioners template. However, the calculations had not been completed on the write up. Actions identified as a result of the audit included providing the GPs with up to date guidance and using posters to educate patients on antibiotic treatments. The other audit related to patients failing to attend for cancer screening appointments. This data collection indicated that the practice was not performing well against recommended standards. Actions recommended as an outcome included raising awareness amongst staff in order to encourage patients to attend. Since neither of these audits had been repeated, it was not possible to evidence if the identified actions had been implemented effectively and had resulted in improvement.
- The lead GP confirmed to the inspection team that the practice did not engage in systematic peer review or benchmarking to monitor and improve performance.

The practice was able to demonstrate that improvements had been made in some areas. For example, we were shown data confirming that unplanned admissions to hospital had reduced by approximately 30% since the practice had been taken over. The lead GP explained that this was largely due to a practice nurse being employed and one of her responsibilities being to review patients on the avoiding unplanned admissions register following an admission to hospital.

Effective staffing

The practice could not demonstrate that staff had the skills, knowledge and experience to deliver effective care and treatment.

- The practice had an induction programme for all newly appointed staff. This included meeting with the building manager for a health and safety and fire safety induction, as well as topics such as data protection.
- The practice could not demonstrate how they ensured role-specific training and updating for relevant staff. For example, for those reviewing patients with long-term conditions. While the practice nurse told us about role specific training courses she had attended, certificates to verify this were not available to view.
- Evidence that staff administering vaccines and taking samples for the cervical screening programme had received specific training which had included an assessment of competence was not available during the inspection. The practice nurse informed us that she had completed such training, but the certificates were not available on site to view. Management staff confirmed that the HCA administered flu vaccines but were unable to confirm during the inspection visit whether appropriate training had been received for this. Two days after the inspection visit, the practice provided the inspection team with a copy of a training certificate confirming the HCA had attended training to administer

flu vaccines in August 2014. No evidence that any update training had been attended by the HCA since this date was provided. Annual updates would be required in order to ensure these vaccines were administered safely.

- The practice was unable to show that a systematic approach to identifying the learning needs of staff was in place. No documentation relating to staff appraisals was available and the lead GP confirmed that while informal discussions with staff had taken place, formal appraisals had not for any staff. Staff told us that they had access to appropriate training to meet their learning needs and to cover the scope of their work. This included ongoing support and coaching and mentoring.
- Staff received training that included: safeguarding, fire safety awareness, basic life support and information governance. Staff had access to and made use of e-learning training modules. The practice provided us with training summaries for a number of staff from the eLearning package used. We confirmed with practice management staff that the timings indicated on the summaries related to the time spent on the training modules. We saw that in a number of cases, staff had completed a large number of modules in a very short space of time, which may mitigate the effectiveness of the training.

Coordinating patient care and information sharing

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

- This included care and risk assessments, care plans, medical records and investigation and test results.
- However, we did note some confusion between different staff members with regards to whose responsibility it was to follow up and action abnormal test results. The long term locum understood that the lead GP took responsibility for this, while the lead GP told us the clinician requesting the test had responsibility to follow it up. The practice did not have clear written protocols in place around this issue.
- The practice shared relevant information with other services in a timely way, for example when referring patients to other services.

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

Consent to care and treatment

The practice did not have a consent policy in place at the time of the visit, however discussions indicated that 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.
- Where a patient's mental capacity to consent to care or treatment was unclear the GP or practice nurse assessed the patient's capacity and, recorded the outcome of the assessment.

Supporting patients to live healthier lives

The practice identified patients who may be in need of extra support. 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. Patients were signposted to the relevant service.
- Smoking cessation advice was provided in house by the practice nurse.

The practice's uptake for the cervical screening programme was 83% in 2014/15, which was comparable to the CCG average of 80% and the national average of 82%. However, the practice provided current unverified date that placed its uptake at 69% for the present year. The practice nurse told us there was a policy to offer telephone reminders for patients who did not attend for their cervical screening test. The practice demonstrated how they encouraged uptake of the screening programme by ensuring a female sample taker was available. While the practice did have a

Inadequate

Are services effective?

(for example, treatment is effective)

cervical smear policy, this document was not specific to the practice; it contained numerous sections where the text was from a policy template advising the provider what information to include.

The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening. There were failsafe systems in place to ensure results were received for all samples sent for the cervical screening programme and the practice followed up women who were referred as a result of abnormal results. The practice nurse informally monitored cervical screening results to ensure adequate samples had been provided, but this had not been formally written up or audited.

Childhood immunisation rates for the vaccinations given were slightly lower than CCG averages. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 70% to 92% and five year olds from 71% to 96%.

Patients had access to appropriate health assessments and checks. These included health checks for new patients and NHS health checks for patients aged 40–74. Appropriate follow-ups for the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.

Requires improvement

Are services caring?

Our findings

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.

All of the 38 patient Care Quality Commission comment cards we received were positive about the service experienced. Patients said they felt the practice staff were helpful, caring and treated them with dignity and respect. However, three cards also expressed concern regarding the lack of continuity of care due to the high turnover of clinical staff.

We spoke with two patients during the inspection visit. One was dissatisfied with the lack of continuity of care and the inability to see the same clinician. They felt this impacted on the quality of care they received. The other was happy with the clinical care received but was frustrated that staff had not advised them that their appointment was running late or why this was the case.

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

- 78% of patients said the GP was good at listening to them compared to the clinical commissioning group (CCG) average of 91% and the national average of 89%.
- 76% of patients said the GP gave them enough time compared to the CCG average of 89% and the national average of 87%.
- 92% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 96% and the national average of 95%.
- 73% of patients said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 87% and national average of 85%.
- 87% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 90% and national average of 91%.
- 88% of patients said they found the receptionists at the practice helpful compared to the CCG average of 88% and the national average of 87%.

Care planning and involvement in decisions about care and treatment

Patients told us via the comment cards 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. One patient we spoke with on the day expressed concerns that the lack of continuity of care might impact the ability to make the most informed decision about their care and treatment.

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

- 71% of patients said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 87% and the national average of 86%.
- 72% of patients said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 83% and national average of 82%.
- 73% of patients said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average of 86% and national average of 85%.

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

- Staff told us that translation services were available for patients who did not have English as a first language.
- Information leaflets were available in easy read format.

Requires improvement

Are services caring?

Patient and carer support to cope emotionally with care and treatment

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

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 73 patients as carers (2.5% of the practice list). Written information was available to direct carers to the various avenues of support available to them.

Staff told us that if families had suffered bereavement, the GP sent them a sympathy card. Further advice was also offered as required and families were signposted to relevant support groups.

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The provider discussed with us how prior to the takeover in June 2015 the practice had been staffed by many locum GPs. The provider felt that since taking over, the clinical team had been stabilised and believed that continuity of care had improved for the patients; only five locums had been used in the previous year, two of these being long term.

- The practice offered an extended hours clinic on a Wednesday morning between 7:30 and 8am for working patients who could not attend during normal opening hours.
- The practice also informed us that patients were also able to access extended hours clinic appointments funded by the Prime Minister's Challenge Fund between 4pm and 8pm each weekday and 9am to 1pm on weekends. The practice told us these appointments were available at the Family Practice.
- There were longer appointments available for patients with a learning disability.
- Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice.
- Same day appointments were available for children and those patients with medical problems that require same day consultation.
- Patients were able to receive travel vaccinations available on the NHS as well as those only available privately.
- There were disabled facilities and translation services available. No hearing loop was available on the reception desk.
- The practice was based on the second floor of the health centre but was easily accessed via a lift.
- A tier two drug and alcohol misuse support service was offered in the practice once per week. The main GP had responsibility for signing any prescriptions this service generated for patients. However, due to the lead GP also spending time at the two other practice locations it was unclear how frequently liaison took place with the substance misuse support worker. Staff informed us that when prescriptions were generated by this service while the lead GP was not present, the scripts would be left for him to sign the next time he was on site.

Access to the service

The practice was open from 8am until 6:30pm Monday to Friday, with appointments with the GP available between 9:30am and 12 noon each morning and between 3:00 and 5:00pm each afternoon. Extended hours appointments were also available between 7:30 and 8am each Wednesday morning. In addition to pre-bookable appointments that could be booked up to one week in advance, urgent appointments were also available for people that needed them. On the day of inspection, the next available routine appointment was one week later.

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

- 74% of patients were satisfied with the practice's opening hours compared to the national average of 78%.
- 65% of patients said they could get through easily to the practice by phone compared to the national average of 73%.
- 67% of patients were able to get an appointment to see or speak to someone the last time they tried compared to the national average of 76%.

People told us on the day of the inspection that they were able to get appointments when they needed them, although one patient was extremely frustrated that the appointment for his young child was over 40 minutes behind schedule and no explanation had been given to him.

The practice had a system in place to assess:

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

However, staff gave us inconsistent information about what this system was, with some saying information regarding the home visit request would be passed directly to the lead GP, while others reported the request information was passed to the practice nurse so that the request could be triaged. Staff were not aware of any written policy or protocol with regards to this process.

Listening and learning from concerns and complaints

Prior to the inspection the provider shared a complaints information leaflet for patients with the inspection team. However, this leaflet was not available to patients on the

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

day of the inspection visit and staff we spoke to were unaware of its existence. The separate practice information leaflet that was available in the waiting area did contain information advising patients to write to the practice manager if they had a complaint and advising them that they would receive a full written response once the complaint had been investigated. However, we noted that the management structure for the practice did not contain a role titled 'practice manager.'

- Its complaints policy was in line with recognised guidance and contractual obligations for GPs in England. However, we did not see that this policy was followed; information to advise patients of their right to escalate complaints and signpost them to appropriate organisations to do this was not readily available to them.
- There was a designated responsible person who handled all complaints in the practice. Staff told us on the day of inspection that this was the managing director.

We were told only one formal complaint had been received in the last 12 months. This related to a service provided by the lead GP at the out of hours spoke clinic funded by the Prime Minister's Challenge Fund. We reviewed the written response the GP provided and saw that it was sent to the complainant in a timely manner and contained an apology for any distress caused. However, the response did not advise the complainant of other avenues to pursue should they be unhappy with the outcome of the investigation of the complaint and resulting response.

The managing director told us that since he had been in post he had dealt with two separate verbal complaints; one related to availability of appointments and one related to a referral on to secondary care. These complaints were resolved verbally but the managing director confirmed that no record of the conversations had been made. Practice meeting minutes we viewed did not contain complaints as an agenda item and staff we spoke to were unable to give any examples where learning from complaints had been fed back to them.

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 staff we spoke to were able to articulate how improving care for the patients was a priority. The management team discussed how they were focussed on turning a struggling practice into a profitable organisation. However, the vision and strategy to achieve this was not documented or clear.

We were informed on the day of inspection that the CCG had identified the surgery as a vulnerable practice (vulnerable GP practices are identified as those where there is greatest concern or those assessed by local commissioners in need of support in view of local intelligence) and had offered financial support as a result. We were told that the practice had accepted this support, however it was unable to demonstrate how it was planning to invest the additional funding in order to improve the service for patients. The lead GP told us he was not aware of the reasons for the practice being included on the vulnerable practice list.

Governance arrangements

The practice lacked an adequate overarching governance framework to support the delivery of good quality care.

- Staff were mostly aware of their own roles and responsibilities, however there were ambiguities around the management structure of the practice.
- The policy documents available to staff were inadequate to govern activity undertaken. None of the documents were dated to indicate when they were produced, reviewed or when their next review was due. The policies were not practice specific, with a number referring to other organisations (for example the infection control policy referencing a mental health trust). Some referred to out of date information or organisations, such as Primary Care Trusts or the Criminal Records Bureau. There was no chaperone policy or consent policy available.
- A comprehensive understanding of the performance of the practice was not maintained; the practice management were not aware of how the performance of the practice benchmarked against others in the area. The provider was not able to demonstrate an understanding of why the CCG had identified the practice as at risk.
- A programme of continuous clinical and internal audit had not been implemented to monitor nor demonstrate improvements were being made. The limited audit activity that had been undertaken had not been completed to full cycles and was insufficiently targeted based on clinical risk.
- There was not a systematic approach to the management of staff training which led to gaps in training completed.
- The identification and management of risks was not comprehensive; for example recruitment checks were inadequate to mitigate any risks associated with the roles being carried out.

Leadership and culture

The leadership team lacked experience in the management of general practice. The management team informed us that they were booked onto a two day leadership course the following week..

There was a degree of ambiguity around the management structure. Prior to the inspection, documentation referred to there being a practice manager in post. Staff on the day of the visit referred to a practice manager. However, the management team discussed the structure as containing a managing director role, who had managerial oversight across the three separate practice locations. The management team told us there was currently a vacant operations manager role specific to the practice.

We noted that when the inspection was announced, we were informed by the provider that there was one salaried GP and one long term locum GP. However, this conflicted with the information given by the provider on the day of inspection.

Staff told us the lead GP and management team were approachable and always took the time to listen to all members of staff. We were told that they were present at the practice approximately two days per week, and were available via telephone and email at other times.

Are services well-led?

Inadequate

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

From the significant event analysis form we were shown, we saw that the practice had attempted to contact patients when things went wrong to offer them an explanation and apology. However, the practice did not always maintain written records of verbal interactions.

There was a leadership structure in place and staff told us they felt supported by management.

- Staff told us the practice held regular team meetings. We reviewed minutes from a selection of these meetings and found that they lacked sufficient detail to provide a robust audit trail of what information had been discussed with whom.
- Staff told us there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and felt confident and supported in doing so.
- Staff said they felt respected, valued and supported.

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

The practice had failed to encourage feedback from patients and the public. There was no Patient Participation Group (PPG) at the practice. The provider had told the inspection team prior to the visit that when the practice was taken over, a random sample of patients had been contacted by letter inviting them to become members of a PPG. We were told that none had responded to this. However, on the day of the visit we were informed that these letters had only been distributed one month earlier. The practice had recently added information to the practice leaflet regarding setting up a PPG and told us one patient had responded the day before the inspection. The practice had not conducted any patient surveys to gather feedback.

The managing director informed us that some patients left comments on the Friends and Family responses. One of these related to the need to improve telephone access. We were told that the practice had looked into a queuing system for the phone line, but that this had not been pursued as the cost was prohibitive.

Staff we spoke to told us that management were responsive to their feedback. One example given related to the rota system implemented to allow staff to have some time away from work during a religious holiday.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **How the regulation was not being met:** There was insufficient leadership and governance arrangements were inadequate. There were key omissions in policy documents to govern activity. For example, there were no consent or chaperone policies available to staff. There was no evidence of document control for policies and procedures that were in place. The documents in place were not embedded and were not practice specific. Risks to patients and staff were not consistently or effectively assessed and managed, for example the infection control audit tool used by the practice was not appropriate or relevant, and vaccines had been administered without appropriate patient specific directions in place. There was no evidence of a planned programme of audit in place to drive quality improvement and to monitor and address gaps in performance. Feedback from patients had not been proactively sought and there was not a systematic approach for maximising learning from complaints. There was no systematic approach to ensuring staff received appropriate support, training and appraisal. This was in breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed

This section is primarily information for the provider

Enforcement actions

Maternity and midwifery services

Surgical procedures

Treatment of disease, disorder or injury

How the regulation was not being met:

Appropriate employment checks were not carried out prior to staff commencing work, and information specified in schedule 3 was unavailable in respect of staff employed in order to ensure they had been safely and effectively recruited and employed.

This was in breach of regulation 19(2) Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014