Bredbury Medical Centre

Quality Report

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Date of inspection visit: 8 November 2016
Date of publication: 26/01/2017

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?	Requires improvement
Are services caring?	Good
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 previously inspected Bredbury Medical Centre in October 2015 and the practice was rated as requiring improvement overall. We found there were gaps in assessment and management of risks and that governance arrangements were not comprehensive. We carried out a further announced comprehensive inspection at the practice on 8 November 2016. Overall the practice is now rated as inadequate, as sufficient improvements have not been made and there are continued areas of concern.

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

- The practice had not undertaken the key action points it had said it would in order to improve following the previous inspection.
- Patients were at risk of harm because systems and processes were not in place to keep them safe. For example appropriate recruitment checks on staff had not been undertaken prior to their employment and actions identified to address concerns with infection control practice had not been taken.There were key gaps in risk assessment documentation in such areas as fire safety and legionella.
- Processes around medicines management were not comprehensive to ensure safety, for example there was no system in place to monitor blank prescriptions.
- There was limited evidence of learning and sharing outcomes with staff following the analysis of significant events.
- There was some evidence of clinical audit demonstrating quality improvement.
- While the GPs were able to discuss areas of weakness in the practice's performance, they did not describe any action being put in place to address them.
- Patients were generally positive about their interactions with staff and said they were treated with compassion and dignity.

Summary of findings

- There were continued gaps in the practice's governance arrangements. There were some key gaps in policy guidance and not all staff were aware of their location. We also found evidence indicating that the practice did not consistently follow its own documented policies and procedures.
- There was a lack of managerial oversight of staff training which had resulted in key omissions, for example only two staff had received fire safety training.
- Learning from complaints was not consistently shared and one patient expressed dissatisfaction with how a verbal complaint they had raised had been handled by the practice.

The areas where the provider must make improvements are:

- Introduce more comprehensive processes for reporting, recording, acting on and monitoring significant events, incidents and near misses.
- Take action to address identified concerns with infection prevention and control practice.
- Improve systems around medicines management so that blank prescriptions are logged and their location monitored and patient group directions available to staff are appropriately signed to demonstrate authorisation.
- Ensure staff training is undertaken and appropriately managed to ensure all staff have completed training and have the skills and qualifications to carry out their roles.
- Implement formal governance arrangements including systems for assessing and monitoring risks and the quality of the service provision.
- Provide staff with appropriate policies and guidance to carry out their roles in a safe and effective manner which are reflective of the requirements of the practice.
- Ensure the complaints policy is followed in practice when handling patient's concerns and complaints.

The areas where the provider should make improvement are:

- Undertake activity to engage patients further in providing feedback on services offered.
- Continue efforts to identify patients who have caring responsibilities in order to facilitate their access to appropriate support.

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

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

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

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Inadequate

At the previous inspection in October 2015 the practice was rated as requiring improvement for providing safe services. Sufficient improvements have not been made since this visit and the practice is now rated as inadequate for providing safe services and improvements must be made.

- Although the practice carried out investigations when there were unintended or unexpected safety incidents, lessons learned were not consistently implemented nor communicated and so safety was not improved.
- Patients were at risk of harm because systems and processes were not implemented in a way to keep them safe. For example, the practice was unable to demonstrate that non-clinical staff had received appropriate training around safeguarding vulnerable children, and staff we spoke with confirmed they had not received up to date training.
- There were ongoing gaps in the practice's recruitment procedures, for example references and appropriate checks through the disclosure and barring service had not been sought.
- Risks to patients and staff were not assessed or managed appropriately. For example the practice did not have risk assessments in place for fire safety. We saw that when workplace risk assessments had been completed for staff, recommended actions resulting from these assessments were not completed.
- There were gaps in the practice's management of medicines. For example patient group directions were not signed to demonstrate appropriate authorisation for the practice nurse to administer medicines and there was no system in place to track blank prescription pads in the practice.

Are services effective?

Requires improvement

The practice was rated as good for providing effective services following our inspection in October 2015. However following our visit in November 2016 we found some areas of concern where the practice had not fully implemented areas of its action plan. The practice is now rated as requires improvement for providing effective services as there are areas where improvements must be made.

Summary of findings

- Data from the Quality and Outcomes Framework (QOF) showed that although some patient outcomes had improved since the previous visit, the majority were still below average compared to the local and national averages. The performance for diabetic foot checks completed had deteriorated from the previous year by almost 10% and was 42% lower than the local average.
- Staff assessed needs and delivered care in line with current evidence based guidance.
- There was some evidence of quality improvement demonstrated via clinical audit.
- Staff had the skills, knowledge and experience to deliver effective care and treatment.
- A system of appraisals had not been fully implemented in order to assess training needs of staff. The practice nurse had not received an appraisal in over 12 months and none of the staff had personal development plans in place.
- Staff worked with other health care professionals to understand and meet the range and complexity of patients' needs.

Are services caring?

Good

The practice was rated as good for providing caring services in October 2015. Following our visit in November 2016 the practice is also rated as good for providing caring services.

- Data from the national GP patient survey showed patients rated the practice either in line with or higher than others for all aspects of care.
- Patients said they were mostly 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.
- However, the practice had identified less than 1% of its patient list as having caring responsibility and would benefit from engaging in further efforts to ensure carers are identified to ensure they receive appropriate support as required.

Are services responsive to people's needs?

Requires improvement

The practice was rated as good for providing responsive services following our inspection in October 2015. However, during our recent visit we found areas of concern and the practice id now rated as requires improvement for providing responsive services as there are areas where improvements must be made.

Summary of findings

- Practice staff reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group to secure improvements to services where these were identified.
- 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.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was limited evidence that learning from complaints was shared with staff. We saw several examples where complaints were only partially addressed by the practice and patients were not routinely provided with information around how to escalate their complaint if they were dissatisfied with the practice's response.

Are services well-led?

Inadequate

The practice was rated as requires improvement for being well-led following our previous inspection in October 2015. In November 2016 we have found continued areas of concern resulting in the practice now being rated as inadequate for being well led and improvements must be made.

- The practice had a vision and a strategy. There was a documented leadership structure and staff told us they felt supported by management but at times they were not sure who to approach with issues.
- The practice had not implemented its action plan to address issues raised at the previous inspection.
- There were continued gaps in risk assessment and management. We found evidence that when risks were identified, mitigating action was not put in place.
- There was a lack of managerial oversight of staff training, which had resulted in continued gaps.
- While the partners were able to discuss the performance of the practice and put forward reasons for areas of weakness, they did not articulate what action was being carried out to address these areas.
- The practice had a number of policies and procedures to govern activity. However the range of policies available was not comprehensive enough to adequately govern activity in the practice. Policy document control was ad-hoc and not all staff were aware of the location of policy and procedure documents.

Summary of findings

- Four staff meetings had been held in the previous year, but meeting minutes did not always document who was present meaning that there was not always a clear audit trail for information flow through the practice.
- We found some evidence that the practice had sought patient feedback on accessing car park facilities at the premises, but a patient participation group had not been set up.
- Appraisal meetings had taken place for most staff, but staff had not had sight of the completed documentation from these meetings and personal development plans had not been formulated. The practice nurse had not had an appraisal for over 12 months.

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 provider was rated as inadequate for safety and for well-led and requires improvement for being effective and responsive. The issues identified as requiring improvement overall affected all patients including this population group. However:

- The practice offered proactive, personalised care to meet the needs of the older people in its population.
- The practice was responsive to the needs of older people, and offered home visits and urgent appointments for those with enhanced needs.
- Regular multidisciplinary meetings were held to discuss patients nearing the end of life in order to ensure their needs were being met.

People with long term conditions

Inadequate

The provider was rated as inadequate for safety and for well-led and requires improvement for being effective and responsive. The issues identified as requiring improvement overall affected all patients including this population group.

- Outcomes for patients experiencing long term conditions were generally lower than local and national averages. For example the practice's rate for the completion of diabetic foot checks was 42% lower than the local average.

However:

- Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority.
- Longer appointments and home visits were available when needed.
- All these patients had a named GP and a structured annual review to check their health and medicines needs were being met. For those patients with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Inadequate

The provider was rated as inadequate for safety and for well-led and requires improvement for being effective and responsive. The issues identified as requiring improvement overall affected all patients including this population group.

Summary of findings

- The practice's uptake for cervical screening was lower than the local and national averages. The GPs felt this was due to these checks not being coded appropriately into the patient's electronic records.

However:

- There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances.
- Immunisation rates were relatively high for all standard childhood immunisations.
- Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this.
- Appointments were available outside of school hours and the premises were suitable for children and babies.
- We saw positive examples of joint working with midwives, health visitors and school nurses. Midwives offered clinics in the practice premises.

Working age people (including those recently retired and students)

Inadequate

The provider was rated as inadequate for safety and for well-led and requires improvement for being effective and responsive. The issues identified as requiring improvement overall affected all patients including this population group. However:

- 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.
- The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group.
- Extended hours appointments were available for those patients unable to attend appointments during normal working hours.

People whose circumstances may make them vulnerable

Inadequate

The provider was rated as inadequate for safety and for well-led and requires improvement for being effective and responsive. The issues identified as requiring improvement overall affected all patients including this population group. However:

- The practice held a register of patients living in vulnerable circumstances including those with a learning disability.

Summary of findings

- 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. Staff were aware of the need to flag up any safeguarding concerns to the GP lead for this area.

People experiencing poor mental health (including people with dementia)

Inadequate

The provider was rated as inadequate for safety and for well-led and requires improvement for being effective and responsive. The issues identified as requiring improvement overall affected all patients including this population group.

- 71% of patients diagnosed with dementia who had their care reviewed in a face to face meeting in the last 12 months, which is below the local average of 85% and national average of 84%.

However:

- The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those with dementia.
- The practice carried out advance care planning for patients with dementia.
- The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations.
- Staff had a good understanding of how to support patients with mental health needs and dementia.

Summary of findings

What people who use the service say

The national GP patient survey results were published in July 2016. The results showed the practice was performing in line with local and national averages. A total of 263 survey forms were distributed and 109 were returned. This represented a response rate of 41% and was 2% of the practice's patient list.

- 84% of patients found it easy to get through to this practice by phone compared to the CCG average of 79% and national average of 73%.
- 90% 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 80% and national average of 76%.
- 88% of patients described the overall experience of this GP practice as good compared to the CCG average of 89% and national average of 85%.
- 84% 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 84% and national average of 80%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection.

However, when we arrived on the morning of the inspection visit, we were informed by practice staff that the comment card collection box had been misplaced. When we inspected previously in October 2015, the practice had also not facilitated any comment cards being completed by patients and inspectors located blank comment cards hidden under a pile of magazines in the patient waiting area.

At the request of the inspection team on 8 November 2016, reception staff prompted patients to complete comment cards during the day of the visit. A total of three comment cards were completed which were all positive about the standard of care received. Comments on the cards praised the practice for offering a friendly service and timely treatment.

We spoke with three patients during the inspection. All three patients said they were satisfied with the care they received and thought clinical staff were caring, committed and thorough. One patient did however express some concern that the manner of non-clinical staff was at times rude.

Areas for improvement

Action the service MUST take to improve

The areas where the provider must make improvements are:

- Introduce more comprehensive processes for reporting, recording, acting on and monitoring significant events, incidents and near misses.
- Take action to address identified concerns with infection prevention and control practice.
- Improve systems around medicines management so that blank prescriptions are logged and their location monitored and patient group directions available to staff are appropriately signed to demonstrate authorisation.
- Ensure staff training is undertaken and appropriately managed to ensure all staff have completed training and have the skills and qualifications to carry out their roles.
- Implement formal governance arrangements including systems for assessing and monitoring risks and the quality of the service provision.
- Provide staff with appropriate policies and guidance to carry out their roles in a safe and effective manner which are reflective of the requirements of the practice.
- Ensure the complaints policy is followed in practice when handling patient's concerns and complaints.

Summary of findings

Action the service SHOULD take to improve

The areas where the provider should make improvement are:

- Undertake activity to engage patients further in providing feedback on services offered.
- Continue efforts to identify patients who have caring responsibilities in order to facilitate their access to appropriate support.

Bredbury Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

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

Background to Bredbury Medical Centre

Bredbury Medical Centre (1 Auburn Avenue, Stockport, SK6 2AH) is situated in a purpose built building in Bredbury, on the outskirts of Stockport. At the time of inspection renovation work was being undertaken to upgrade and update sections of the building. The practice has a patient list size of 4692. The practice is part of the NHS Stockport Clinical Commissioning Group (CCG) and services are provided under a Personal Medical Services Contract (PMS).

The age profile of the practice population broadly mirrors those of local and national averages, although the practice does have a slightly higher proportion of patients over the age of 65 years (19.8% compared to the national average of 17.1%). The proportion of the practice's patient list who suffer from a long standing health condition is also similar to local and national averages.

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

There are two male GP partners. The practice also employs a practice nurse and health care assistant (both female) as well as a pharmacist for one day per week. Non-clinical staff consisted of a practice manager, a business manager, an accounts manager and ten administrative and reception staff. Bredbury Medical Practice is a teaching practice, supporting medical students.

The practice opens at 8.00am on Monday and Friday, and at 7.30am Tuesday, Wednesday and Thursday. It closes at 6.00pm on Mondays and Fridays, 6.30pm on Tuesdays and Thursdays and 5.00pm on Wednesdays. Appointments are offered between 7.30 and 11.30am each morning on Wednesday, Thursday and Friday, between 8.00 and 12 midday on a Monday morning and between 8.00am and 11.00am on a Friday morning. Surgery times in the afternoon start at 3.30pm on a Monday and Friday, and at 4.00pm on a Tuesday and Thursday, and run until 6.00pm, except on Tuesday when the practice offers a late night surgery by appointment until 9:00pm. Routine appointments are not offered on a Wednesday afternoon, but the GPs are available should urgent appointment requests be made.

When the practice is closed, patients are able to access out of hours services offered locally by the provider Mastercall.

One of the GP partners had retired from the practice in December 2015, and at the time of this most recent inspection the practice had not updated their registration with CQC to reflect this. During the visit the practice manager told us she was aware this was the case and had started to complete the paperwork to update the practice's registration accordingly.

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 8 November 2016. During our visit we:

- Spoke with a range of staff including the GPs, practice nurse, practice manager, business manager, accounts manager, reception and administration staff and spoke with patients who used the service.
- Observed how staff interacted with patients.
- Reviewed an anonymised sample of the personal care or treatment records of patients.
- Reviewed comment cards that had been completed on the day of the visit where patients and members of the public shared their views and experiences of the service. Unfortunately any comment cards completed by patients in the two weeks prior to the visit were not available to us on the day of inspection as the provider informed us the comment card box had been lost.

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

The previous inspection in October 2015 rated the practice as requires improvement for providing safe services. We found there were gaps in the practice's management of risks posed to patients and staff and that there were gaps in the practice's recruitment procedures. The practice subsequently submitted an action plan to us informing us how they planned to address these shortfalls. However, during our inspection in November 2016 we found that this plan had not been implemented sufficiently to demonstrate the required improvement.

Safe track record and learning

There was not an effective system in place for reporting and recording significant events.

- Staff told us they would inform the practice manager of any incidents and there was a recording form available on the practice's computer system.
- While the practice carried out and documented an analysis of the significant events, these records did not consistently demonstrate that appropriate action had been completed to minimise the chances of the events being repeated.

The practice had identified and written up four significant events that had occurred in the previous 12 months. Two of these related to aggressive patients in the reception area. We saw that for three of the events, actions identified in the write ups consisted of discussions being held at staff meetings to brief or train staff. However, the practice was unable to provide evidence that these events had been discussed with staff at meetings. For example, when we discussed the two events relating to abusive patients (which occurred in July and August 2016) with practice management staff, they indicated these events had been discussed at a staff meeting and showed the inspection team meeting minutes dated 6 April 2016 where zero tolerance signs in the reception area were discussed. Staff we spoke to during the inspection were unable to feed back the outcomes of any recent significant events.

Overview of safety systems and processes

The practice lacked clearly defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from abuse:

- Arrangements to safeguard children and vulnerable adults from abuse were not sufficient. While the practice did have safeguarding adult and children policies, not all staff were aware of their location. The policies did outline who to contact for further guidance if staff had concerns about a patient's welfare. There was a lead member of staff for safeguarding. The GPs attended safeguarding meetings when possible and always provided reports where necessary for other agencies. Staff demonstrated they understood their responsibilities however the practice could not demonstrate all had received training on safeguarding children and vulnerable adults relevant to their role. We saw training certificates demonstrating GPs were trained to child protection or child safeguarding level 3, and that six of the staff and one GP had received safeguarding adults at risk e-learning training. While management staff told us that all other staff had received appropriate training around safeguarding children, they were unable to provide any documentary evidence to corroborate this. The staff we spoke to told us they had either not received this training, or had done many years ago. Following the inspection the practice sent evidence that the practice nurse had completed safeguarding children level two training the day after the inspection visit.
- There was no notice in the waiting room advising patients that chaperones were available if required. The business manager informed us that all non-clinical members of staff were asked to carry out chaperone duties if required by the clinicians. However, the practice's training matrix indicated that only four of the eleven staff had received training for this role at the time of inspection. Management staff told us that chaperone training was booked for the other staff later in November. We found evidence that one of the reception staff who had been trained for the role of chaperone had not 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). No risk assessment had been completed in place of this check. Management staff had previously informed the inspection team that all staff had received a DBS check.
- The practice maintained appropriate standards of cleanliness and hygiene. We observed the premises to

be clean and tidy. The practice nurse was the infection control clinical lead who liaised with the local infection prevention teams to keep up to date with best practice. There was an infection control protocol in place and the practice showed us a signed register sheet to demonstrate that nine of the 12 staff had received infection prevention and control training in May 2016, although there was no documentation available to specify what topics the training course had contained. The practice's policy stated that infection prevention and control audits and risk assessments would be completed on at least an annual basis. However, the most recent audit undertaken was completed in March 2016. This document identified a number of issues that required action, but the document did not detail whether these actions had been completed. For example the audit indicated that the practice required a policy around clostridium difficile (a bacterium that affects the bowel and can cause diarrhoea) immediately. We asked the infection control lead to show us this policy but they were unable to locate it on the day of inspection.

- There were some weaknesses in arrangements for managing medicines, including emergency medicines and vaccines (including obtaining, prescribing, recording, handling, storing, security and disposal). Processes were in place for handling repeat prescriptions which included the review of high risk medicines. However, we noted the practice continued to use paper slips to document and communicate acute prescription requests between reception staff and GPs, meaning there was no audit trail of these requests should these paper slips be misplaced. The GPs told us this would no longer be an issue once the practice had migrated to a new electronic record system where they would be able to use electronic tasks for this purpose. The practice carried out regular medicines audits, with the support of the local CCG pharmacy teams, to ensure prescribing was in line with best practice guidelines for safe prescribing.
- Blank prescription forms and pads were securely stored, however the practice did not have systems in place to monitor their use. Patient Group Directions (PGDs) had been adopted by the practice to allow nurses to administer medicines in line with legislation (PGDs are written instructions for the administration of medicines to groups of patients). We asked the practice nurse to show us the PGDs being used. We were shown hard copies of the PGD documents; the PGD for the flu vaccine had expired on 31 August 2016 and while it had been signed by the practice nurse, it had not been signed by a GP to document appropriate authorisation. The Hepatitis and Typhoid PGD was in date, but had been signed by neither the nurse nor GP. The nurse explained to us that updated versions of the PGDs were stored electronically. We saw that the versions stored on the practice's shared drive were in date, but had not been signed.
- We reviewed two personnel files for staff who had started working at the practice in the previous 12 months and found appropriate recruitment checks had not been undertaken prior to employment. While we saw that proof of identification had been documented, references had not been sought for either employee. Checks through the Disclosure and Barring Service had not been undertaken for either employee by the practice, nor had risk assessments been documented to record the rationale for this decision. However, we did see that for one of the employees, a copy of a DBS certificate obtained during previous employment, two years prior to commencing work at the practice, was stored on file.

Monitoring risks to patients

Risks to patients were not assessed nor well managed.

- The procedures in place for monitoring and managing risks to patient and staff safety were insufficient. The practice did not have an appropriate fire risk assessment in place. Management staff informed us after the inspection visit that they felt written observations they had made following a fire drill the previous week constituted their risk assessment. Only two members of staff had completed fire safety training. We referred the practice to the local fire safety officer who visited the practice. Feedback from the fire safety officer confirmed that the practice lacked understanding of what was required of it under the fire safety regulations. All electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly. Other risk assessments to monitor safety of the premises such as control of substances hazardous to health (COSHH) and infection control and legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings) were not

available for the inspection team to view. Management staff reported that the COSHH risk assessments were held off site by their cleaning contractor. The business manager showed us an email chain between himself and the local health protection nurse lead documenting that he had queried action required in relation to legionella. While the practice had followed advice and removed an unused shower head, there was no documented risk assessment relating to legionella.

- The practice had completed workplace risk assessments in July and August 2016 for three administration staff who we were told had complained of head and neck pains while working at their desks. Management staff reported that as a result the practice planned to facilitate raised computer screens for the staff to mitigate the risk identified. However, this action had not been taken at the time of the inspection visit.
- 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.

Arrangements to deal with emergencies and major incidents

The practice had adequate arrangements in place to respond to emergencies and major incidents.

- There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency.
- All staff received annual basic life support training and there were emergency medicines available in the treatment room.
- The practice had a defibrillator available on the premises and oxygen with adult and children's masks. A first aid kit and accident book were available.
- Emergency medicines were 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.
- The practice had a business continuity plan in place for major incidents such as power failure or building damage. The plan included the identification of an alternative GP practice to which services could be relocated in the event of an emergency. However, we noted the plan did not contain emergency contact numbers for staff.

Requires improvement

Are services effective?

(for example, treatment is effective)

Our findings

Following our previous inspection in October 2015 the practice was rated as good for providing effective services. However, during our inspection in November 2016, we found that the practice had not fully implemented actions around planned staff appraisal and found further gaps in the management of staff training.

Effective needs assessment

The practice assessed needs and delivered care in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines. Clinical staff told us how they accessed up to date clinical guidance on appropriate websites. However, there was not a systematic approach to disseminating and discussing updates to best practice guidance in the practice. The GPs confirmed that peer discussion around guidance updates had not taken place recently.

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent published results were 91.3% of the total number of points available, which was 5.8% lower than the local CCG average and 4% below the national average. The practice recorded an exception reporting rate of 4.3% across the clinical domains, which was 2.9% below the local average and 5.5% below the national average (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).

Data from 2015/16 showed:

- Performance for diabetes related indicators was below the local and national averages. For example:
  - The percentage of patients with diabetes on the register in whom the last IFCC-HbA1c was 64mmol/mol or less in the preceding 12 months was 72% compared to the clinical commissioning group (CCG) average of 80% and national average of 78%.
  - The percentage of patients with diabetes on the register in whom the last blood pressure reading (measured in the last year) was 140/80 mmHg or less was 71%, compared to the CCG average of 81% and national average of 78%.
  - The percentage of patients with diabetes on the register whose last measured total cholesterol (measured in the preceding 12 months) was five mmol/l or less was 78% compared to the CCG average of 85% and national average of 80%.
  - The percentage of patients with diabetes on the register who had had influenza immunisation in the preceding 1 August to 31 March was 86% compared to the CCG average of 96% and national average of 95%.
  - The percentage of patients on the diabetes register with a record of a foot examination and risk classification within the last 12 months was 46% compared to the CCG average of 88% and national average of 89%.
- Performance for mental health related indicators was generally below the local and national averages. For example:
  - The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who had a comprehensive, agreed care plan documented in the record in the preceding 12 months was 85% compared to the CCG average of 93% and national average of 89%.
  - The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses whose alcohol consumption had been recorded in the preceding 12 months was 93% compared to the CCG average of 93% and national average of 89%.
  - The percentage of patients diagnosed with dementia whose care had been reviewed in a face to face review in the preceding 12 months was 71% compared to the CCG average of 85% and national average of 84%.
- The percentage of patients with hypertension in whom the last blood pressure reading measured in the preceding 12 months was 150/90mmHg or less was 78% compared to the CCG average of 84% and national averages of 83%.

Requires improvement

Are services effective?

(for example, treatment is effective)

- The percentage of patients with asthma on the register who had an asthma review in the preceding 12 months that included an appropriate assessment of asthma control was 74%, compared to the CCG average of 75% and national average of 76%.
- The percentage of patients with COPD who had had a review undertaken including an appropriate assessment of breathlessness in the previous 12 months was 97%, compared to the CCG average of 91% and national average of 90%.

The GPs were aware that the practice had previously been an outlier for its QOF performance in 2014/15 in a number of indicators including flu vaccinations, cholesterol control and foot examinations for diabetic patients, and blood pressure in hypertensive patients. The QOF results for 2015/16 demonstrated the practice had made improvements in all these areas other than diabetic foot checks, which had deteriorated by 9%. The practice attributed this deterioration to the fact that their patients had their foot checks completed by the podiatry service, and that this service had not uploaded its data in a timely manner meaning the practice results were not an accurate reflection of performance.

There was some evidence of quality improvement including clinical audit.

- The practice shared one clinical audit with us that had been completed 11 months ago. This was a completed two cycle audit where changes had been made and results monitored.
- The practice participated in local audits, national benchmarking and accreditation.
- Findings were used by the practice to improve services. For example, the audit we were shown demonstrated that the practice had become aware that the rate of dementia diagnosis was significantly below the national average. A regime of work was undertaken in order to cross reference medication searches with patient records and also to liaise with local care homes. This resulted in the number of patients appropriately coded on the practice's computer record system with a diagnosis of dementia increasing from 12 to 39. The audit did not acknowledge whether there had been a corresponding increase in the number of face-to-face reviews for these patients.

Information about patients' outcomes was used in an effort to make improvements. For example, following a significant event whereby poor communication channels with a local hospital resulted in a delay in an urgent blood test being completed for a patient, one of the GPs wrote to the hospital in an effort to raise the issue and instigate improved communication and processes. This letter was sent in July 2016, but at the time of our inspection no response had been received.

Effective staffing

Staff had the skills, knowledge and experience to deliver effective care and treatment, although there were some gaps in the management of staff training.

- The practice offered an induction for all newly appointed staff. While staff were given the opportunity to shadow more experienced colleagues, there were gaps in the training offered. For example, such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality were not included as part of the induction.
- The practice could demonstrate how they ensured role-specific training and updating for relevant staff. For example, we saw an appropriate range of training certificates for the practice nurse and health care assistant who reviewed patients with long-term conditions.
- Staff administering vaccines and taking samples for the cervical screening programme had received specific training which had included an assessment of competence. Staff who administered vaccines could demonstrate how they stayed up to date with changes to the immunisation programmes, for example by access to on line resources and discussion at practice meetings. We noted the practice nurse had not attended an immunisation and vaccination update course since August 2015.
- The learning needs of staff had not been comprehensively identified because a system of appraisals, meetings and reviews of practice development needs had not been fully implemented. The practice were unable to demonstrate that staff had consistent access to appropriate training to meet their learning needs and to cover the scope of their work. We saw that all non-clinical staff had completed a pre-appraisal assessment form and had met with the business manager to discuss this in May 2016. The

business manager had added his own comments following the meeting and this paperwork was held by him, It was not signed by the staff and staff confirmed to us that they had not seen it following them completing it. The business manager told us he had noticed a trend in the outcome of the discussions that staff lacked awareness of the management structure of the practice. He intended to use the outcome of the meetings and pre-appraisal paperwork to produce personal development plans for all staff, however this had not yet been completed. There was no documentation to evidence that the practice nurse had received an appraisal. The nurse told us she was last appraised by a GP partner who had retired from the practice in December 2015.

- There was limited evidence of the training received by non-clinical staff. There were gaps in training around topics including safeguarding, fire safety awareness, and information governance. Staff had access to e-learning training modules, however there was limited evidence of its use. For example only two of the staff had completed the e-learning module on fire safety.

Coordinating patient care and information sharing

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

- This included care and risk assessments, care plans, medical records and investigation and test results.
- The practice shared relevant information with other services in a timely way, for example when referring patients to other services.

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

Consent to care and treatment

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

- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005.
- When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance.
- 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 noted that consent for joint injections was only sought verbally. Written consent for this procedure was not obtained.

Supporting patients to live healthier lives

The practice identified patients who may be in need of extra support. For example:

- Patients receiving end of life care, carers, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation. Patients were signposted to the relevant service.
- Smoking cessation advice was available at the practice from the practice nurse and health care assistant.

The practice's uptake for the cervical screening programme was 71%, which was lower than the CCG and the national averages of 81%. This was a slight deterioration from the previous year's results (1% lower). The GPs discussed with us that they were aware this figure was low, but felt this did not reflect the practice's actual uptake of cervical smears. They believed discrepancies in coding these checks accurately into patient records had resulted in under reporting. However, they did not discuss with us any action being taken to rectify this. The practice nurse was able to discuss how the practice encouraged uptake of the screening programme by ensuring a female sample taker was available and offering this screening opportunistically when patients attended the practice for other appointments. There were failsafe systems in place to ensure results were received for all samples sent for the cervical screening programme and the practice followed up women who were referred as a result of abnormal results. The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening.

Requires improvement

Are services effective?

(for example, treatment is effective)

Childhood immunisation rates for the vaccinations given were comparable to CCG and national averages. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 69% to 91% and five year olds from 86% to 92%.

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

Good

Are services caring?

Our findings

Kindness, dignity, respect and compassion

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

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

All of the three 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 three patients during the visit. They also told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected, although one did express some concerns that the manner of staff could be rude at times. Comment cards highlighted that staff responded compassionately when they needed help and provided support when required.

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

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

Care planning and involvement in decisions about care and treatment

Patients told us they mostly 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. We also saw that care plans were personalised.

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

- 91% of patients said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 88% and the national average of 86%.
- 85% of patients said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 85% and national average of 82%.
- 92% of patients said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average of 88% and national average of 85%.

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

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

Patient and carer support to cope emotionally with care and treatment

Good

Are services caring?

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 a limited number of support groups was also available on the practice website.

The practice held a list of patients who were also a carer, although the GPs were not aware that the practice held a formal register of these patients. The practice had identified 43 patients as carers (0.9% of the practice list). Written information was available to direct carers to the various avenues of support available to them.

Staff told us that if families had suffered bereavement, they would be signposted to support services available.

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Following our last inspection visit in October 2015, the practice was rated as good for providing responsive services. However, during our visit in November 2016 we found areas that required improvement.

Responding to and meeting people's needs

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

- The practice offered extended hours appointments from 7.30am three mornings each week, and one evening until 9pm 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 and were referred to other clinics for vaccines available privately.
- There were disabled facilities and translation services available.
- All consultation and treatment rooms were situated on the ground floor of the premises and so were accessible to those patients experiencing difficulties with mobility.
- Midwives offered clinics from the surgery premises. The practice's in-house pharmacist undertook medication reviews to ensure patient's medicine was the most appropriate and effective.

Access to the service

The practice opened at 8.00am on Monday and Friday, and at 7.30am Tuesday, Wednesday and Thursday. It closed at 6.00pm on Mondays and Fridays, 6.30pm on Tuesdays and Thursdays and 5.00pm on Wednesdays. Appointments were offered between 7.30 and 11.30am each morning on Wednesday, Thursday and Friday, between 8.00am and 12 midday on a Monday morning and between 8.00am and 11.00am on a Friday morning. Surgery times in the afternoon started at 3.30pm on a Monday and Friday, and at 4.00pm on a Tuesday and Thursday, and ran until 6.00pm, except on Tuesday when the practice offered a late night surgery by appointment until 9:00pm. Routine appointments were not offered on a Wednesday afternoon, but the GPs were available should urgent appointment requests be made. In addition to pre-bookable appointments that could be booked in advance, urgent appointments were also available for people that needed them.

One the day of inspection, the next available pre-bookable appointment was available within four working days' time.

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

- 87% of patients were satisfied with the practice's opening hours compared to the CCG average of 81% and national average of 79%.
- 84% of patients said they could get through easily to the practice by phone compared to the CCG average of 79% and national average of 73%.

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

The practice had a system in place to assess:

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

This was done through the practice's telephone triage system. We did note however, that a significant event had been documented in September 2016, the outcome of which was that the telephone triage system required review and reception staff needed updated training. At the time of inspection this had not taken place. 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 in place for handling complaints and concerns.

- Its complaints policy and procedures were mostly in line with recognised guidance and contractual obligations

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

for GPs in England, although we noted that patients were not routinely provided with information on where to escalate their complaint to should they be dissatisfied with the practice's response.

- 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 in the form of a leaflet behind the reception desk made available to patients on request.

We looked at four complaints received in the last 12 months. The practice complaints procedure available to patients stated that patients would be provided with an acknowledgement within three working days. We saw that in three cases this acknowledgement was not documented. We also noted that in two cases, as well as complaining about systems in place within the practice, complainants also raised concerns regarding the manner of staff. In both cases, the practice's response only acknowledged the issues around practice systems (for example the telephone triage system) and did not make reference to the other aspect of the complaint. In one of the four cases, we saw that lessons learned from the complaint had been implemented and shared with staff and the complainant; the handling of telephone triage was altered as a result. We did not see evidence that lessons were learned from analysis of trends of complaints and action taken as a result to improve the quality of care.

One of the patients we spoke to during our visit expressed dissatisfaction with how their verbal complaint about the appointment system was managed by the practice. They did not feel it was acknowledged and escalated by the member of staff they were speaking to.

Are services well-led?

Inadequate

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

Our findings

Following our inspection in October 2015, the practice was rated as requires improvement for its leadership as we found gaps in the governance arrangements that were in place.

We continued to encounter limited engagement from the provider in our regulatory activity and found that this in turn resulted in a negative impact on patient care.

Vision and strategy

The practice vision was documented in the practice information leaflet that was available to patients from reception. It detailed that the practice aspired to provide a well organised, responsive service while maintaining the highest possible standards of medical care. Staff were able to discuss with us how they prioritised patient care in their work.

The GPs discussed with us how they had now resolved previous issues around the ownership of the premises, and had undertaken refurbishment work to improve office space on the upper floor of the premises. This work was underway at the time of inspection. The GPs also discussed future plans to carry out work to improve the ground floor of the building, in the hope that a local pharmacy may relocate to be housed in the premises in the future.

Governance arrangements

In October 2015 we found gaps in the practice's governance arrangements. During our most recent visit we again found the practice lacked an overarching governance framework to support the delivery of the strategy and good quality care.

- Following our previous inspection the practice had submitted an action plan informing us how it would address the concerns raised. This action plan stated, for example, that:
  - A systematic approach to risk identification and management would be implemented.
  - An improved system to monitor and manage staff training would be put in place, which would specifically include training topics such as safeguarding and fire safety.
  - DBS checks would be included as part of pre-employment checks.
  - Templates would be devised and implemented in order to record and track the movement of blank prescriptions through the practice.

  On re-inspection in November 2016 we found that none of these actions had been appropriately implemented.
- Although there was a staffing structure in place, the business manager discussed with us that it had become apparent following meetings with staff earlier in the year that they were unclear of the management structure in place and how it related to their roles. For example, staff were unsure who their direct line manager was.
- A range of practice specific policies were in place. However, not all staff were aware of how to access these policies and we found evidence that document control was ad-hoc; for example neither the safeguarding adults nor safeguarding children policies were dated to indicate when they were created now whether they had been reviewed.
- There were also key gaps in policy documents to govern activity within the practice, for example there was not a fire safety policy available.
- Where policies were in place, the practice did not consistently follow them, for example the infection control policy stated that annual IPC audits would be completed and the last audit was completed in March 2015, and the complaints policy indicated all complaints would be acknowledged within three days but this was not always done.
- The partners demonstrated they had an awareness of the performance of the practice, however, they were unable to articulate how the practice intended to address weaknesses, such as low completion of diabetic foot checks and low uptake of cervical screening.
- While some clinical and internal audit was used to monitor quality and to make improvements, audit activity was limited, with only one completed audit cycle around dementia diagnosis rates available for the inspection team to review.
- There were continued areas of concern around practice systems for identifying, recording and managing risks,

Are services well-led?

Inadequate

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

issues and implementing mitigating actions. Key risk assessments had not been completed, such as fire risk assessments, and when workplace risk assessments had been completed three months previously the identified mitigating actions had not been carried out.

- Appraisal meetings had taken place for most staff, but staff had not had sight of the completed documentation from these meetings and personal development plans had not been formulated. The practice nurse had not had an appraisal for over 12 months.
- There continued to be a lack of managerial oversight around staff training, which had resulted in key gaps in topics such as safeguarding and fire safety.

Leadership and culture

Staff told us the partners were approachable and took the time to listen to all members of staff.

The provider was aware of 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). We saw examples of complaints where the practice had responded and informed the patient what had been done to ensure the situation was not repeated. The partners encouraged a culture of openness and honesty. The practice had systems in place to ensure that when things went wrong with care and treatment:

- The practice gave affected people support, truthful information and an apology
- The practice kept records of written correspondence. However, written records of verbal interactions were not always maintained.

We saw there was a leadership structure in place.

- Staff told us the practice held team meetings. We saw minutes to document that four practice meetings had taken place since the previous inspection visit. However, the minutes did not consistently indicate who was present at the meetings, meaning the practice did not always have a clear audit trail of what information had been given to whom.
- Staff told us there was an open culture within the practice and they had the opportunity to raise any issues at team meetings.
- Staff said they felt respected and supported by the partners in the practice.

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

There was some evidence that the practice had sought patient feedback in the previous year. This had addressed the specific issue of limited car parking space being available due to the misuse of the practice's car park. The practice completed a survey of patients in order to gauge whether they would be happy submitting their number plates to the practice on entry should a number plate recognition system be installed in the car park. The practice reported that 103 responses to the survey were received, all of which supported the initiative. The partners told us the new number plate recognition system was due to be installed before the end of 2016.

- The practice did not have a patient participation group (PPG) in place to facilitate closer liaison with its patient cohort. The GPs attributed the reason for the lack of a PPG as being due to practice staff not having the time to commit to facilitating a group. They told us they hoped a member of staff would volunteer to set up a patient group in the near future.
- The practice told us feedback was gathered from staff generally through staff meetings, appraisals and discussion. An example given of staff feedback influencing change was around receptionists finding the telephone triage system challenging and the system being updated. However, separate discussions with management staff indicated this update had been initiated following a complaint from a patient.

Continuous improvement

The partners and management in the practice were focussed on ensuring the premises were improved and work was underway to achieve this.The practice were in negotiations with NHS England to secure the move of a local pharmacy so that it would be housed within the ground floor of the practice in the future.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **How the regulation was not being met:** An infection prevention and control audit had not been completed since March 2015 and the provider was unable to demonstrate that required actions following the audit had been completed and embedded into practice. Appropriate documentation to demonstrate nursing staff were authorised to administer medicine was incomplete. The provider had not implemented a system to log and audit the location of blank prescription forms in the practice. This was in breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.