# Dr John Cormack

## Quality Report

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

## Ratings

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

# Summary of findings

## Contents



## Overall summary

**Letter from the Chief Inspector of General Practice**

We carried out an announced comprehensive inspection at Dr John Cormack on 10 November 2016. Overall the practice is rated as requires improvement.

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

- There were insufficient systems and support for staff to identify report, investigate and learn from significant incidents.
- The practice had not consistently actioned patient safety and medicines alerts placing patients at risk.
- Not all clinical staff had undertaken safeguarding training. The practice did not follow up on children and vulnerable patients who failed to attend hospital appointments or patients who had not collected their prescriptions.
- Not all clinical staff had undertaken infection prevention control training. The practice cleaning schedules lacked detail to confirm when, where and how rooms and equipment had last been cleaned.
- Some clinical staff members had not received training in the Mental Capacity Act in relation to obtaining consent.
- The practice cold chain policy for the safe storage of medicines had not been adhered to. Staff had failed to report and investigate when the fridge temperature exceeded recommended levels.
- We found the practice nurse had administered vaccinations to children and vulnerable patients without the written direction from a GP.
- Appropriate recruitment checks had not been completed for a member of the practice clinical team.
- We found not all members of the clinical team had undertaken emergency life support training. They had access to appropriate equipment and checks were conducted and recorded.

# Summary of findings

- Emergency medicines were available and in date but some recommended medicines in relation to the services provided, were not being stored and a risk assessment had not been undertaken.
- The clinical team had access to NICE guidance and the nursing team were working within their Mid Essex formulary, shared care protocols and competency levels.
- The practice had consistently strong clinical performance in their QOF performance in 2014/2015 and 2015/2016. They achieved 97% with below the local exception rates.
- We found that patient blood results, test results and out of hours information was managed in a timely and appropriate way. Patient referrals were also found to be appropriate and demonstrated a clear understanding of local and national guidelines.
- There was evidence of appraisals and personal development plans for all staff.
- Data from the national GP patient survey showed patients rated the practice higher than others for all aspects of care.
- Patients consistently told us they received a personalised service where they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.
- There was a lack of quality improvement processes in place at the practice, including clinical audit.
- The practice was active within their Clinical Commissioning Group and worked with their Commissioners.
- There was a clear staff structure and staff were trusted to fulfil their roles with minimal oversight. However the system of governance in place was not identifying where some patients were at risk and there was a lack of clinical oversight and supervision of staff carrying out their duties. Meetings were irregular and not consistently recorded, including an absence of discussions and decisions.
- The practice had an active and supportive Patient Participation Group. They represented the practice and patients within the wider health forums to improve services.

The areas where the provider must make improvements are:

- Ensure there are systems and support for staff to identify, report, investigate and learn from significant incidents.
- Ensure that there is an effective system in place to action patient safety and medicine alerts.
- Ensure that the system in place to manage and act on safeguarding issues affecting children and vulnerable adults is effective.
- Ensure that authorities are obtained for the safe administration of medicines by the nurse working at the practice
- Ensure recruitment checks are undertaken for all staff in line with guidance.
- Ensure that staff are appropriately supervised and trained to carry out their roles.
- Ensure the effective assessment of risks and preventing, detecting and controlling the spread of infections.
- Maintain a recommended supply of emergency medicines for use in relation to the services provided or undertake a risk assessment as to why they are not required.
- Ensure there is an effective system of governance and clinical oversight in place at the practice including quality improvement processes.

The areas where the provider should make improvements are:

- Cleaning records should demonstrate when, where and how rooms and equipment were cleaned.
- Improvements to be made in the capturing and recording of complaints.

This service is rated as requires improvement overall. However the practice is rated as inadequate for providing safe services. Where a service is rated as inadequate for one of the five key questions or one of the six population groups or overall, it will be re-inspected within six months after the report is published. If, after re-inspection, the service has failed to make sufficient improvement, and is still rated as inadequate for any key question or population group or overall, we will place the service into special measures. Being placed into special measures represents a decision by CQC that a service has to improve within six months to avoid CQC taking steps to cancel the provider's registration.

**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.

- There were insufficient systems and support for staff to identify report, investigate and learn from significant incidents.
- The practice had not consistently actioned patient safety and medicine alerts placing patients at risk.
- Not all clinical staff had undertaken safeguarding training. The practice policy placed an emphasis on patient consent to escalate concerns. The practice did not follow up on children and vulnerable patients who failed to attend hospital appointments.
- The practice did not follow up on patients who failed to collect their prescriptions to ensure there were no safeguarding concerns.
- Not all clinical staff had undertaken infection prevention control training. The practice cleaning schedules lacked detail to confirm when, where and how rooms and equipment had last been cleaned.
- The practice cold chain policy for the safe management of medicines had not been adhered to. Staff had failed to report and investigate when the fridge temperature exceeded recommended levels.
- The practice nurse had administered vaccinations to children and vulnerable patients without the written direction from a GP.
- Appropriate DBS recruitment checks had not been completed for a member of the practice clinical team who also undertook chaperone duties.
- The practice had procedures in place for the identification and management of environmental risks such as trips, hazards, fire, and legionella.
- We found not all members of the clinical team had undertaken emergency life support training. They had access to appropriate equipment and checks were conducted and recorded.
- Emergency medicines were available and in date but not sufficient to address the full extent of their activities.

**Are services effective?**

**Requires improvement**

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

# Summary of findings

- The clinical team had access to NICE guidance and the nursing team were working within their Mid Essex formulary, shared care protocols and competency levels.
- The practice had consistently strong clinical performance in their QOF performance in 2014/2015 and 2015/2016. They achieved 97% with below the local average exception reporting rates.
- There was a lack of quality assurance activity taking place at the practice.
- Staff had the skills, knowledge and experience to deliver effective care and treatment. However, not all had attended relevant training including safeguarding, infection control, Mental Capacity Act and emergency life support.
- We found patient blood results, test results and out of hours information was managed in a timely and appropriate way. Patient referrals were also found to be appropriate and demonstrated a good understanding of local and national guidelines.
- There was evidence of appraisals and personal development plans for all staff.
- Staff worked with other health care professionals to understand and meet the range and complexity of patients' needs.

**Are services caring?**

Good

The practice is rated as good for providing caring services.

- Data from the national GP patient survey showed patients rated the practice higher than others for all aspects of care.
- Patients consistently told us they received a personalised service where they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.
- Information for patients about the services available was easy to understand and accessible.
- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.

**Are services responsive to people's needs?**

Good

The practice is rated as good for providing responsive services.

- Practice understood and had responded to the needs of their patients, offering extended hours and an emergency on the day clinic every morning between 9am and 10am.
- Patients said they found it easy to make an appointment with a named GP and there was continuity of care, with urgent appointments available the same day.

# Summary of findings

- The practice had good facilities and was well equipped to treat patients and meet their needs.
- Information about how to complain was available. Improvements were required in the capturing and recording of complaints. The practice tried to resolve complaints at the time of reporting. They discussed concerns raised relating to their practice and partner health and social care services.

**Are services well-led?**

**Requires improvement**

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

- The practice was active within their Clinical Commissioning Group and worked with their Commissioners.
- The practice reported continuing financial challenges. Their response to these was not documented within their business plan.
- There was a clear staff structure and staff were allocated roles within the practice. However there was a lack of clinical oversight and governance, and risks to patients were not being acted on and mitigated. There was a lack of leadership in relation to patient safety.
- There was a lack of quality improvement processes in place to assess and monitor the services provided.
- Meetings were irregular and not consistently recorded, including an absence of discussions and decisions.
- The practice had an active and supportive Patient Participation Group. They represented the practice and patients within the wider health forums to improve services.

# Summary of findings

## The six population groups and what we found

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

### Older people

Requires improvement

The practice is rated as requires improvement in effective and well led. It is rated as inadequate for safe and good for caring and responsive. The issues identified as requires improvement overall affected all patients including this population group.

- The practice did not follow up on patients who failed to collect their prescriptions to ensure there were no safeguarding concerns.
- The practice was responsive to the needs of older people, and offered home visits and urgent appointments for those with enhanced needs.
- The patients had a named GP who oversaw their care
- The practice maintained a frailty register and designed and maintained care plans for patients in partnership with the community services.
- Senior health checks were offered and patient encouraged to attend. These were conducted by the healthcare assistant and nurse led clinics.
- The practice participated in multidisciplinary reviews meetings with health and social care professionals.
- The practice provided services to two residential/nursing homes.
- The practice participated in the admission avoidance programme and identified and supported patients to reduce their admission rates into hospital.
- Patients over 75 were encouraged to have the flu vaccination and the uptake was monitored.

### People with long term conditions

Requires improvement

The practice is rated as requires improvement in effective and well led. It is rated as inadequate for safe and good for caring and responsive. The issues identified as requires improvement overall affected all patients including this population group.

- The practice did not follow up on patients who failed to collect their prescriptions to ensure there were no safeguarding concerns.
- Patients at risk of hospital admission were identified as a priority and care plans put in place to reduce their need to be admitted to hospital.
- Longer appointments and home visits were available when needed.

# Summary of findings

- The practice operated an annual and biannual review of patients with long term conditions reviewing their medication and conditions.
- The practice operated a chronic disease monitoring recall system every six months.
- The lead GP spoke or met directly with the McMillan nursing team to discuss individual patient's needs.
- Patients receiving end of life care were provided the GP's direct contact number. The GP could be contacted when the surgery was closed.
- The practice participated in multidisciplinary reviews meetings with health and social care professionals.

**Families, children and young people**

Requires improvement

The practice is rated as requires improvement in effective and well led. It is rated as inadequate for safe and good for caring and responsive. The issues identified as requires improvement overall affected all patients including this population group.

- Not all clinical staff had completed safeguarding training.
- The practice failed to follow up on children who did not attend hospital appointments.
- The practice operated a walk in nurse led emergency clinic every morning Monday to Friday from 9am to 10am. This was for same day emergency access and could be booked on the day in person.
- The practice offered preconception, antenatal and postnatal care and had fortnightly appointments in the surgery with the community midwife.
- The practice had an established and productive relationship with their health visitors.
- The practice conducted six weekly baby checks and provided all childhood immunisations.
- 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.
- Appointments were available outside of school hours and the premises were suitable for children and babies.
- Patients can access information and sexual health advice and contraception during nurse and GP appointments.

# Summary of findings

**Working age people (including those recently retired and students)**

Requires improvement

The practice is rated as requires improvement in effective and well led. It is rated as inadequate for safe and good for caring and responsive. The issues identified as requires improvement overall affected all patients including this population group.

- Appointments could be booked in person, by telephone or via the practice website.
- The practice provided travel advice and vaccinations through the appointments system
- The practice is a yellow fever vaccination centre. This service was provided to the practice patients and non-registered patients could be referred from other practices.
- Patients were offered a choice of services, locations and dates when accessing specialist health services.
- The practice offered a full range of health promotion and screening that reflected the needs for this age group.

**People whose circumstances may make them vulnerable**

Requires improvement

The practice is rated as requires improvement in effective and well led. It is rated as inadequate for safe and good for caring and responsive. The issues identified as requires improvement overall affected all patients including this population group.

- Not all clinical staff had completed mandatory safeguarding training.
- The practice failed to follow up on children who failed to attend hospital appointments.
- The practice did not follow up on patients who failed to collect their prescriptions to ensure there were no safeguarding concerns.
- The practice held a register of patients living in vulnerable circumstances including homeless people and 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.
- Staff knew how to recognise signs of abuse in vulnerable adults and children. However some clinicians had not received training in the Mental Capacity Act 2005 in relation to the capacity of a patient to consent to care and treatment.

# Summary of findings

**People experiencing poor mental health (including people with dementia)**

Requires improvement

The practice is rated as requires improvement in effective and well led. It is rated as inadequate for safe and good for caring and responsive. The issues identified as requires improvement overall affected all patients including this population group.

- The practice did not follow up on patients who failed to collect their prescriptions to ensure there were no safeguarding concerns.
- The practice maintains a register of patients who experienced poor mental health. The register supported clinical staff to offer patients annual health checks and medication reviews.
- Patients were referred to appropriate support services such as psychiatry and counselling services.
- The practice worked with adult and children mental and emotional health provision to deliver continuity of care.
- The practice conducted additional safeguarding checks on vulnerable patients to ensure they were accessing sufficient support at the weekends and over bank holiday periods.
- The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those with dementia.

# Summary of findings

## What people who use the service say

The national GP patient survey results were published in July 2016. The results showed the practice was performing in line with local and national averages. 237 survey forms were distributed and 126 were returned. This represented a response rate of 53% which was above the national average response rate of 38%.

- 96% of respondents found it easy to get through to this practice by phone compared to the local average 63% and the national average of 73%.
- 91% of respondents were able to get an appointment to see or speak to someone the last time they tried compared to the local average 86% and the national average of 85%.
- 96% of respondents described the overall experience of this GP practice as good compared to the local average 83% and the national average of 85%.
- 96% of respondents said they would recommend this GP practice to someone who has just moved to the local area compared to the local average 76% and the national average of 78%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 28 comment cards which were all positive about the standard of care received. Patients told us of the consistent kindness and compassion showed to them and their families. How the clinical team went out of their way to check on their wellbeing and support them during diagnosis, treatments and bereavements.

During the inspection we spoke to a member of the patient participation group and three patients. They told us patients reported receiving a positive service from both administrative and clinical staff. They told us staff were approachable, committed and caring and they could always get an appointment.

## Areas for improvement

**Action the service MUST take to improve**

- Ensure there are systems and support for staff to identify, report, investigate and learn from significant incidents.
- Ensure that there is an effective system in place to action patient safety and medicine alerts.
- Ensure that the system in place to manage and act on safeguarding issues affecting children and vulnerable adults is effective.
- Ensure that authorities are obtained for the safe administration of medicines by the nurse working at the practice
- Ensure recruitment checks are undertaken for all staff in line with guidance.
- Ensure that staff are appropriately supervised and trained to carry out their roles.
- Ensure the effective assessment of risks and preventing, detecting and controlling the spread of infections.
- Maintain a recommended supply of emergency medicines for use in relation to the services provided or undertake a risk assessment as to why they are not required.
- Ensure there is an effective system of governance and clinical oversight in place at the practice including quality improvement processes.

**Action the service SHOULD take to improve**

- Cleaning records should demonstrate when, where and how rooms and equipment were cleaned.
- Improvements to be made in the capturing and recording of complaints.

# Dr John Cormack

**Detailed findings**

## Our inspection team

**Our inspection team was led by:**

Our inspection team was led by a CQC Lead Inspector and was supported by a GP specialist adviser.

## Background to Dr John Cormack

Dr John Cormack is also referred to as The Greenwood Surgery, Tylers Ride. They have a practice list size of 4364 patients. The practice is situated in the heart of South Woodham Ferrers with free street parking available.

The practice is owned and managed by the lead GP who is male. They are supported by two male locum GPs and an extensive clinical team consisting of two female nurse practitioners, a female nurse prescriber, female practice nurse, a female healthcare assistant and phlebotomist. All staff are supported by the administrative team overseen by the practice manager.

The practice is open between 8am and 6.30pm from Monday to Friday. Extended hours appointments are offered on Tuesday evening until 8.30pm. The practice operates a walk in nurse led emergency clinic every morning Monday to Friday from 9am to 10am. A GP is available during this time should they be required to support the nursing team with clinical consultations. Booked appointments are from 10.30am to 12.30pm and 2pm to 5.20pm and emergency appointments are reserved for the end of the day. In addition to pre-bookable appointments that could be booked up to six weeks in advance, urgent appointments were also available for people that needed them.

Female and male life expectancy is above the local and national averages. Serving an affluent community with lower levels of deprivation for children and older people than local and national averages.

The practice maintains a website providing patients with details on their opening times, services, staff roles and responsibilities and forums to capture patient feedback.

## 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 10 November 2016. During our visit we:

- Spoke with a range of staff (the GP, practice manager and administrative team).
- 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.

# Detailed findings

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.

Inadequate

# Are services safe?

## Our findings

### Safe track record and learning

We asked the practice how they identified and managed significant incidents. We found there was no policy in place defining significant incidents, how they were to be recorded, investigated or learning disseminated. The practice had recorded two significant incidents within the last year, relating to a vaccine being administered inappropriately and a delay in receiving patient blood results. We reviewed both incidents. The administration of the vaccination had occurred in November 2015, only to be discussed several months later on 9 February 2016. The significant event form stated all staff requested to be present but there were no details of who had attended and contributed to the discussion. The form was also incomplete, with no evaluation or learning documented and it had not been signed off as complete. We were told the incident had been discussed in a practice meeting and the minutes shared with the practice team. However, no members of the nursing team spoken to during the inspection knew of the event. We found no evidence of the other significant incident being discussed with staff.

We reviewed the practice meeting minutes from February 2016 and found two additional significant incidents had been listed for discussion. However, we found no supporting documentation to show they had been recorded as significant events, evaluated and learning shared.

Overall, we found there was an absence of significant incident recording, analysis and learning to demonstrate the practice had fulfilled their responsibilities under the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).

We asked the practice how they managed Medicines and Health Regulatory products Agency (MHRA) alerts and patient safety alerts. The MHRA is sponsored by the Department of Health and provides a range of information on medicines and healthcare products to promote safe practice. The practice told us that they shared the alerts with their clinical team, conducted a search of patients who may be adversely affected and discussed them. The practice were able to demonstrate that they had acted on a safety alert from February 2016. However, when we checked patient records in respect of previous MHRA alerts we found patients remained at risk;

- In 2012 an MHRA alert related to the prescribing of conflicting medicines. We found within the past 12 months there was 3 patients being prescribed the two medicines in conflicting quantities. We found no evidence that the GP had discussed the risks with the patient.
- In September 2016 an MHRA alert related to a batch of glucagon hypo kits with faulty needles. The device contained medicine used to treat a diabetic patient in an emergency if hypoglycaemic. Without a fast response this condition can result in loss of consciousness and coma for the patient. The surgery had no evidence that they had acted on this alert. We found four patients who had been prescribed this since 01/08/16 so potentially could be at risk.

### Overview of safety systems and processes

The practice had some defined systems, processes and practices in place, but these were not sufficient to keep patients safe and safeguarded from abuse, which included:

- Some arrangements were in place to safeguard children and vulnerable adults from abuse. Policies were accessible to all staff. The policy clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. These arrangements reflected relevant legislation and local requirements. Safeguarding of children was discussed during the practice clinical meetings. For example, in October 2015 the practice agreed that further details would be recorded of the persons attending with a child at risk. The GPs reported where necessary for other agencies. Staff demonstrated they understood their responsibilities but not all had received training on safeguarding children and vulnerable adults relevant to their role. The GPs told us they were trained to child safeguarding level 3. However, when we checked their recruitment file we found an absence of evidence to show they had received the training. Two members of the clinical team updated their training after the inspection including the lead GP for safeguarding.
- We found the practice did not follow up on children or patients who failed to attend hospital appointments.

Inadequate

# Are services safe?

- Notice in the waiting room advised patients that chaperones were available if required. The nursing team (including healthcare assistants) acted as chaperones. They were trained for the role and all but one of the nursing team 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). There was no risk assessment in place for the member of the nursing team without a DBS. The practice accepted this was an oversight and was unaware this was not in place prior to the inspection.
- We found the premises to be clean and tidy. The nurse practitioner was the infection control clinical lead. We reviewed the last infection prevention control audit. Six improvement actions had been identified and all had been appointed owners and resolved. However, the audit did not differentiate between consultation and treatment rooms. The audit did not define where minor surgery was being conducted and consider the enhanced risks presented to patients. The practice maintained individual cleaning schedules for each room but these were not sufficiently detailed to demonstrate when weekly or monthly scheduled items had been completed. We found not all clinical staff had received training in infection control. The practice did not maintain full records of cleaning they conducted prior to and in-between surgical interventions.
- The arrangements for managing medicines, including emergency medicines and vaccines, were not sufficient in the practice to keep patients safe. We found the temperature of the vaccination fridge had exceeded the required range on two occasions within November 2016. Staff had recorded the temperature rise but failed to follow their cold chain policy to ensure the integrity of the medicine. We checked the practice policy on the management medicines that clearly stated the escalation procedures should such an incident occur. We spoke to the staff on the day of the inspection and they told us that they did not appreciate the significance of the incident and had not reported them.
- We reviewed the prescribing practices of staff. We found all staff were aware of their roles and the practice prescribing nurses were trained and proficient at reviewing and handling repeat prescriptions which included the review of high risk medicines. Patients on high risk medicines had shared care plans in place.
- The practice worked with the support of the local medicine management teams, to ensure prescribing was in line with best practice guidelines for safe prescribing. We reviewed the annual prescribing review 2016-17 for Mid Essex Clinical Commissioning Group and saw the practice were not outliers for prescribing.
- Blank prescription forms and pads were securely stored and there were systems in place to monitor their use.
- We asked the practice what they did with prescriptions that were not collected from the surgery. They told us they left them for three months, recorded it on their patient record system and shredded the prescription. The GPs and nurses were not contacted to alert them to a potential risk due to the patient not having received their medicine.
- One of the nurses had qualified as an Independent Prescriber and could therefore prescribe medicines for specific clinical conditions. The lead GP was available for advice to the prescribing nurses but there was no recorded supervision of their practice in this extended role, other than their appraisal.
- We reviewed 13 Patient Group Directions. Patient group directions are written instructions for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment. All had been endorsed by the practice nurse. However, none had been signed by an authorising manager confirming the staff member had been assessed as competent to work under the direction and had their organisational approval to allow nurses to administer medicines in line with legislation. Health Care Assistants were trained to administer vaccines and medicines against a patient specific prescription or direction from a prescriber. Since the inspection we have been informed by the practice these have been appropriately authorised.
- The practice had appointed two members of staff, one clinical and one administrative, within the last year. We reviewed their personnel files and found some of the appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body. However, risks were identified. For example; a recently employed member of the clinical team had not had an appropriate

DBS check and was working independently. We checked with the Disclosure and Barring Service who confirmed they had not received the documentation so we were unable to confirm that it had been submitted.

### Monitoring risks to patients

Risks to patients were assessed and well managed.

- There were procedures in place for monitoring and managing risks to patient and staff safety. We reviewed the practice overarching risk assessment for the practice dated July 2016. It included hazards such as slips and trips and sharps injuries. It identified staff members responsible for issues, actions, timescales for completion and progress.
- The practice had an up to date fire risk assessment dated January 2016. All electrical equipment was checked in September 2016 to ensure the equipment was safe to use. Staff had read and signed the fire evacuation procedure. The practice had appointed and trained two staff members as fire marshals. They had recently had a new fire alarm installed in October 2016, which they tested weekly.
- Their medical equipment had been checked (calibrated) in April 2016 to ensure it was working effectively.
- 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 infection control and legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings). The practice assessment found the premises to be a low risk. However, they had employed mitigation strategies to reduce the risk further by regular testing of their water system.
- 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. Staff told us they try to cover for their colleagues during both planned and unplanned absence.

### Arrangements to deal with emergencies and major incidents

The practice had 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.
- Not all members of the clinical team had undertaken annual basic life support training. The four outstanding clinical staff undertook the training immediately after the inspection.
- The practice had a defibrillator available on the premises and oxygen with adult and children's masks. We were told that the equipment was checked weekly and shown records to support this. A first aid kit and accident book were available.
- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and stored securely. However, they did not have a supply of atropine cardiac medicine, used to respond to complications that can occur during the fitting of contraceptive devices. There was no risk assessment in place to reflect why the storage of this emergency medicine was not necessary. Since the inspection we have been advised by the practice that this emergency medicine is now being stocked.
- The practice had a business continuity plan in place for major incidents such as power failure or building damage. In the event their premises could not be occupied alternative accommodation was available. The plan included emergency contact numbers for staff and support services.

Requires improvement

# Are services effective?

(for example, treatment is effective)

## Our findings

### Effective needs assessment

The practice had systems in place to keep their clinical staff up to date with changes to guidelines such as those from National Institute for Health and Care Excellence (NICE). However, we found the GPs were inconsistent in their application of NICE. We did find the practice nursing team had a clear knowledge and consistent adherence to mid Essex formulary, shared care and local protocols. They escalated appropriate clinical concerns to GPs when they fell outside their professional remit.

### Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). The 2014/2015 QOF results showed the practice achieved above the local and national averages with 97% of the total number of points available. The practice had an 8.9% exception rate, below the local average of 9% and the national average of 9.2%. (Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects).

This practice was not an outlier for any QOF (or other national) clinical targets. Data from 2014/2015 showed the practice performed comparatively or above national averages for their management of long term conditions. For example;

- Performance for diabetes related indicators were comparable with the national average. For example, the percentage of patients with diabetes, on the register in whom the last IFCC-HbA1C is 64mmol/mol or less in the preceding 12 months. The practice achieved 74% as opposed to the local average of 72% and the national average of 78%.
- Patients on the diabetic register who had the influenza immunisation were above the national average, achieving 99% in comparison with the local average of 93% and the national average of 94%.
- The practice conducted 94% of the patients on the diabetes register, with a record of a foot examination and risk classification within the preceding 12 months. This was above the local average of 83% and the national average of 88%.
- The practice achieved 80% of their asthma reviews of patients in the preceding 12 months. This was above the local average of 71% and the national average of 75%.

The practice performed above the national averages for their management of patients with poor mental health. For example;

- 100% of their patients with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive care plan documented in their records within the last 12 months. The local average was 83% and the national average was 88%.
- The practice had recorded the alcohol consumption for all their patients (100%) with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive care plan documented in their records within the last 12 months. This was above the local average of 80% and the national average of 90%.
- The practice had conducted 97% face to face reviews with patients diagnosed with dementia in the preceding 12 months. This was above the local average of 81% and the national average of 84%.
- The percentage of patients with hypertension having regular blood pressure tests was above the local average of 84% and the national average of 84% achieving 89%.

The practice high exception reporting for patients with poor mental health was 23%. This was above the local average of 12.9% and the national average of 11.1%. Therefore, we checked patient records. We found patients with poor mental health receiving high risk medicines were being appropriately monitored.

The most recent QOF data for 2015/2016 showed the practice had maintained their clinical performance achieving 97% of the points available. The practice were not an outlier in any of the clinical domains. Their exception rate had increased slightly to 11% but this was below the local average and just above the national average by 1%.

The practice had below the local and national average for accident and emergency admissions for ambulatory care

Requires improvement

# Are services effective?

(for example, treatment is effective)

sensitive conditions. The practice achieved 11.09 per 1,000 of the population as opposed to the local average of 12.14 per 1,000 and the national average of 14.8 per 1,000 of the population. Ambulatory care sensitive conditions are those which it is possible to prevent acute exacerbations and reduce the need for hospital admission through active management, such as vaccination; better self-management, disease management or case management; or lifestyle interventions. Examples include congestive heart failure, diabetes, asthma, angina, epilepsy and hypertension. The practice told us they believed this was attributable to having good appointment availability and the open emergency clinics every morning.

There was some evidence of quality improvement including clinical audit. We saw two completed audits. One of the completed two cycle audits related to offering patients a cholesterol tablet if they had high risk of heart disease. They identified that 16 out of 32 patients would benefit from the intervention in accordance with NICE guidance. This was being audited annually. The practice also told us of an additional audit which had examined the management of female patients post breast cancer treatment. They told us the audit showed a lower incidence of a reoccurring condition with use of a medicine. The practice had shared their findings with their clinical team.

There was no other system of quality improvement taking place at the practice.

### Effective staffing

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 covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality.
- There was an absence of practice oversight to ensure staff had undertaken all appropriate training to cover the scope of their work. This was despite the learning needs of staff being identified through a system of appraisals, meetings and reviews of practice development needs. We found not all clinical staff had conducted all their training in emergency first aid and safeguarding.
- Staff had access to and made use of e-learning training modules, in-house training and GP Summit meetings. The latter were held by their Clinical Commissioning Group six monthly for GPs and their practice manager.

### Coordinating patient care and information sharing

The information needed to plan and deliver care and treatment was available to the practice staff in a timely and accessible way. However, the practice had recently transferred to a new computer system in October 2016 and had identified that care plans had not transferred across correctly. They were addressing this at the time of our inspection to ensure the patient records were accurate and accessible to all services involved in assessing and delivering their care.

We found that blood results, out of hours information and test results were checked and actioned in a timely and appropriate manner by the nursing team. They had been trained for the role and escalated concerns to GPs where appropriate.

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.

We reviewed 20 referrals, four of which were urgent. They had been made by both GPs and nurses. They were all appropriate and demonstrated clinical care and understanding of local and national guidelines.

We reviewed the minutes from the October 2016 multidisciplinary team. The meeting had representation from the community matron, mental health team, community agent (health and social care signposting service) and the MDT coordinator. The meetings were held monthly and care plans were routinely reviewed and updated for patients with complex needs. We checked patient records and found the community matron and the meeting facilitator had entered the narrative discussion into the patient record.

### Consent to care and treatment

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

Requires improvement

# Are services effective?

## (for example, treatment is effective)

- The practice recorded patient consent for interventions such as steroid injections, minor surgery and coil fitting.
- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005. However, not all members of the clinical team had received specific training.
- When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance.
- Where a patient's mental capacity to consent to care or treatment was unclear the GP worked with the community nursing teams in 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. Patients were signposted to the relevant service.

The practice reported a higher prevalence of new cancer diagnosis within their patient population than the local and national averages. They encouraged their patients to attend national screening programmes. Data from the National Cancer Intelligence Network showed the practice had comparable local and national rates of screening for their patients. For example,

- The practice's uptake for the cervical screening programme for 25- 64year old women in the preceding five years was 84%, which was comparable with the local average of 83% and the national average 82%. There was a policy to offer reminders for patients who did not attend for their cervical screening test.
- The practice screened 77% of their female patients aged 50-70 years of age for breast cancer in the last 36months. This was comparable to the local average of 77% and national average of 72%.
- The practice screened 64% of their patients aged 60-69 years of age for bowel cancer in the last 30 months. This was comparable with local averages of 61% and the national average of 58%.

Childhood immunisation rates for the vaccinations given were comparable to local and national averages. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 95% to 99% and five year olds from 93% to 100%.

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

Good

# Are services caring?

## Our findings

### Kindness, dignity, respect and compassion

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

- Dignity screens or separate examination rooms are used 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 by reception to discuss their needs.

All of the 28 patient Care Quality Commission comment cards we received were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect.

We spoke with one member of the patient participation group (PPG). They also told us they were happy with the care provided by the practice and said their dignity and privacy was respected. Comment cards highlighted that staff responded compassionately when they needed help and provided support when required.

Results from the national GP patient survey, published in July 2016 showed patients felt they were treated with compassion, dignity and respect. The practice was above average for its satisfaction scores on consultations with GPs and nurses. For example:

- 98% of respondents said the GP was good at listening to them compared to the clinical commissioning group (CCG) average of 88% and the national average of 89%.
- 97% of respondents said the GP gave them enough time compared to the CCG average of 86% and the national average of 87%.
- 98% of respondents said they had confidence and trust in the last GP they saw compared to the CCG average of 95% and the national average of 95%.
- 97% of respondents said the last GP they spoke to was good at treating them with care and concern compared to the local average of 84% and the national average of 85%.
- 93% of respondents said the last nurse they spoke to was good at treating them with care and concern compared to the local average of 92% and the national average of 91%.
- 94% of respondents said they found the receptionists at the practice helpful compared to the CCG average of 86% and the national average of 87%.

### Care planning and involvement in decisions about care and treatment

Patients told us they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them.

Patient feedback from the comment cards we received was also positive and aligned with these views.

Results from the national GP patient survey, published in July 2016 showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. Results were in line with local and national averages. For example:

- 98% of respondents said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 85% and the national average of 86%.
- 93% of respondents said the last GP they saw was good at involving them in decisions about their care compared to the local average 80% and the national average of 82%.
- 93% of respondents said the last nurse they was good at involving them in decisions about their care compared to the local average 86% and the 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 and staff could access resources on their computers to meet individual patient communication needs.

Good

# 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 90 patients as carers (2% of the practice list). Carers were identified as part of their patient registration checks and through consultations with the clinical team. Written information was available to direct carers to the various avenues of support available to them.

Patients receiving end of life care were provided the GP's direct contact number. The GP could be contacted when the surgery was closed. Staff told us that if families had suffered bereavement, their usual GP contacted them. The GP told us they often attended soon after the bereavement of a patient and spoke with the immediate family. The practice team provided advice to bereaved parties on how to find a support service.

The practice had received 47 cards for the NHS Friends and Family Test in October 2016. 46 of the patients stated they were extremely likely or likely to recommend the practice to their family and friends.

Good

# Are services responsive to people's needs?

(for example, to feedback?)

## Our findings

### Responding to and meeting people's needs

The practice understood the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified.

- The practice operated a walk in nurse led emergency clinic every morning Monday to Friday from 9am to 10am. This was intended for same day emergency access and could be booked on the day in person. GPs were available to support the nursing team where a clinical need existed.
- The practice offered a 'Commuter's Clinic' on a Tuesday evening until 8.30pm for working patients who could not attend during normal opening hours.
- 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 including yellow fever.
- There were facilities for the disabled, a hearing loop and translation services available.
- The practice was situated over two floors without lift access. However, arrangements were made for less able patients to be seen on the ground floor.
- Staff supported patients who were unable to read or who might benefit from additional support when reading and writing.
- The practice provided a range of additional services for their patients, including; conducting blood testing and dosage for patients taking blood thinning medicine, cryotherapy, heart monitoring testing and 12/24 hour ambulatory blood pressure monitoring.
- The practice offered extensive family planning services including; coil fitting and removal

### Access to the service

The practice was open between 8am and 6.30pm Monday to Friday. Extended hours appointments were offered on Tuesday evening until 8.30pm. The practice operated a walk in nurse led emergency clinic every morning Monday to Friday from 9am to 10am. We saw that a GP was available during this time should they be required to support the nursing team with clinical consultations. Booked appointments were from 10.30am to 12.30pm and 2pm to 5.20pm and emergency appointments were reserved for the end of the day. In addition to pre-bookable appointments that could be booked up to six weeks in advance, urgent appointments were also available for people that needed them.

Results from the national GP patient survey, published in July 2016 showed that patient's satisfaction with how they could access care and treatment was comparable to local and national averages.

- 79% of respondents were satisfied with the practice's opening hours compared to the local average of 72% and the national average of 78%.
- 96% of respondents said they could get through easily to the practice by phone compared to the local average of 63% and the national average of 73%.

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

We asked the practice if they monitored the number of appointments where patients had failed to attend. They told us they actively monitored it with their Patient Participation Group. In September 2016 patients had 76 missed appointments, amounting to approximately 19 hours of underutilised clinical time. This increased in October 2016 with 107 missed appointments, approximately 26 hours of underutilised clinical time. The practice had written to patients who failed to attend to attend appointments requesting they notify the surgery if they could not attend.

### Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns.

- We reviewed the complaint policy reviewed May 2016. Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. It made reference to advocacy services and patients right to appeal their decision to The Parliamentary and Health Service Ombudsman.
- The practice manager and the lead GP led on complaints providing administrative and clinical oversight.

Good

# Are services responsive to people's needs?

## (for example, to feedback?)

- We saw that information was available to help patients understand the complaints system such as complaints leaflets explain patients' rights.

The practice had not received any written complaints for a year. The practice told us they tried to resolve issues at the time of reporting to the satisfaction of patients or may record concerns on the patient record. The practice manager spoke directly with staff to obtain accounts and ensure the timely and appropriate resolution of issues. The practice acknowledged the benefits of recording all concerns and issues raised to identify trends and themes.

We reviewed the practice clinical meeting minutes for 9 February 2016. We saw the practice considered if any complaints had been made against the service or partner services. They had discussed a complaint a patient had raised directly with NHS England relating to a commissioned pharmacy service that had alleged a breach of confidentiality. Lessons learnt were shared with the practice and staff were reminded of their responsibilities to safeguard patient data.

# Are services well-led?

Requires improvement

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

## Our findings

### Vision and strategy

The practice was a family practice and wished to increase their patient numbers and extend their services. The practice told us of their financial challenges relating to funding. We reviewed the practices draft business development plan, dated 2016. The plan included the proposed relocation of the surgery to a primary care hub, retention of staff improving technology and monitoring of patient satisfaction. The document referred to a potential increase in their patients but there was an absence of discussion about how they would ensure their patient care needs would be met.

### Governance arrangements

The practice had an absence of formal governance arrangements to support the delivery of safe care. We found;

- There was a lack of governance at the practice in order to identify and act on risks to patients and staff. These included risks in relation to the storage of emergency medicines, safeguarding, acting on patient safety and medicines alerts, staff training and the investigation and analysis of significant events.
- There was a clear staffing structure and staff were aware of their own roles and responsibilities. However, they were not formally overseen to ensure relevant staff were discharging their responsibilities appropriately. For example; Patient Group Directives had not been signed authorising the nurse to administer vaccinations to children and vulnerable adults.
- There was an absence of practice policies to inform and guidance staff in the reporting of risks. For example, the practice had no policy on the reporting of significant incidents. When asked they referred to the NHS England guidance but were not using the supporting documentation.
- We reviewed minutes from the practice clinical meeting. They lacked details of who was in attendance. There was a lack of narrative regarding the discussion, decision and reviewing of any action to ensure issues were progressed.

We found the practice had a comprehensive understanding of their QOF performance. However, there was an absence of clinical and internal audit used to monitor quality and to make improvements.

### Leadership and culture

The practice acknowledged the benefits of working with others in primary care. They met regularly with five neighbouring GP practices forming a sub locality group. They shared ideas, information and services such as joint injections, coil insertions and removals, implants insertion and removal and liquid nitrogen. They collectively were successful in gaining funding to employ a frail and elderly care co-ordinator to support them in their assessment and delivery of care to patients in care homes and on their admission avoidance registers.

The practice was working with NHS England regarding the introduction of their new computer system to improve the sharing of information more easily with community services. The practice had also worked alongside other surgeries within South Woodham Ferrers to contribute to discussion relating to the planned primary care hub development. It is intended to be the new premises for the GP surgeries and local integrated care teams.

On the day of inspection the led GP spoke extensively about the challenges the service had faced within the financial climate and had shared their concerns with their Commissioners. It was evident the practice had clear rationales for their appointment of staff and how this fitted within the broader strategy such as the proposed increase in patient numbers. However, none of this was recorded or documented within the business plan.

Whilst the staff and patients spoke highly of the practice we found an absence of leadership to ensure it was safe. The practice placed a reliance on their staff having the appropriate skills and competencies without having systems in place to ensure this was maintained.

There was an absence of understanding and policies and procedures to ensure compliance with the requirements of the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).This included support training for all staff on communicating with patients about notifiable safety incidents. The practice adopted a pragmatic approach seeking to resolve issues at the time of reporting. Written records of verbal interactions were absent. Themes and trends were not identified, or discussed to reduce the potential repetition of incidents and promote learning.

# Are services well-led?

Requires improvement

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

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

- Practice meetings were irregular and not consistently recorded. They lacked details of discussions and decisions made.
- The practice told us they had high staff retention rates. Staff said they felt respected, valued and supported, particularly by the practice management. Staff were respected by one another and trusted to undertake their roles proficiently.

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

The practice encouraged and valued feedback from patients, the public and staff. It proactively sought patients' feedback and engaged patients in the delivery of the service.

- The practice had an organised Patient Participation Group (PPG) who also supported a virtual patient participation group. We reviewed PPG meeting minutes and saw their meetings were structured, discussions well documented. They were actively involved with the practice and externally within the wider health landscape representing the practice and patients. They spoke regularly with the practice and met at least quarterly. The PPG carried out patient surveys and submitted proposals for improvements to the practice management team and supported the surgery by raising funds through donations. For example, for blood pressure monitoring equipment and basic medical supplies.
- The staff told us they enjoyed working at the practice and found it supportive. They felt listened to and would provide feedback as issues arose to their colleagues and the practice management team. Staff told us they felt involved and engaged to improve how the practice was run.

This section is primarily information for the provider

# Requirement notices

## Action we have told the provider to take

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

| Regulated activity | Regulation |
|---|---|
| Diagnostic and screening procedures<br>Family planning services<br>Maternity and midwifery services<br>Surgical procedures<br>Treatment of disease, disorder or injury | Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment<br>The provider failed to have systems and processes established and operating effectively to prevent abuse of service users. Some clinical staff had not received appropriate training, children and vulnerable adults who failed to attend appointments including those with secondary care or had attended accident and emergency were not followed up and patients who had failed to collect their prescriptions were not identified and appropriate actions taken.<br>This was in breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. |

| Regulated activity | Regulation |
|---|---|
| Diagnostic and screening procedures<br>Family planning services<br>Maternity and midwifery services<br>Surgical procedures<br>Treatment of disease, disorder or injury | Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed<br>The provider had failed to ensure all clinical staff had undertaken appropriate recruitment checks. For example, a DBS for clinical staff.<br>This was in breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. |

| Regulated activity | Regulation |
|---|---|
| Diagnostic and screening procedures<br>Family planning services<br>Maternity and midwifery services<br>Surgical procedures<br>Treatment of disease, disorder or injury | Regulation 17 HSCA (RA) Regulations 2014 Good governance<br>The provider failed to assess monitor and improve the quality and safety of the services. The provider failed to assess, monitor and mitigate risks relating to the health, |

This section is primarily information for the provider

# Requirement notices

safety and welfare of service users. For example; The provider failed to identify, report, investigate and learn from significant incidents. The provider had an absence of systems or processes to ensure the timely and effective management of medicines including adherence to cold chain procedures. The provider had an absence of governance systems to identify staff who had not undertaken DBS checks or appropriate training to conduct their roles safely. The provider did not ensure staff had been appropriately trained to undertake their roles and responsibilities in mental capacity act, infection prevention control, safeguarding and life support. The provider did not have appropriate emergency medicines to respond to complications that can occur during the fitting of contraceptive devices. The provider failed to ensure the effective assessment of risks in relation to the prevention, detection and control of the spread of infections. The provider did not follow up on children and vulnerable patients who failed to attend hospital appointments or who failed to collect their prescriptions. The provider did not have effective systems of governance and clinical oversight in place at the practice including quality improvement processes such as the recording of verbal complaints to identify trends. 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<br>Family planning services<br>Maternity and midwifery services<br>Surgical procedures<br>Treatment of disease, disorder or injury | Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment<br>The provider failed to ensure; Risks were identified and assessed relating to the health and safety of service users receiving care and treatment. The practice does all that is reasonably practicable to mitigate any risks. Staff had appropriate training to undertake their roles and responsibilities. For example; undertaking first aid training, supervising the nursing team and authorising the administration of immunisations. Appropriate emergency medicines are available to manage the risks related to regulated activities. The effective assessment |

This section is primarily information for the provider

# Requirement notices

of risks and preventing, detecting and controlling the spread of infections. This was in breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.