Eastmoor Health Centre

Quality Report

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

Ratings

Overall rating for this service	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 a focussed inspection of the provider on 12 April 2017. This was to follow up areas of non-compliance identified at an earlier comprehensive inspection carried out in August 2016. As a result of this earlier inspection the practice had been rated as Requires Improvement overall with individual domain ratings of:

- Safe – Requires Improvement
- Effective – Requires Improvement
- Caring – Good
- Responsive – Good
- Well-led – Requires Improvement

During the course of the focussed inspection we identified a number of new concerns. As a result of these, we returned to complete a comprehensive inspection of the practice on 20 April 2017. Overall the practice is rated as inadequate.

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

- Patients were at risk of harm because systems and processes were not in place to keep them safe. For example, the practice had not monitored and actioned all medicine and patient safety alerts.
- Concerns regarding quality, effectiveness and competency had led to the suspension of the cytology and travel vaccination services within the practice.
- The reporting and actioning of significant events and safeguarding concerns was inconsistent and there was no evidence of learning and communication with staff regarding these occurrences. In addition, meetings to discuss safeguarding concerns were not held on a formal basis and relied on ad hoc meetings where minutes were not kept. We were told when incidents occurred the practice was open in its approach and informed and apologised to patients.

Summary of findings

- Little or no reference was made to audits or quality improvement activity within the practice, and there was no evidence that the practice was comparing its performance to others; either locally or nationally. For example, clinical audit activity was limited and did not address key issues of performance and improvement.
- We observed patients being treated with compassion and respect. However the practice had only limited engagement with patients. For example, there was no patient participation group in operation within the practice. In many areas the national GP patient survey showed that the practice was rated by patients below local and national averages.
- The practice had limited formal governance arrangements. Staff meetings were held infrequently, staff appraisals had not been rolled out to all staff and there was evidence of limited oversight, monitoring and supervision of staff in some specialist areas of work.
- There was no active tracking of policies and procedures to ensure that these were kept up to date. For example, the infection prevention and control protocol had been due for review in January 2017 however; a review had not been carried out. In addition all staff did not have access to the practice intranet where key policies and procedures were stored.
- Some staff personnel records were incomplete and lacked detail with regard to identity checks and verifying the full immunity status of staff.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There had been only limited progress made with regard to areas identified as requiring improvement during the inspection carried out in August 2016.

The areas where the provider must make improvements are:

- The provider must provide care and treatment in a safe way by assessing, monitoring, managing and mitigating risks to the health and safety of service users. This includes making improvements to the incident reporting processes, infection prevention and control practices, participation in national screening programmes such as those in relation to breast and bowel cancer, and the proper and safe management of medicines; including the monitoring and actioning of safety alerts.
- The provider must establish systems and processes and operate these effectively to ensure good governance. This includes implementing systems for assessing and monitoring risks and the quality of services provided, and improving communication and information sharing across the practice.
- The provider must ensure that persons employed receive appropriate support, training, supervision, monitoring and appraisal to enable them to carry out the duties they are employed to perform.

The areas where the provider should make improvement are:

- The practice should review its operating procedure which allowed patient family members to act as interpreters and ensure safeguarding processes around this practice are effective.
- The practice should continue to review their engagement with patients and the results of patient satisfaction surveys to ensure that it can meet the needs of the patient population in the future and improve outcomes.

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.

Summary of findings

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 and improvements must be made.

- The practice had processes in place regarding reporting incidents, near misses and concerns. However, the recording of these events and incidents was inconsistent.
- In a number of cases where significant events had been recognised and recorded, other than immediate actions, there was little to show that these had been analysed in depth, followed up in any way or that outcomes and learning opportunities had been identified and shared with others.
- There was an inconsistent approach to the identification and recording of safeguarding concerns. In addition, there were no standing regular meetings held with the local health visitor where concerns could be discussed. Meetings that had been held were on an ad hoc basis and minutes of agreed actions had not been kept.
- An annual Infection Prevention and Control audit had taken place in November 2016; however there was no evidence that actions had been taken to address any improvements required as a result.
- Not all medicines and patient safety alerts had been managed or actioned by the practice.
- The management of emergency medicines including diazepam within the practice was poor. An audit carried out by the CCG in conjunction with the practice on the day prior to our first visit had identified that a quantity of diazepam tablets could not be accounted for. When we reviewed the emergency medicines records these were unclear and incomplete.
- A number of personnel records did not contain information with regard to the proof of identity checks and ensuring that the full immunity status of staff was understood.
- A fire evacuation drill had not been carried out in the practice for over a year.

Are services effective?

Inadequate

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

- Care and treatment was not always delivered in line with recognised professional standards and guidelines. For example, the cytology service had been suspended on two occasions due

Summary of findings

to concerns over the quality and effectiveness of the service and the travel vaccination service had been suspended due to staff not attending training updates to enable them to deliver this service. Staff had not been adequately supervised or monitored by the practice in these areas of work.
- Little or no reference was made to audits or quality improvement activity within the practice. There was no evidence that the practice was comparing its performance to others; either locally or nationally.
- There was limited recognition of the benefit of an appraisal process for staff, and the process itself had not been rolled out to all staff. There did not appear to be adequate levels of staff supervision and monitoring in place within the practice.
- 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.
- Childhood immunisations were carried out in line with the national childhood vaccination programme.

Are services caring?

Requires improvement

The practice is rated as requires improvement for providing caring services, as there are areas where improvements should be made.

- Data from the national GP patient survey showed patients rated the practice lower than others for some aspects of care. For example:
  - 80% of patients said the GP was good at listening to them compared to the clinical commissioning group (CCG) average and national average of 89%
  - 77% of patients said the GP gave them enough time compared to the CCG average of 86% and the national average of 87%.

There had been no active analysis or action taken with regard to these GP patient survey results by the practice.

- The practice did not have an operational Patient Participation Group (PPG), and as a result the opportunity for direct patient engagement and effective feedback from patients regarding the care they received was limited.
- 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.

Summary of findings

- The practice had identified 76 patients as carers (3% of the practice list).This identification allowed the practice to actively signpost and offer other support to carers within their patient community.
- Staff told us that interpretation and translation services were available for patients who did not have English as a first language. We were told that the practice allowed patient's family members to act as interpreters. The practice should review their approach for patients who are solely reliant on family members for interpretation to ensure that appropriate safeguards are in place with regard to this practice.

Are services responsive to people's needs?

Requires improvement

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

- At the time of the inspection visits the practice had suspended the delivery of cytology and travel vaccination services.
- Results from the national GP patient survey showed that patient's satisfaction with how they could access care and treatment was mixed when compared to local and national averages.
  - 85% of patients were satisfied with the practice's opening hours compared with the CCG average of 78% and the national average of 76%.
  - 63% of patients said they could get through easily to the practice by phone compared to the CCG average of 70% and the national average of 73%.
- The practice operated a weekly 30 minute young person's clinic to meet the needs of this specific patient group.
- The practice hosted an alcohol and drug abuse clinic and a weekly physiotherapy clinic.
- Patients could get information about how to complain in a format they could understand. However, there was no evidence that learning from complaints had been shared with staff due to the infrequency of team meetings and the inability of all staff to access the practice intranet.

Are services well-led?

Inadequate

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

- The practice was not able to demonstrate that it had an effective governance framework in place to support the delivery of good quality care. For example, whilst a staffing structure was in place, staff were not always clear on the roles and

responsibilities of others. In addition critical areas of work which included significant event processes, medicines management, quality improvement and staff supervision was not being managed effectively.

- At the time of inspection there was limited evidence that the practice had a focus on continuous learning and improvement at all levels. This was evidenced by the limited approach to clinical audit and learning from past incidents.
- We were told that the practice was currently developing a vision for Eastmoor Health Centre. Notwithstanding this they said that they always sought deliver quality care and promote good outcomes for patients.
- The practice had a number of policies and procedures to govern activity; however there was no active tracking of these to ensure that they were kept up to date. For example, the Infection Prevention and Control Policy had been due for review in January 2017 and this review had not taken place.
- The practice did not hold regular governance meetings.
- The practice could not evidence that they actively sought feedback from staff or patients and did not have a patient participation group.
- Staff had not received regular performance appraisals or reviews.

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 the care of older people. The practice is rated as inadequate for providing safe, effective and well led services, and requires improvement for caring and responsive services. The issues identified impact on the overall care provided to this population group.

- The practice offered personalised care to patients. However, there was no evidence of emergency care planning within the practice to support the avoidance of unplanned admissions of older at risk patients.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs.
- The practice supported patients who resided in care homes and offered visits, care planning and medication reviews.
- Nationally reported data showed that outcomes for patients for conditions commonly found in older people were poor. For example, only 36% of patients with rheumatoid arthritis had received a face-to-face annual review in the preceding 12 months which was below the CCG average of 88% and the national average of 91%.

People with long term conditions

Inadequate

The practice is rated as inadequate for the care of people with long-term conditions. The practice is rated as inadequate for providing safe, effective and well led services, and requires improvement for caring and responsive services. The issues identified impact on the overall care provided to this population group.

- Overall performance for diabetes related indicators was 78% which was lower than the CCG average of 91% and the national average of 90%.
- There was limited evidence of effective care planning for patients with long-term conditions. Care planning template usage was very limited and nationally reported data for some long-term conditions was well below the local and national averages. For example, overall performance for diabetes related indicators was 78% which was lower than the CCG average of 91% and the national average of 90%. In addition, the numbers

of reviews carried out in respect to long-term conditions were low for conditions such as Chronic Obstructive Pulmonary Disease, which were 16% below the CCG average and 18% below the national average.

- Longer appointments and home visits were available to patients when required.
- All patients had a named GP and we saw some evidence that for those patients with more complex needs that the practice worked with other health and care partners to deliver a multidisciplinary package of care.

Families, children and young people

Inadequate

The practice is rated as inadequate for the care of families, children and young people. The practice is rated as inadequate for providing safe, effective and well led services, and requires improvement for caring and responsive services. The issues identified impact on the overall care provided to this population group.

- There were some systems to identify and follow up children living in disadvantaged circumstances and who were at risk. However, during the inspection we identified an incident involving a child which should have been identified as a potential safeguarding risk but had not been identified and actioned as such.
- Due to concerns regarding the quality of the cytology service delivered within the practice the cervical screening service had recently been suspended. This was the second instance of suspension within the last 12 months. Using the most recently published data the practice's uptake for the cervical screening programme was 71%; this was significantly below the CCG average of 83% and the national average of 82%.
- The practice had some contact with local health visitors, however this contact was on an ad hoc basis and we did not see evidence of minutes in relation to these meetings.
- Appointments were available outside of school hours and the premises were suitable for children and babies.
- The practice delivered a weekly young person's health clinic which operated for 30 minutes each week.

Working age people (including those recently retired and students)

Inadequate

The practice is rated as inadequate for the care of working age people. The practice is rated as inadequate for providing safe, effective and well led services, and requires improvement for caring and responsive services. The issues identified impact on the overall care provided to this population group.

Summary of findings

- 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, flexible and offered continuity of care. For example, the practice offered extended opening on Thursday evenings 6.30pm to 8pm.
- Practice patients could access a local extended hours/out of hours service, Trinity Care, which operated across the local network. Patients could call the service on weekdays 8am to 8pm and on weekends and bank holidays 9am to 3pm. Calls were triaged and an appointment made with a doctor should this be necessary.
- The practice offered online services which included appointment booking, ordering repeat prescriptions and access to some medical records.
- The practice performance with regard to screening for other cancers was below CCG and national averages. For example, 53% of female patients aged 50 to 70 had been screened for breast cancer in the previous 36 months compared to a CCG average of 71% and a national average of 73%.

People whose circumstances may make them vulnerable

Inadequate 

The practice is rated as inadequate for the care of people whose circumstances may make them vulnerable. The practice is rated as inadequate for providing safe, effective and well led services, and requires improvement for caring and responsive services. The issues identified impact on the overall care provided to this population group.

- Whilst staff had received training with regard to the recognition of safeguarding concerns in vulnerable adults and children, it was unclear if all incidents were being recognised or reported to the appropriate partners.
- 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 and for patients with complex needs.
- There was evidence that the practice 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.
- The practice hosted an alcohol and drug abuse clinic which was provided by external health care professionals.

Summary of findings

People experiencing poor mental health (including people with dementia)

Inadequate

The practice is rated as inadequate for the care of people experiencing poor mental health. The practice is rated as inadequate for providing safe, effective and well led services, and requires improvement for caring and responsive services. The issues identified impact on the overall care provided to this population group.

- 69% of patients with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive care plan documented in the record, in the preceding 12 months which was below the CCG average of 90% and the national average of 89%.
- 79% of patients diagnosed with dementia had a care plan that had been reviewed in a face-to-face meeting in the preceding 12 months which was below the CCG and national averages of 84%.
- The practice 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 how to access various support groups and voluntary organisations.
- Patients were given double appointment times when necessary.

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 below local and national averages. Of 347 survey forms which were distributed 104 were returned for a response rate of 30%. This represented 4% of the practice's patient list.

- 63% of patients found it easy to get through to this practice by phone compared to the CCG average of 70% and the national average of 73%.
- 79% of patients were able to get an appointment to see or speak to someone the last time they tried compared to the CCG average of 83% and the national average of 85%
- 79% of patients described the overall experience of this GP practice as good compared to CCG average of 86% and the national average of 85%
- 69% of patients said they would recommend this GP practice to someone who has just moved to the local area compared to the CCG average of 79% and the national average of 78%

When we discussed this performance with the practice we were told that they felt that this lower than average satisfaction was due to previous recruitment and staffing issues.

The practice was unable to supply us with details of the most recent Friends and Family Test results for the practice as we were told that these had not been collated or submitted for verification.

We attempted to speak with patients during the inspection visits but were unable to due to communication difficulties.

Areas for improvement

Action the service MUST take to improve

- The provider must provide care and treatment in a safe way by assessing, monitoring, managing and mitigating risks to the health and safety of service users. This includes making improvements to the incident reporting processes, infection prevention and control practices, participation in national screening programmes such as those in relation to breast and bowel cancer, and the proper and safe management of medicines; including the monitoring and actioning of safety alerts.
- The provider must establish systems and processes and operate these effectively to ensure good governance. This includes implementing systems for assessing and monitoring risks and the quality of services provided, and improving communication and information sharing across the practice.
- The provider must ensure that persons employed receive appropriate support, training, supervision, monitoring and appraisal to enable them to carry out the duties they are employed to perform.

Action the service SHOULD take to improve

- The practice should review its operating procedure which allowed patient family members to act as interpreters and ensure safeguarding processes around this practice are effective.
- The practice should continue to review their engagement with patients and the results of patient satisfaction surveys to ensure that it can meet the needs of the patient population in the future and improve outcomes.

Eastmoor Health Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector**.** The team included a GP specialist adviser and a second CQC inspector.

Background to Eastmoor Health Centre

The practice surgery is located at Eastmoor Health Centre, Windhill Road, Wakefield, West Yorkshire WF1 4SD. The practice serves a patient population of around 2,650 people and is a member of NHS Wakefield Clinical Commissioning Group.

The surgery is located in purpose built premises and is readily accessible for those with a disability, for example the entrance door is wide enough to allow wheelchair access, and a hearing loop had been installed for those with a hearing impairment. There is limited parking available on site for patients, although there is on-street parking available nearby. An independent pharmacy is located close to the practice.

The practice age profile shows that 23% of its patients are aged under 18 years (compared to the CCG average of 20% and the England average of 21%), whilst it is below both the CCG and England averages for those over 65 years old (13% compared to the CCG average of 18% and England average of 17%). Average life expectancy for the practice population is 75 years for males and 79 years for females (CCG average is 77 years and 81 years and the England average is 79 years and 83 years respectively). The practice serves an area of higher than average deprivation and is ranked in the most deprived 10% of areas in the country. The practice population is primarily composed of White British patients, although there are significant numbers of patients from other ethnic backgrounds.

The practice provides services under the terms of the Personal Medical Services (PMS) contract. In addition the practice offers a range of enhanced local services including those in relation to:

- Childhood vaccination and immunisation
- Influenza and Pneumococcal immunisation
- Rotavirus and Shingles immunisation
- Dementia support
- Minor surgery
- Learning disability support
- Extended hours

At the time of inspection services in relation to cytology and travel vaccinations had been suspended and were not being delivered within the practice. Since these suspensions and following our inspection visits the practice have put in place temporary alternate measures which allowed patients to receive these services.

As well as these enhanced services the practice also offers additional services such as those supporting long term conditions management including diabetes and coronary heart disease.

Attached to the practice or with the ability to work closely with the practice is a team of community health professionals that includes health visitors, midwives, members of the district nursing team and health trainers.

The practice is operated by one principal GP (male). The clinical team within the practice composes two salaried GPs (male and female), a long term GP locum (female), a

practice nurse, a phlebotomist/health care assistant (both female) and a pharmacist (male). Clinical staff are supported by a practice manager and an administration and reception team.

The practice appointments include:

- Pre-bookable appointments which can be made from four to 12 weeks in advance
- On the day/urgent appointments
- Telephone triage/consultations where patients could speak to a GP or advanced nurse practitioner. This service is delivered in conjunction with local network partners.

Appointments can be made in person, via telephone or online.

The practice is open between 8am and 6.30pm Monday to Friday. Extended hours appointments are offered on a Thursday evening from 6.30pm to 8pm.

The practice also participates in a local extended hours/out of hours service, Trinity Care, which operates across the local network. Patients can call the service on weekdays 8am to 8pm and on weekends and bank holidays 9am to 3pm. Calls are triaged and an appointment made with a doctor should this be necessary.

Out of hours care is provided by Local Care Direct Limited and is accessed via the practice telephone number or patients can contact NHS 111.

The practice had previously been inspected in August 2016 and was rated as Requires Improvement overall with individual domain ratings of:

- Safe – Requires Improvement
- Effective – Requires Improvement
- Caring – Good
- Responsive – Good
- Well-led – Requires Improvement

This last inspection rating is clearly displayed in the practice waiting room, but is not published on the practice website.

Why we carried out this inspection

We carried out an announced focussed inspection and 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 such as the Clinical Commissioning Group to share what they knew. We carried out an announced focussed inspection on 12 April 2017 and in light of concerns identified at this inspection a comprehensive inspection on 20 April 2017. During our inspections we:

- Spoke with a range of staff including the lead GP, salaried GP, pharmacist, practice manager, practice nurse and healthcare assistant. We also received written feedback from members of the administration and reception team. We were unable to speak with patients who used the service on the days of our visits.
- Observed how patients were being greeted and dealt with on arrival in the reception area and when requesting services.
- Reviewed an anonymised sample of care and treatment records.
- Looked at information the practice used to deliver care and treatment plans.

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

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

Detailed findings

- Is it well-led?

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

- older people
- people with long-term conditions
- families, children and young people
- working age people (including those recently retired and students)
- people whose circumstances may make them vulnerable
- people experiencing poor mental health (including people living with dementia).

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

Inadequate

Are services safe?

Our findings

During the previous inspection of this practice carried out in August 2016 the following concerns were identified with regard to the safety of services:

- There was an inconsistent approach to the reporting of significant events and incidents.
- Medicine and patient safety alerts were not being monitored or actioned.
- There were areas of non-compliance with regard to infection prevention and control.
- Staff experienced difficulties in accessing information stored on the practice IT system.

Findings in relation to the inspections carried out in April 2017 included:

Safe track record and learning

There was a system for reporting and recording significant events.

- Staff told us they would inform the practice manager of any incidents and there was a recording form. The incident recording form supported the recording of notifiable incidents under the duty of candour where appropriate. (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). However, the recording of significant events and incidents was inconsistent. For example, instances of the patient safety and medicines alerts not being monitored or actioned had not been identified and recorded as a significant event at the time of the initial inspection.
- In a number of cases where significant events had been recognised and recorded, other than immediate actions, there was little to show that these had been analysed in depth,followed up in any way or that outcomes and learning opportunities had been identified and shared with others.
- We were told that when things went wrong with care and treatment, patients were informed of the incident, received reasonable support, truthful information, a written apology and were told about any actions to improve processes to prevent the same thing happening again.
- The practice held infrequent practice meetings, only two had been held since January 2017, and these had not been attended by all members of staff. We could find little evidence that incidents and learning had been shared by others in the practice. Issues regarding access to the practice intranet meant all staff could not access minutes of meetings if significant events were discussed
- The practice had not monitored trends in significant events or evaluated any action taken.

Overview of safety systems and processes

The practice had some processes and practices in place to minimise risks to patient safety. However there was only limited assurance that these were being fully implemented and monitored.

- There were arrangements in place for safeguarding which reflected relevant legislation and local requirements. Policies had been developed but these were not accessible to all staff due to intranet access issues. The policies and flowcharts displayed in clinical rooms outlined who to contact for further guidance if staff had concerns about a patient's welfare. The main GP acted as the safeguarding lead for the practice. We were told by the practice that there were no regular standing meetings with the local health visitor to discuss concerns, but that meetings were held on an ad hoc basis. There were no minutes kept of these meetings.
- There appeared to be an inconsistent approach to the identification and recording of safeguarding concerns. During the inspection we were made aware of an incident concerning an unaccompanied young child who had attended the practice to pick up a prescription. This had not been identified as an issue by the practice or raised as a safeguarding concern or a significant event.
- Staff interviewed had an understanding of their responsibilities regarding safeguarding and had received training on safeguarding children and vulnerable adults relevant to their role. GPs were trained to safeguarding level three, and the practice nurse who

had been in post at the time of inspection for around six months had been trained to level one and two at a previous practice. The reception and administration team were trained to level one.

- A notice in the waiting room advised patients that chaperones were available if required (a chaperone is a person who serves as a witness for both a patient and a medical professional as a safeguard for both parties during an intimate medical examination or procedure). Staff who acted as chaperones had received training for the role and 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 vulnerable adults).

The practice had some controls in place with regard to cleanliness and hygiene.

- We observed the premises to be clean and tidy. There were cleaning schedules and monitoring systems in place.
- The practice nurse had recently been allocated the infection prevention and control (IPC) clinical lead. There was an IPC policy in place, although this was past its review date of January 2017. We saw that staff had received up to date training. An annual IPC audit had taken place in November 2016; however we could see no evidence that actions had been taken to address any improvements required as a result. Recently implemented cleaning schedules did not evidence regular or ongoing checks.

The arrangements for managing medicines, including emergency medicines, and the monitoring and actioning of medicines and patient safety alerts within the practice was inadequate.

- We saw evidence that not all medicines and patient safety alerts had been monitored or actioned by the practice. Records of alerts and action taken, where these were kept, were incomplete. This had been raised with the practice at the inspection carried out in August 2016 and was subject to a Requirement Notice. There was no evidence that alerts were circulated to the wider clinical team when these were received. Since the inspections in April 2017 the practice GP and pharmacist had reviewed and assessed previously issued alerts and had introduced a revised alerts process.
- The procedures and processes in relation to the handling of emergency medicines were poor. An audit carried out by the CCG in conjunction with the practice on 11 April 2017 had identified that a quantity of diazepam tablets could not be accounted for. Diazepam is a medicine with the potential for misuse. On review of the emergency medicines records these were found to be unclear and incomplete. Since this incident the practice have introduced a revised checking and recording procedure and informed appropriate bodies with regard to the unaccounted for medicines.
- The procedures and processes in relation to patients who receive high risk medicines which require additional monitoring was unclear. Records showed that some recall and monitoring was being undertaken, however the last dates recorded were for January 2017 and appear to not have been updated. In addition the records themselves lacked clarity.
- There were processes for handling repeat prescriptions, prescriptions were signed before being dispensed to patients and there was a process to ensure this occurred.
- Blank prescription forms and pads were securely stored and there were systems to monitor their use.
- Patient Group Directions had been adopted by the practice to allow the practice nurse to administer medicines in line with legislation (PGDs are documents permitting the supply of prescription-only medicines to groups of patients, without individual prescriptions). In addition the health care assistant was trained to administer vaccines and medicines against Patient Specific Directions (a PSD is a written instruction, signed by a prescriber eg a doctor for medicines to be supplied and/or administered to a named patient after the prescriber has assessed the patient on an individual basis).
- The practice participated in a local Wakefield Vanguard programme (Vanguard programmes seek to develop new care models which support the improvement and integration of services) and via this was able to access the services of a dedicated pharmacist. The practice used this additional resource for activities such as carrying out medication reviews, dealing with queries with regards to medicines and supporting care home visits.

Inadequate

Are services safe?

We reviewed four personnel files and found that whilst some recruitment checks had been undertaken this was not fully complete in all cases. For example, some personnel records did not contain information with regard to proof of identity checks and ensuring the full immunity status of staff was understood. This issue had been raised with the practice at the previous inspection in August 2016.

Monitoring risks to patients

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

- There was a health and safety policy.
- The practice had an up to date fire risk assessment and carried out regular fire alarm tests. However a fire evacuation drill had not been carried out in the practice for over a year.
- Electrical and clinical equipment was checked and calibrated to ensure it was safe to use and was in good working order.
- There were some arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. However, we were told that there had been some issues in the past regarding staff not being available to cover sessions or being contactable. The practice had recorded these as significant events and these had been reviewed and procedures had been put in place to manage this.

Arrangements to deal with emergencies and major incidents

The practice had arrangements to respond to emergencies and major incidents.

- There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency.
- All staff received annual basic life support training and there were emergency medicines available.
- 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.
- There was an issue with regard to signage in the Health Promotion room. This indicated that adrenaline for use in emergencies was being stored in a particular cupboard. We saw that the adrenaline was no longer being kept in the cupboard and in an emergency situation this could mislead staff and mean a delay in a patient receiving the necessary treatment. The practice told us that they would rectify the situation and remove the sign.
- The practice had a business continuity plan for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff.

Inadequate

Are services effective?

(for example, treatment is effective)

Our findings

During the previous inspection of this practice carried out in August 2016 the following concerns were identified with regard to the effectiveness of services:

- Data showed that patient outcomes were low compared to local and national averages.
- There was limited evidence of clinical audit driving improvement in patient outcomes.
- The staff appraisal process was limited in depth and scope.
- There was no evidence that the lead GP had received training with regard to the Mental Capacity Act 2005.

Findings in relation to the inspections carried out in April 2017 included:

Effective needs assessment

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

- The practice had some systems in place to keep all clinical staff up to date. We were told that best practice standards and guidelines were available on the practice intranet. However, not all staff reported having access to the intranet and on the day of inspection it was not possible for the inspection team to assess this due to access and connection issues experienced within the practice. In addition there were limited opportunities to discuss best practice guidance at team meetings as these were held infrequently and not attended by all clinical staff.
- There was only limited evidence that the practice monitored that guidelines were being followed as the level of clinical audit and supervision within the practice was low.

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent published results showed that the practice had attained 84%of the total number of points available compared with the clinical commissioning group (CCG) average of 96% and national average of 95%. The overall exception reporting rate at the practice was 9% which was comparable to the CCG rate of 8% and the national rate of 10%. (Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects).

This practice was an outlier for a number of QOF (or other national) clinical targets. For example, data from 2015/2016 showed:

- Overall performance for diabetes related indicators was 78% which was lower than the CCG average of 91% and the national average of 90%.
- Overall performance for Chronic Obstructive Pulmonary Disease (COPD) was 71% which was below the CCG average of 95% and the national average of 95%.
- 75% of patients with cancer, diagnosed within the preceding 15 months had a patient review recorded as occurring within 6 months of the date of diagnosis which was below the CCG average of 96% and a national average of 95%.
- 36% of patients with rheumatoid arthritis had received a face-to-face annual review in the preceding 12 months which was significantly below the CCG average of 88% and the national average of 91%.
- 69% of patients with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive care plan documented in the record, in the preceding 12 months which was below the CCG average of 90% and the national average of 89%.
- 79% of patients diagnosed with dementia had a care plan that had been reviewed in a face-to-face meeting in the preceding 12 months which was below the CCG and national averages of 84%.

We discussed these areas of low attainment with the practice, they told us that they felt that this was due to past staffing and recruitment issues and historical coding problems.

There was limited evidence of quality improvement including clinical audit:

- During the inspection carried out in August 2016, it was identified that there had been limited clinical audit activity. During the inspection visits carried out on 12

Inadequate

Are services effective?

(for example, treatment is effective)

and 20 April 2017 we saw that there had been little immediate progress made with regards to clinical audit other than a single cycle spirometry audit which lack detail and depth.

- The practice was unable to demonstrate that information about patient outcomes was used to make improvements to the services provided.

Effective staffing

Evidence reviewed showed that not all staff had the support, skills and knowledge to deliver effective care and treatment.

- The practice did not have a dedicated and consistent induction system in place for newly appointed staff. Although there was evidence that staff had received some induction covering such areas as fire safety and confidentiality, we saw no clear evidence of systematic induction or handover covering specialised tasks or specific areas of work such as cytology.
- The practice showed us evidence that staff had received some role-specific training. For example, we saw that the lead GP had recently completed training with regard to mental capacity and consent. However, one week prior to the first inspection visit the practice became aware that a staff member who administered travel vaccinations had not received update training to allow them to carry out these tasks. This led to the travel vaccination service being suspended by the practice.
- There did not appear to be adequate levels of staff supervision and monitoring in place within the practice. The cytology service had been suspended on two occasions due to concerns over quality and effectiveness and it was felt that staff had not been adequately supervised or their competency assessed in this area of work. In addition, the concerns raised with regard to overall medicines management showed little supervision and monitoring of staff implementing checks on medicines.
- There was limited opportunity for the learning needs of staff to be identified. The practice staff appraisal process had not been implemented fully and at the time of inspection only one member of staff had received an appraisal. In addition staff meetings were held infrequently which gave staff limited opportunities to identify and discuss training and development needs. Staff told us they were not invited to meetings which could be relevant to their role.
- We did see that staff had received mandatory training which included: safeguarding, fire safety awareness, basic life support and information governance. Staff had access to and made use of e-learning training modules and attendance at training events.

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. However, we were made aware that all staff did not have access to the intranet.

We saw evidence that some care plans had been developed for patients with long-term conditions, however there was no evidence of emergency care planning being in place, or that staff had the knowledge to access and utilise all the available care plan templates available.

Staff worked together and with a limited range of 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. Meetings took place with some health care professionals on a monthly basis when patients' needs were discussed and reviewed. We were told that no minutes were kept of this meeting but an action log was maintained regarding decisions made.

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

Consent to care and treatment

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

- There was a general understanding of consent within the practice. 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.

Inadequate

Are services effective?

(for example, treatment is effective)

- 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.
- We were told that the practice allowed patient family members to act as interpreters. We were not informed of any consent or safeguarding measures in place with regard to this practice.

Supporting patients to live healthier lives

The practice identified patients who may be in need of extra support and signposted those to relevant services. These included patients:

- who were in the last 12 months of their lives
- at risk of developing a long term condition
- who required healthy lifestyle advice, such as in relation to diet and weight management and alcohol reduction
- In addition the practice offered in-house smoking cessation support.

The practice's uptake for the cervical screening programme was 71%, which was significantly below the CCG average of 83% and the national average of 82%. At the time of the comprehensive inspection on 20 April 2017 the practice, in conjunction with NHS England, had suspended their cytology service due to concerns regarding the effectiveness and quality of screening.

The practice performance with regard to screening for other cancers was also below CCG and national averages. For example:

- 51% of patients aged 60 to 69 had been screened for bowel cancer in the last 30 months compared to CCG and national averages of 58%.
- 53% of female patients aged 50 to 70 had been screened for breast cancer in the previous 36 months compared to a CCG average of 71% and a national average of 73%.

Childhood immunisations were carried out in line with the national childhood vaccination programme. Uptake rates for the vaccines given were comparable to CCG averages. For example, rates for the vaccines given to under two year olds ranged from 92% to 100% and five year olds from 91% to 100%.

Patients had access to appropriate health assessments and checks. These included NHS health checks for patients aged 40 to 74. We were told that 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

During the previous inspection of this practice carried out in August 2016 the following concerns were identified with regard to services being caring:

- Curtains in consultation rooms were not being changed on a regular basis.
- Data from the nation GP patient survey showed patients rated the practice lower than others for several aspects of care.

Findings in relation to the inspections carried out in April 2017 included:

Kindness, dignity, respect and compassion

During our inspection we observed that members of staff were courteous and 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. During the inspection curtains were found to be in a clean condition and were subject to being changed on a regular basis.
- Consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- Reception staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs. However, it was noted during the inspection that conversations between reception staff and patients could be overheard by others in the waiting room.
- Due to the staffing mix within the practice, patients had the opportunity of being treated by a clinician of the same sex.

The practice, as in August 2016, did not have an operational Patient Participation Group (PPG) and as a result the opportunity for direct patient engagement and effective feedback from patients regarding the care they had received was limited. Little progress had been made regarding the formation of a PPG since the last inspection.

The practice was below average for its satisfaction scores on consultations with GPs and nurses. For example:

- 80% of patients said the GP was good at listening to them compared to the clinical commissioning group (CCG) average and national average of 89%
- 77% of patients said the GP gave them enough time compared to the CCG average of 86% and the national average of 87%
- 87% of patients said they had confidence and trust in the last GP they saw compared to the CCG and national average of 95%
- 78% of patients said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 86% and the national average of 85%
- 88% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the CCG and national average of 91%
- 85% of patients said they found the receptionists at the practice helpful compared to the CCG and national average of 87%

There had been no active analysis or action taken with regard to these survey results by the practice. The practice felt that these results were due to previous staffing and recruitment issues experienced by the Health Centre.

Care planning and involvement in decisions about care and treatment

Results from the national GP patient survey showed the practice performed generally below local and national averages to questions about their involvement in planning and making decisions about their care and treatment. For example:

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

The practice had distributed a standardised questionnaire to patients with long-term conditions asking their views on

the services they received, and how they felt they were being supported in managing their condition. At the time of inspection responses to these questionnaires had not been collated by the practice.

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

- Staff told us that interpretation and translation services were available for patients who did not have English as a first language. We were told that the practice allowed patient family members to act as interpreters. We were not informed of any consent or control measures in place with regard to this practice.
- Some information leaflets were available in easy read format.
- A hearing loop was available to assist those with a hearing impairment.

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. Support for isolated or house-bound patients included signposting to relevant support and volunteer services.

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 76 patients as carers (3% of the practice list).This identification allowed the practice to actively signpost and offer other support to carers within their patient community. Written information was available to direct carers to the various avenues of support available to them.

Staff told us that if families had experienced bereavement, the practice would send then a bereavement services guide. Families could also contact the practice for further support and guidance.

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

During the previous inspection of this practice carried out in August 2016 the following concern was identified with regard to the responsiveness of services:

- Data from the national GP patient survey showed that patients had mixed views with regard to the responsiveness of services. For example, patients rated the practice below local and national averages for telephone access.

Findings in relation to the inspections carried out in April 2017 included:

Responding to and meeting people's needs

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

- The practice offered late evening opening on a Thursday from 6.30pm to 8pm.
- There were longer appointments available for patients with a learning disability and for those with complex needs.
- Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice.
- Same day appointments were available for children and those patients with medical problems that require same day consultation.
- There were disabled facilities, a hearing loop and translation and interpretation services available.
- The practice offered a range of nurse led clinics which included those in respect to:
  - Asthma
  - Diabetes
  - Hypertension
  - Coronary Heart Disease
  - Family planning
  - Baby immunisations
- The practice operated a weekly 30 minute young person's clinic to meet the needs of this specific patient group.
- The practice supported patients in nursing and care homes.
- Online appointment booking and repeat prescription ordering was available to practice patients.
- The practice hosted an alcohol and drug abuse clinic which was provided by external health care professionals.
- The practice hosted a weekly physiotherapy clinic.
- The practice had given some initial consideration to the NHS England Accessible Information Standard to ensure that disabled patients received information in formats that they can understand and that they received appropriate support to help them to communicate. However, at the time of inspection they had not implemented any changes to improve services in this specific area.
- Due to concerns regarding the effectiveness of services the practice had suspended services in relation to cytology and travel vaccinations.

Access to the service

The practice was open between 8am and 6.30pm Monday to Friday. Extended hours appointments were available on a Thursday evening from 6.30pm to 8pm.

The practice also participated in a local extended hours/ out of hours service, Trinity Care, which operated across the local network. Patients could call the service on weekdays 8am to 8pm and on weekends and bank holidays 9am to 3pm. Calls are triaged and an appointment made with a doctor should this be necessary.

The practice appointments included:

- Pre-bookable appointments which could be made from four to 12 weeks in advance
- On the day/urgent appointments
- Telephone triage/consultations where patients could speak to a GP or advanced nurse practitioner. This service was delivered in conjunction with local network partners.
- Home visits

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

- 85% of patients were satisfied with the practice's opening hours compared with the CCG average of 78% and the national average of 76%.

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

- 63% of patients said they could get through easily to the practice by phone compared to the CCG average of 70% and the national average of 73%.
- 79% of patients said that the last time they wanted to speak to a GP or nurse they were able to get an appointment compared with the CCG average of 83% and the national average of 85%.
- 94% of patients said their last appointment was convenient compared with the CCG average of 93% and the national average of 92%.
- 66% of patients described their experience of making an appointment as good compared with the CCG average of 72% and the national average of 73%.
- 47% of patients said they don't normally have to wait too long to be seen compared with the CCG average of 62% and the national average of 58%.

The practice had a system in place whereby a GP assessed:

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

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

Listening and learning from concerns and complaints

The practice had a system for handling complaints and concerns.

- Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England.
- The practice manager was the designated responsible person who handled all complaints in the practice.
- We saw that information was available to help patients understand the complaints system.

The practice had received five complaints since the last inspection, one of which was a formal written complaint and four of which were verbal. The practice told us that they felt that the logging of complaints could be inconsistent and they were working to raise awareness in this area. Due to the lack of regular meetings, and issues accessing any minutes held on the intranet by some staff, the opportunity to share learning from complaints was limited.

Are services well-led?

Inadequate

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

Our findings

During the previous inspection of this practice carried out in August 2016 the following concerns were identified with regard to services being well-led:

- Governance arrangements required improvement. For example, medicines and patient safety alerts were not being monitored or actioned, quality improvement activity was limited, and there were deficiencies in record keeping in recruitment files.
- The staff appraisal process was limited in depth and scope and staff meetings were being infrequently held.

Findings in relation to the inspections carried out in April 2017 included:

Vision and strategy

We were told that the practice was currently developing a vision for Eastmoor Health Centre. Notwithstanding this, they said that they always sought deliver quality care and promote good outcomes for patients.

Whilst the practice did not have a dedicated formalised strategy, they told us that they had a number of objectives for the next 12 months which included:

- Increasing online access
- Developing an effective and stable workforce
- Overall service and performance improvement

Governance arrangements

The practice was not able to demonstrate that it had an effective governance framework in place to support the delivery of good quality care. For example:

- Whilst a staffing structure was in place staff were not always clear on the roles and responsibilities of others.
- There was no active tracking of policies and procedures in operation within the practice. To illustrate this, the Infection Prevention and Control Policy was out of date and had been due to be reviewed in January 2017.
- There was limited evidence that there was adequate understanding of key performance issues within the practice.
- Team meetings were held on an infrequent basis and therefore did not provide an opportunity for staff to learn about the performance of the practice or raise concerns. Key staff members were not always invited.
- Critical areas of work which included significant event processes, medicines management and quality improvement were not being managed effectively.
- Staff supervision and monitoring was ineffective and gave limited assurance that services were being delivered in a safe or effective manner.
- The majority of issues highlighted in the last inspection in August 2016 were still outstanding at the two inspection visits made on 12 April and 20 April 2017.

Leadership and culture

There was limited evidence of effective management, leadership and oversight within the practice. For example, the practice had experienced continued issues with their cytology service which had led to it being suspended twice in a period of six months. Whilst some investigative work had been carried out with regard to the initial suspension of the service and actions had been put in place for improvement, the practice were unable to show how this was managed effectively, or how they could have prevented a second suspension of the service in April 2017.

We did see that the practice team members had a caring attitude towards their patients and showed compassion.

The practice culture was one of openness and honesty. Whilst significant events were not always fully actioned we saw that they were being identified and recorded by staff in the majority of applicable cases.

We found that the practice had systems to ensure that when things went wrong with care and treatment:

- The practice gave affected people reasonable support, truthful information and a verbal and written apology.
- The practice kept written records of formal complaints; however we were told that the recording of all verbal complaints could be improved and the practice was already raising staff awareness of this.

The lead GP and practice manager were seen by staff as leading the development of the practice. There were however mixed messages regarding how well staff felt supported within their roles.

Are services well-led?

Inadequate

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

- Practice meetings were held infrequently and had only recently begun to be fully minuted. Not all staff attended these meetings and there were identified issues of staff not being kept informed. There were other identified communication issues which included all staff being unable to access the practice intranet. Meetings with other health professionals were held, some on a formalised basis and some ad hoc.
- Staff generally told us there was an open culture within the practice and whilst they had limited opportunity to raise any issues at team meetings they said they felt confident they could raise this on a one-to-one basis with the lead GP or practice manager. However, we were also told of and observed areas of conflict within the team.

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

The practice had very limited engagement with patients other than from one-to-one feedback, complaints and past NHS Friends and Family Test results. For example:

- At the time of inspection the practice did not have a Patient Participation Group operating.
- There was no evidence that the practice had considered or actioned feedback from the national GP patient survey. However, the practice had distributed a standardised questionnaire to patients with long-term conditions asking their views on the services they received, and how they felt they were being supported in managing their condition. This though had not been collated at the time of inspection.

Engagement and feedback with staff happened on a non-formalised ad hoc basis. Team meetings were infrequent and the staff appraisal process had not been fully rolled out to staff.

Continuous improvement

At the time of inspection there was only limited evidence that the practice had a focus on continuous learning and improvement at all levels as evidenced for example by the limited approach to clinical audit and learning from past incidents. However, the practice had begun to engage more effectively with others and participate in some improvement programmes. For example the practice:

- Participated in a Wakefield Vanguard programme.
- Worked with network partners as a member of Trinity Care, which gave patients access to extended hours care.

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 Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Staffing **How the regulation was not being met:** The registered person did not do all that was reasonably practicable to ensure that persons employed received appropriate support, training, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform. For example: • Staff carrying out cytology services had not received adequate supervision and monitoring to ensure the screening process is effective. • Staff administering travel vaccinations had not been trained or had not received necessary update training to deliver this service effectively and safely. • All staff had not received an annual appraisal. This was in breach of regulation 18(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Safe care and treatment **How the regulation was not being met:** The registered person did not do all that was reasonably practicable to assess, monitor, manage and mitigate risks to the health and safety of service users. This was because: The process for recording and fully actioning safeguarding concerns and significant events or incidents was being implemented inconsistently. Not all incidents had been recorded and some of those that had did not show detailed action or analysis. The practice had delivered travel vaccinations without ensuring that staff had received the necessary training to deliver this service. There was no assurance that staff taking cytology samples were effectively trained, monitored or supervised. No formal fire evacuation drill had been carried out in the practice for over a year. There was no evidence that all medicines and patient safety alerts had been monitored or actioned prior to 12 April 2017. Records, where these existed, showed gaps indicating no action had been taken. There was a lack of effective medicines management within the practice. Medicines could not be accounted for and the record of emergency medicines was found to be unclear, incomplete and had been subject to overwriting.

This section is primarily information for the provider

Enforcement actions

There was no clear evidence of a formal and clearly understood procedure for monitoring patients on high risk medication.

There was limited evidence of detailed care planning taking place within the practice or that the system in place was effective to meet the needs of the population. In addition there was no evidence that emergency care planning was taking place.

Findings from an Infection Prevention and Control audit carried out in November 2016 had not been actioned.

Patient participation in national screening programmes such as those in relation to breast and bowel cancer was below local and national averages.

This was in breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Good governance **How the regulation was not being met:** The registered person did not have systems in place to ensure that adequate governance and monitoring systems were in place. This was because: There was no evidence of structured or formalised meetings being held between the safeguarding lead and local health visitors. Meetings were held on an ad hoc basis and minutes were not kept.

This section is primarily information for the provider

Enforcement actions

There was limited evidence of progress being made with regard to breaches in regulations identified during an inspection carried out by the CQC in August 2016.

There was little evidence of quality improvement planning or activity being carried out within the practice.

Information sharing and communication within the practice was poor. Practice meetings were being held infrequently, meetings were not attended by all staff and minutes of meetings were not available to all staff.

There was no active tracking of policies and procedures to ensure that these were kept up to date. At the time of inspection the Infection Prevention and Control policy was outside its review date of January 2017.

Personnel records were not fully complete.

This was in breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.