Iwade 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?	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 carried out an announced comprehensive inspection at Iwade Health Centre on 6 June 2017. Overall the practice is rated as inadequate and urgent conditions have been placed on the providers registration which include: the restriction of new patients being registered; an urgent review of patient demand to determine the correct level of service provision and resource; the implementation of a sustainable system to ensure repeat prescription requests, medication reviews and correspondence are reviewed and actioned without delay and ensuring capable and sufficient staffing at the practice to deliver a safe service.

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

- The approach to investigating and reviewing significant events was insufficient. There was no evidence of learning from events or action taken to improve safety.
- Patients were at risk of harm because systems and processes were not in place to keep them safe. For example, there was no system for ensuring patient safety information was appropriately shared and acted upon.
- The practice were not able to provide documents or a training schedule to show who had received training. This included basic life support, safeguarding children and vulnerable adults relevant to their role and competence based training.
- The practice did not have a system to ensure staff who acted as chaperones were trained for the role or had received a Disclosure and Barring Service (DBS) check.
- An annual infection prevention control audit had been completed. However there were no records to show that action had been taken to address improvements identified as a result
- There were insufficient systems to ensure the safe prescribing and management of medicines, which included the review of high risk medicines and prescription pads were not monitored throughout the practice.

Summary of findings

- Appropriate recruitment checks had not been undertaken prior to staff being employed
- Risk assessments regarding health and safety, fire safety COSHH and legionella had not been carried out or had not been actioned.
- The practice had achieved 96% of the total number of QOF points available.
- Although some single cycle audits had been carried out, we saw no evidence that these were informing and improving patient outcomes.
- Basic care and treatment requirements were not met. For example, there was an insufficient system to review patients regarding their medicine.
- The information needed to plan and deliver care and treatment was not available to relevant staff in a timely and accessible way.
- Multi-disciplinary meetings were not taking place.
- The majority of patients who responded to the national GP patient survey (2016) said they were treated with compassion, dignity and respect. However, patients spoken with reported a lack of continuity in their care due to the use of different locum GPs and nurses.
- There was no system to offer support to patients who identified themselves as carers.
- Information about how to complain was available to patients; however there was no evidence of learning being shared to mitigate further risk.
- Urgent appointments were usually available on the day they were requested.
- There was no clear division between the local and the corporate leadership structure and staff told us they were unsure where responsibility for governance lay.
- The most recent patient participation group meeting minutes were from 2015.

The areas where the provider must make improvements are:

- Ensure that sufficient numbers of suitably qualified, competent, skilled and experienced clinical staff members are deployed.
- Ensure systems and process to assess, monitor, manage and mitigate risks to the health and safety of patients who use services are in place.
- Introduce effective systems or processes to identify, report, record and act on and significant events, incidents and near misses.
- Ensure staff have the qualifications, competence, skills and experience to provide safe care and treatment, including safeguarding adults and children at the appropriate level and basic life support training.
- Ensure the proper and safe management of medicines.
- Establish and operate effective recruitment procedures to ensure that fit and proper persons are employed.
- Establish an appropriate system to ensure that the information needed to plan and deliver care and treatment is made available to relevant staff in a timely and accessible way.
- Ensure that people employed by the service receive training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform.
- Introduce effective systems to assess, monitor and improve the quality and safety of the services provided.

The areas where the provider should make improvement are:

- Review the recommendations made in the fire risk assessment are actioned and that fire evacuation procedures are rehearsed.
- Review the process for offering support to patients identified as carers.
- Review the process to alert the GP that a home visit request has been received.
- Improve the accessibility of the service.
- Review and update procedures and guidance.

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

Summary of findings

further six months, and if there is not enough improvement we will move to close the service by adopting our proposal to remove this location or cancel the provider's registration.

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

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Inadequate

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

- The approach to investigating and reviewing significant events was insufficient. There was no evidence of learning from events or action taken to improve safety.
- Patients were at risk of harm because systems and processes were not implemented in a way to keep them safe.
- The practice were not able to show who had received training on safeguarding children and vulnerable adults relevant to their role
- There were insufficient processes to ensure the proper and safe management of medicines.
- Appropriate recruitment checks had not been undertaken prior to staff being employed.
- There were not enough staff to keep patients safe. The clinical team at the practice had resigned and the practice was reliant on locum GPs and nurses. Substantial and frequent staff shortages and poor management of agency or locum staff increased the risk of harm to people who used the service.

Are services effective?

Inadequate

The practice is rated as inadequate for providing effective services, as there are areas where improvements should be made.

- Data showed patient outcomes were comparable to or below the national average.
- The practice had systems to keep clinical staff up to date. Staff had access to guidelines from NICE as part of the practice IT system.
- There was no evidence that audit was driving improvement in patient outcomes.
- There was insufficient evidence to show that staff had the skills and knowledge to deliver effective care and treatment.
- Staff did not have an appraisal process and training was not up to date.
- There was no system of clinical supervision in place for nurses working in advanced roles such as prescribing or diagnosis of acute illness.
- The practice could not demonstrate role-specific training, for example, for nurses reviewing patients with long term conditions.

Summary of findings

- Clinical documents and requests for medication were not reviewed and actioned appropriately
- Multi-disciplinary meetings were not taking place.
- End of life care was not effectively coordinated.

Are services caring?

Good

The practice is rated as good for providing caring services.

- Data from the national GP patient survey showed patients rated the practice lower than others for some aspects of care. For example, 66% of respondents described their overall experience of this surgery as good, compared with the CCG average of 82% and the national average of 85%. 18% of respondents describe their overall experience of this surgery as poor compared with the CCG average of 7% and the national average of 5%.
- The practice had identified 0.8% of the patient list as carers, they did not offer a carers pack and were unable to demonstrate how people who identified themselves as carers were supported.

Are services responsive to people's needs?

Requires improvement

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

- Patients reported low levels of satisfaction with opening hours. The national GP patient survey showed 55% of respondents were satisfied with the practice's opening hours compared with the clinical commissioning group (CCG) average of 72% and the national average of 76%.
- Feedback from patients reported that access to a GP and continuity of care was not always available quickly, although urgent appointments were usually available the same day.
- 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.

Are services well-led?

Inadequate

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

- There was no clear division between the local and the corporate leadership structure. Staff told us they were unsure where responsibility for governance lay.
- The practice did not have a clear vision and strategy and staff were not clear about their responsibilities in relation to this.

Summary of findings

- There was no effective system for identifying, capturing and managing issues and risks.
- The practice had a number of policies and procedures to govern activity, but these were out of date or not reflective of the processes carried out.
- The practice did not hold governance meetings, clinical meetings or regular staff meetings.
- The practice had not proactively sought feedback from staff or patients. The last minutes of a meeting with the patient participation group were from 2015.
- Staff told us they had not received regular performance reviews and did not have clear objectives.
- The specific training needs of staff were not addressed and there was a lack of support and mentorship for those appointed to extended roles.

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 could not demonstrate that staff had completed training in safeguarding adults.
- We saw evidence which showed that basic care and treatment requirements were not met. For example, three urgent prescriptions for patients resident in a care home had not been actioned after seven days.
- The practice were not able to demonstrate that there was a system to ensure medicine reviews were carried out as required, including where medicine relied on accuracy of blood tests to determine the safe amount prescribed.
- The care of older patients was not managed in a holistic way, as multi-disciplinary meetings were not being conducted at the practice.
- The practice had a register of older patients who were approaching the end of life; however this information was not co-ordinated with other health and social care professionals.
- The practice offered home visits for patients who were unable to attend the practice.

People with long term conditions

Inadequate

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

- Longer appointments and home visits were available when patients needed them or when required.
- The practice relied on locum clinical staff including GPs and nurses. There was no named GP on site for this patient group.
- Structured annual reviews were not undertaken to check that patients' health and care needs were being met.
- There was no evidence that nurses carrying out reviews for patients with long term conditions had received specific training to do so.
- The practice could not demonstrate that they worked with relevant health and care professionals to deliver a multidisciplinary package of care to patients with the most complex needs.

Families, children and young people

Inadequate

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

Summary of findings

- The practice could not demonstrate that staff had completed training in safeguarding children.
- There were no systems to follow up where children did not attend their appointment.
- There were no systems to identify and follow up patients in this group who were living in disadvantaged circumstances and who were at risk.
- The practice could not demonstrate role-specific training, for example, for nurse immunising children and babies.
- Immunisation uptake rates were highlighted as a negative variation within CQC data and relatively low for a number of the standard childhood immunisations. For example, the percentage of children aged two who had been immunised with pneumococcal conjugate booster vaccine was 73% against the national target of 90%.
- The premises were suitable for this population group.

Working age people (including those recently retired and students)

Inadequate

The practice is rated as inadequate for the care of working age people (including those recently retired and students).

- The percentage of respondents to the GP patient survey who were 'very satisfied' or 'fairly satisfied' with their GP practice's opening hours was highlighted as a negative variation in CQC data. 55% of respondents said they were very or fairly satisfied compared to the CCG average of 72% and the national average of 76%.
- Appointments could be made on-line, on the telephone or by person.
- The practice was difficult to access by telephone. For example, 49% of respondents to the national GP patient survey said they could get through easily to the practice by phone compared with the clinical commissioning group (CCG) average of 64% and the national average of 73%.
- There were no early or extended opening hours for patients who worked or students.
- Health checks were available, if requested.

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.

Summary of findings

- The practice were not able to demonstrate that staff had been trained to recognise the signs of abuse in vulnerable adults and children.
- The safeguarding policy was out of date and did not provide appropriate information for staff.
- The practice had not worked with multi-disciplinary teams in the case management of vulnerable patients.
- The practice provided longer appointments for patients living with a learning disability. These patients were not flagged on the system to alert administrative staff to their needs.
- The practice had a register of 33 patients who were living with learning disabilities. A random selection of five of these patients was made and none of these had received an annual review.
- The practice did not identify those whose circumstances may make them vulnerable who were approaching the end of life.

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 (including people with dementia).

- 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 68% compared to the CCG average of 93% and the national average of 89%.
- The percentage of patients diagnosed with dementia whose care plan has been reviewed in a face-to-face review in the preceding 12 months was 74% compared to the CCG average of 83% and the national average of 84%.
- The practice had not worked with multi-disciplinary teams in the case management of patients experiencing poor mental health.
- Medication reviews were not consistently conducted for patients on high risk medicines.
- We reviewed the care of two patients living with mental health conditions and found that their care had not been reviewed since 2014.
- The practice did not have a system to follow up patients who had attended accident and emergency (A&E) where they may have been experiencing poor mental health.
- The practice were unable to demonstrate that they followed up or provided after care to a patient sectioned under the Mental Health Act in 2016.

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. 290 survey forms were distributed and 104 were returned. This represented 2% of the practice's patient list.

- 66% of respondents described the overall experience of this GP practice as good compared with the Clinical Commissioning Group (CCG) average of 82% and the national average of 85%.
- 18% of respondents described the overall experience of this GP practice as poor compared with the CCG average of 7% and the national average of 5%.
- 59% of respondents described their experience of making an appointment as good compared with the CCG average of 66% and the national average of 73%.
- 25% of respondents described their experience of making an appointment as poor compared with the CCG average of 17% and the national average of 12%.
- 53% of patients said they would recommend this GP practice to someone who has just moved to the local area which was lower than the CCG average of 74% and the 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. We received no comment cards during this inspection.

We spoke with five patients during the inspection. These patients told us that they were unable to get through to the practice by the telephone. The practice had a call waiting system and they were often told they were eighteenth in the queue. They told us that sometimes they had to wait over 20 minutes to get through so now visit the practice in person to make an appointment. Patients told us that when they got an appointment it was often during working hours resulting in them having to take time off work, and that they did not see the same GP which was a concern for patients with long term or complex conditions. We looked at the reviews on the NHS Choices website for this practice and saw that all of the reviews received since November 2016 have rated the practice as a 1 star service. The practice had not responded to the comments left by patients detailing concerns.

Areas for improvement

Action the service MUST take to improve

- Ensure that sufficient numbers of suitably qualified, competent, skilled and experienced clinical staff members are deployed.
- Ensure systems and process to assess, monitor, manage and mitigate risks to the health and safety of patients who use services are in place.
- Introduce effective systems or processes to identify, report, record and act on and significant events, incidents and near misses.
- Ensure staff have the qualifications, competence, skills and experience to provide safe care and treatment, including safeguarding adults and children at the appropriate level and basic life support training.
- Ensure the proper and safe management of medicines.
- Establish and operate effective recruitment procedures to ensure that fit and proper persons are employed.
- Establish an appropriate system to ensure that the information needed to plan and deliver care and treatment is made available to relevant staff in a timely and accessible way.
- Ensure that people employed by the service receive training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform.
- Introduce effective systems to assess, monitor and improve the quality and safety of the services provided.

Action the service SHOULD take to improve

The areas where the provider should make improvement are:

Summary of findings

- Review the recommendations made in the fire risk assessment are actioned and that fire evacuation procedures are rehearsed.
- Review the process for offering support to patients identified as carers.
- Review the process to alert the GP that a home visit request has been received.
- Improve the accessibility of the service.
- Review and update procedures and guidance.

Iwade Health Centre

Detailed findings

Our inspection team

Our inspection team was led by:

The team was led by a CQC Lead Inspector**.** The team included a GP specialist adviser, a second CQC inspector and a practice manager specialist adviser.

Background to Iwade Health Centre

Iwade Health Centre is located in a semi-rural residential location in the village of Iwade in Kent and provides primary medical services to approximately 6,000 patients. Iwade Health Centre holds an Alternative Provider Medical Services (APMS) contract. The practice is housed in a purpose built building, with consulting and treatment rooms based on the ground floor and administration and meeting/training rooms on the first floor. There are parking facilities and the building is accessible for patients with mobility issues and those with babies/young children.

The practice patient population includes more younger patients from 0-14 years than the England average age distribution, less 14 to 29 year old patients, more 30 to 49 year old patients and significantly less older people. It is situated in an area where the population is considered to be less deprived.

The provider for the practice is Malling Health Ltd which is an organisation with multiple locations, and the service is provided by a number of locum GPs. On the day of the inspection a lead locum GP had been employed by the practice for a three or four month period to work four days each week. There are a number of locum practice nurses and an advanced nurse practitioner, all female, as well as a permanent health care assistant. There is a practice management team and reception/administration staff.

The practice is open from Monday to Friday between 8.00am and 6.30pm. In addition to appointments that can be booked up to four weeks in advance, urgent on the day appointments are available for people that need them. Appointments can be booked over the telephone or in person at the practice. There are arrangements with other out of hours providers to deliver services to patients outside of the practice working hours.

Services are provided from:

1 Monins Road, Iwade, Sittingbourne, Kent, ME9 8TY

The practice had been inspected previously in February 2015 and was found to be complaint with the Health and Social Care Act 2008, being rated good overall and in all domains. The inspection at the practice on 6 June 2017 was a responsive comprehensive inspection conducted in response to complaints and concerns raised with the Care Quality Commission.

Why we carried out this inspection

We carried out a responsive 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.

Detailed findings

How we carried out this inspection

We carried out an announced visit on 6 June 2017. During our visit we:

- Spoke with a range of staff including a locum GP, a practice nurse, the practice manager, a second practice manager from an affiliated practice, administrative and reception staff and spoke with patients who used the service.
- Observed how patients were being cared for in the reception area.
- Reviewed a sample of the personal care or treatment records of patients.
- 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?
- 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

Safe track record and learning

There was a system for reporting and recording significant events however this was not sufficiently embedded to keep people safe. 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.

From the sample documented examples we reviewed we found that when things went wrong with care and treatment, the approach to reviewing and investigating causes was insufficient. For example, we reviewed the significant incidents tracker provided by the practice. This showed 15 incidents had been reported within the past twelve months including the resignation of members of the clinical team, deterioration of a patient's health, patient's presenting as unwell and collapsing at the practice and GP locums not attending the practice when expected. We looked at specific records for five of these incidents and they all lacked detail of the circumstances, investigation, risks and learning from the event to reduce the risk of a reoccurrence. There was no evidence of who had contributed or been present for the discussions of the incidents.

We found on two occasions patients had presented unwell at the practice. One patient presented as 'very sick' on 27 March 2017 and the second on 24 April 2017. On the first occasion the GP had not been notified immediately of the patient's presentation. The action identified as a result of this significant event was for staff to complete online training to 'spot a sick child'. The practice were unable to provide evidence to demonstrate this training had been sought, which staff had been identified to undertake the training, the date for the training to be completed by or evidence of a review to check understanding and changes had been embedded.

The second incident related to a locum GP who was due to arrive at the practice at 8am but did not arrive until 11am. The practice cited learning from this as a need to remind the locum agency to remind locum GPs that they were working. However, three weeks later in May 2017 the locum GP failed to attend the practice for the duration of one day meaning there was no GP at the site.

The practice were unable to provide recent minutes of meetings to show that learning from significant events was shared with staff to help mitigate the risk of incidents being repeated. The practice provided two copies of meeting minutes one from September 2014 and one from February 2015. There were no details of staff members present for the discussion or their conclusions. The significant event records were not coded according to type and therefore the practice did not monitor trends.

We spoke with the lead locum GP who was aware of significant events and the requirement to record them. However he was not aware of the process within the practice and could not locate an incident form.

We reviewed safety records, incident reports and patient safety alerts. The practice were not able to provide recent minutes of meetings. We reviewed the practice policy regarding the management of safety alerts which was dated November 2016. It stated that medicine alert information would be dealt with by the practice, distributed to relevant staff, who were unspecified in the policy and actioned (through audit) filed and discussed during a clinical policy meeting. The practice were not able to provide documents to demonstrate that this was being carried out.

The practice manager told us that medicine safety alerts had not been actioned since March 2017 as there was not a lead clinician to assign them to. We checked the patient clinical system and found safety alerts from 2015 had not been actioned. For example;

- In January 2015, February 2016 and in April 2017 a medicine safety alert was sent relating to a medicine used to treat epilepsy and bi-polar disorders which carried a risk of developmental disorders on babies if taken during pregnancy. The latest alert repeated the urgency of the earlier notifications and asked clinicians to review all patients taking the medicine. We checked the practice patient records and found six women of childbearing age were prescribed the medicine. Two of the six women had been initiated on the medicine in June 2015 and December 2016 after the safety alerts had been issued. We found no evidence within their clinical record of them having been contacted and informed of the associated risks or of contraception advice being given. Babies born to mothers who take this medicine during pregnancy have a 30–40% risk of developmental disability and a 10% risk of birth defects.

The practice were unable to provide evidence of clinical meetings being held or of audits being conducted to demonstrate patients had been informed of risks and action taken to mitigate them.

Overview of safety systems and processes

Systems, processes and practices do not keep people safe. There was routine disregard of standard operating or safety procedures

- There was an insufficient safeguarding system at the practice. There was a safeguarding policy but this was out of date, including the names of two GPs and a practice nurse who had left the practice. There was a lead member of staff for safeguarding (who was the lead locum GP who had just started at the practice on the day of the inspection). The practice were not able to provide evidence of GPs attending safeguarding meetings when possible or providing reports where necessary for other agencies. A check was carried out regarding children who did not attend their booked appointments at the practice during May 2017. It was found that six children did not attend appointments and the reason for this was not followed up.
- Staff interviewed demonstrated they understood their responsibilities regarding safeguarding. However the practice were not able to provide documents or a training schedule to show who had received training on safeguarding children and vulnerable adults relevant to their role. The lead locum GP was trained to child protection or child safeguarding level three.
- A notice in the waiting room advised patients that chaperones were available if required. Staff who acted as chaperones told us they were trained for the role, however no evidence was seen to support this and not all staff had received a Disclosure and Barring Service (DBS) check. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).

The practice maintained appropriate standards of cleanliness and hygiene.

- We observed the premises to be clean and tidy. There were cleaning schedules and monitoring systems in place.
- The practice were not aware of who the infection prevention and control (IPC) clinical lead was. An annual IPC audit had been completed however there were no records to show that action had been taken to address improvements identified as a result. Three out of date sharps bins were found within the practice.
- The practice was not able to demonstrate which staff had received up to date infection control training.

The arrangements for managing medicines, including emergency medicines and vaccines, in the practice did not minimise risks to patient safety (including obtaining, prescribing, recording, handling, storing, security and disposal).

- There were insufficient processes for handling repeat prescriptions which included the review of high risk medicines. This was a systemic problem. For example, there was no policy for the management of high risk medicines and there were no systems to ensure patients receiving high risk medicines such as disease modifying anti-rheumatic drugs (DMARDs) had appropriate medicine reviews prior to the reissuing of prescriptions and administrative staff were able to print out these prescriptions independently of the GP. This exposed patients to potential risks of their medication being reissued without appropriate reviews having been conducted.
- We reviewed the care of patients receiving high risk anti-coagulant medicine which required weekly blood testing initially increasing to monthly intervals if the patient was stable. We saw that one patient whose last recorded monitoring of their INR was conducted in 2015 (INR is the International Normalised Ratio which measures how long it takes for blood to clot when anti-coagulant medicine is used by a patient) but had received a prescription in May 2017. A second patient had been prescribed the medicine in May 2017 but their INR had last been checked in January 2017.
- We found three urgent prescription requests two of which were dated 29 May 2017 and one 31 May 2017 for residents at a care home which had not been actioned by 6 June 2017.
- Staff told us they were not aware of the findings of medicines audits carried out with the support of the local clinical commissioning group pharmacy teams.
- Blank prescription forms were securely stored in a locked cupboard however there was no system for checking these into the practice or out for use. Blank prescription pads were stored in a locked filing cabinet, however, there was no system for logging these in or out

so no way of knowing if any were missing. Patient Group Directions had been adopted by the practice to allow nurses to administer medicines in line with legislation however these were signed by the nurse practitioner and not by the GP as required. The practice were able to assure us that all of the PGD's needed were available, and some of them had expired.

We reviewed eight personnel files and found that appropriate recruitment checks had not been undertaken prior to employment. All files were inconsistent and there was a lack of proof of identification, evidence of satisfactory conduct in previous employments in the form of references, qualifications, registration with the appropriate professional body and the appropriate checks through the DBS.

Monitoring risks to patients

The practice did not sufficiently assess, monitor or manage risks to people who used the services. Opportunities to prevent or minimise harm were missed.

- There was a health and safety policy available which had not been personalised to the practice. It included a health and safety risk assessment however this had not been completed.
- There had been a review of the fire risk assessment at the practice in September 2016.

Actions were identified that were required to be carried out, however there were no records available to demonstrate that these had been undertaken. For example, the risk assessment noted that the last fire evacuation drill was conducted on 20 August 2014 and that this was overdue and was required to be carried out. Records seen showed that the last recorded fire drill at the practice was 20 August 2014, indicating that action had not been taken as required.

- Most of the electrical and clinical equipment was checked and calibrated to ensure it was safe to use and was in good working order in 2016. However, two fridges which were in use at the practice had not been checked or calibrated.
- The practice had a risk assessment regarding the control of substances hazardous to health; however this did not reflect all of the products being used. The practice were unable to provide a copy of a legionella risk assessment. (Legionella is a term for a particular bacterium which can contaminate water systems in buildings).

There were not sufficient arrangements for planning and monitoring the number and mix of staff needed to meet patients' needs. Substantial and frequent staff shortages and poor management of agency or locum staff increased the risk of harm to people who used the service.

Arrangements to deal with emergencies and major incidents

The practice did not have adequate 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.
- The practice were unable to produce certificates or a training schedule to show that staff received annual basic life support training.
- Emergency medicines were easily accessible to staff in a secure area of the practice and staff knew of their location. Emergency medicines available in the treatment room were checked for expiry date weekly, however, there was no log of medicines so it was not possible to know whether something had been used or were missing. The practice were not able to provide a policy regarding emergency drugs or the process for checking these. All the medicines we checked were in date and stored securely.
- 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.
- The practice had a basic 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

Effective needs assessment

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

- The practice had systems to keep clinical staff up to date. Staff had access to guidelines from NICE and used this information to deliver care and treatment to patients'.
- The clinician spoken with on the day was able to demonstrate that they were aware of and kept up to date with NICE guidelines. The practice IT system incorporated pop-up templates for local and NICE guidelines.

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 96% of the total number of points available compared with the clinical commissioning group (CCG) average of 95% and national average of 95%.

The practice's overall exception rate was 6% which was comparable to the CCG average of 5% and the same as 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).

This practice was not an outlier for any QOF (or other national) clinical targets. Data from 2015/16 showed:

- The percentage of patients with diabetes, on the register, whose last measured total cholesterol (measured within the preceding 12 months), was 5 mmol/l or less was 74% which was comparable to the CCG average of 79% and comparable to the national average of 80%.
- The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) was 140/80 mmHg or less was 89% compared to 78% at CCG and national average.

Performance for mental health related indicators were lower than and comparable to the national average. For example:

- The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who had a comprehensive, agreed care plan documented in their record, in the preceding 12 months was 68% compared to 93% at CCG level and 89% at national average.
- The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses whose alcohol consumption has been recorded in the preceding 12 months was 92% compared to 94% at CCG level and 89% at national average.
- The percentage of patients diagnosed with dementia whose care plan has been reviewed in a face-to-face review in the preceding 12 months was 74% compared to 83% at CCG level and 84% at national average.

There was evidence of single cycle clinical audit:

- There had been three single clinical audits commenced in the last two years however the second cycle of these audits had not been completed. There was no documented evidence to show that improvements had been made as a result of these audits.

Effective staffing

There was insufficient evidence to show that staff had the skills and knowledge to deliver effective care and treatment.

- Staff told us that there was an induction pack for all newly appointed staff. The locum induction pack was examined. It detailed the role specification but did not cover such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality. Staff spoken with told us that they were not familiar with the fire or safeguarding procedures and had not been inducted in how to use the system.
- The practice could not demonstrate how they ensured role-specific training and updating for relevant staff.

Inadequate

Are services effective?

(for example, treatment is effective)

- The practice could not demonstrate that staff administering vaccines and taking samples for the cervical screening programme had received specific training which had included an assessment of competence.
- The practice were unable to demonstrate that the learning needs of staff were identified through a system of appraisals, or that staff had access to appropriate training to meet their learning needs and to cover the scope of their work.
- The practice were unable to show that staff received training that included: safeguarding, fire safety awareness, basic life support and information governance. Staff had access to e-learning training modules but there were no records available to show which training had been carried out, when or by which member of staff. The practice was closed half day each month for training.

Coordinating patient care and information sharing

- The practice were not able to demonstrate that the information needed to plan and deliver care and treatment was made available to relevant staff in a timely and accessible way through their patient record and intranet system. For example, we reviewed the practice policy on their management of investigations and hospital results and found the policy was not being adhered to and that 286 documents were waiting to be read and actioned since 15 May 2017. This placed patients at risk of possible harm, as the content of the medical information had not been assessed or appropriately actioned. The practice manager was not aware of the number of documents outstanding and had not tasked their GPs to ensure they were read and that action was taken.
- The practice were not able to provide records to show that administrative staff were trained to identify and prioritised prescriptions or that there was a system to ensure clinicians reviewed and responded to prescriptions. Staff spoken with presented differing versions of the system for repeat prescribing and we found prescriptions marked urgent from 29 May 2017 and 31 May 2017 which had not been actioned.
- We reviewed the care of two patients living with mental health conditions and found that their care had not been reviewed since 2014. One of the patients had been sectioned under the Mental Health Act in 2016 and there was no evidence of any follow up care being provided to the patient. There were no alerts on patient notes for those vulnerable patients with learning disabilities or systems in place to ensure they were invited to annual health reviews. We reviewed patient notes for five of the 33 patients identified as having a learning disability. We found none of the patients had evidence of an annual review being carried out.

The practice were not able to provide minutes of any multi-disciplinary meetings to show how they worked 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. Staff told us that there had been no multi-disciplinary meetings since March 2017. Minutes of previous meetings were requested but these were not provided.

The practice had systems to identify vulnerable patients who were approaching the end of their lives, however, there were no records of meetings with other health care professionals and the practice could not assure us that end of life care was being delivered in a coordinated way

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. Staff spoken with had knowledge of this legislation.
- When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance.
- As there was no minor surgery or implant or removal of long acting contraception the practice relied on implied consent.

Supporting patients to live healthier lives

The practice's uptake for the cervical screening programme was 81%, which was the same as the CCG and the national average. There was a policy to offer telephone or written reminders for patients who did not attend for their cervical screening test. The practice ensured a female sample taker was available however, nursing services at the practice were provided by locum nurses and staff told us that there were not sufficient nurses to check results or follow these up.

Inadequate

Are services effective?

(for example, treatment is effective)

The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening.

- The practice's uptake for females aged between 50-70 years, screened for breast cancer in last 36 months was 69%, which was comparable to the CCG and national average of 73%.
- The practice's uptake for patients aged between 60-69 years, screened for bowel cancer in last 30 months was 54% compared to the CCG average of 57% and the national average of 58%.

Childhood immunisations were carried out in line with the national childhood vaccination programme. Three areas of childhood immunisations were highlighted as negative variations in CQC data as two areas were below the 90% standard for achievement for example, the Immunisation data for 2015-2016 showed the percentage of children aged two with pneumococcal conjugate booster vaccine was 73% and 89% of eligible one year olds had been fully immunised. 92% of the eligible children had received Meningitis C and Influenza vaccinations and 96% of eligible five year old children were immunised against MMR for dose 1 and 89% were immunised for dose 2. Overall the practice scored 8.6 out of 10 and the national average is 9.1.

Patients had access to appropriate health assessments and checks. These included health checks for new patients which staff told us were only available on request 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

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.
- 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.

As part of the inspection process, Care Quality Commission comment cards were provided to the practice for patients to complete. None of these were completed regarding the service experienced.

We spoke with five patients; however this did not include members of the patient participation group (PPG). They told us that they were unable to get through to the practice by the telephone, as the practice had a call waiting system and they were often told they were eighteenth in the queue. They told us that sometimes they had to wait over 20 minutes to get through so now visit the practice in person to make an appointment. Patients told us that when they got an appointment it was often during working hours resulting in them having to take time off work, and that they did not see the same GP which was a concern for patients with long term or complex conditions.

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

- 86% of respondents said the GP was good at listening to them compared with the clinical commissioning group (CCG) average of 87% and the national average of 89%.
- 83% of respondents said the GP gave them enough time compared to the CCG average of 85% and the national average of 87%.
- 90% of respondents said they had confidence and trust in the last GP they saw compared to the CCG average of 92% and the national average of 92%
- 80% of respondents said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 83% and the national average of 85%.

The practice was comparable to or below average for its satisfaction scores on consultations with nurses. For example:

- 84% of respondents said the nurse was good at listening to them compared with the clinical commissioning group (CCG) average of 93% and the national average of 91%.
- 85% of respondents said the nurse gave them enough time compared with the CCG average of 94% and the national average of 92%.
- 91% of respondents said they had confidence and trust in the last nurse they saw compared with the CCG average of 97% and the national average of 97%.
- 85% of respondents said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 92% and national average of 91%.
- 82% of respondents said they found the receptionists at the practice helpful compared with the CCG average of 88% and the national average of 87%.

Care planning and involvement in decisions about care and treatment

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

- 87% of respondents said the last GP they saw was good at explaining tests and treatments compared with the CCG average of 85% and the national average of 86%.
- 81% of respondents said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 80% and the national average of 82%.

Good

Are services caring?

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

- 83% of respondents said the last nurse they saw was good at explaining tests and treatments compared with the CCG average of 91% and the national average of 90%.
- 81% of respondents 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%.

We saw that care plans were personalised.

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

- Staff told us that interpretation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patients this service was available.
- Information leaflets were available in easy read format.
- The Choose and Book service was used with patients as appropriate. (Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital.

Patient and carer support to cope emotionally with care and treatment

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

The practice had identified 46 patients as carers (0.8% of the practice list) however, they did not provide a carers pack or show how people who identified themselves as carers were supported. Staff spoken with were not aware of carers being flagged on the IT system or given support.

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

- The practice did not offer extended hours appointments.
- There were longer appointments available for patients with a learning disability, but these patients were not flagged on the system to alert staff to their needs.
- Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice.
- The practice sent text message reminders of appointments.
- Patients were able to book appointments on-line, by telephone or in person.
- Patients were able to request repeat prescriptions on-line.
- Patients were able to receive travel vaccines available on the NHS.
- The practice provided seasonal flu clinics.
- There were accessible facilities, which included a hearing loop, and interpretation services available.
- The practice had a lift to improve access to the first floor.

Access to the service

The practice was open between 8am and 6.30pm Monday to Friday. In addition to pre-bookable appointments that could be booked up to four weeks in advance, urgent appointments were also available for patients that needed them.

Results from the national GP patient survey (July 2016) showed that patient's satisfaction with how they could access care and treatment were lower than local and national averages.

- 55% of respondents were satisfied with the practice's opening hours compared with the clinical commissioning group (CCG) average of 72% and the national average of 76%.
- 49% of respondents said they could get through easily to the practice by phone compared with the clinical commissioning group (CCG) average of 64% and the national average of 73%.
- 66% of respondents said that the last time they wanted to speak to a GP or nurse they were able to get an appointment which was the same as the CCG average and compared to the national average of 77%.
- 80% of respondents said their last appointment was convenient compared with the CCG average of 91% and the national average of 92%.
- 59% of respondents described their experience of making an appointment as good compared with the CCG average of 66% and the national average of 73%.

The result regarding waiting at the practice to be seen was comparable to the local and national average.

- 60% of respondents said they don't normally have to wait too long to be seen compared with the CCG average of 55% and the national average of 58%.

We asked the practice when the next routine appointment was available for the GP and were told this was on the nearly a three week wait; for the nurse practitioners it was two weeks and for the HCA it was on the over two weeks. Urgent on the day appointments were available.

The practice had a system to assess:

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

The practice told us they recorded all requests for a home visit on the day and shared the record with the GP. The GP would triage each request to assess the patient's clinical need. 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. Non clinical staff told us that they did not immediately alert the GP that a request for a home visit had been received but that a message was placed on the IT system which would be seen by the GP when the messages were checked. This was contrary to the process highlighted as good practice in a recent NHSE patient safety alert.

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.
- There was a designated responsible person who handled all complaints in the practice.
- We saw that information was available to help patients understand the complaints system and there was a complaints leaflet displayed on the practice website.

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

- We looked at 17 verbal and written complaints received in the last 12 months. The complaints related to appointments, prescriptions, clinical care and staffing. We found complaints had been acknowledged and honest responses given. There was no evidence of trend analysis or lessons learnt being shared with staff. We spoke to the staff who told us team meetings were infrequent and they could not recall the sharing of learning from complaints or incidents.

Are services well-led?

Inadequate

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

Our findings

Vision and strategy

The practice did not have a clear vision or guiding values.

- The core clinical team at the practice had resigned from employment and left between December 2016 and March 2017, with a nurse practitioner leaving in June 2017. One health care assistant was employed at the practice with the remainder of the team provided via locum agencies. On the day of the inspection the lead locum GP had started work at the practice for four days each week. The practice were not able to provide evidence of a forward view, clear strategy or a practice development plan although recruitment for a permanent GP was on-going.

Governance arrangements

The practice did not have a clear governance framework to support the delivery of good quality care. Governance arrangements such as structures and procedures were out of date or not available.

- The practice were not able to demonstrate that there was a clear staffing structure and that staff were aware of their own roles and responsibilities. The practice was operating using a changing clinical team of locums.
- Practice specific policies were unclear. For example there were two separate policies regarding chaperones which each stated different information; or they were from a different practice, for example the building risk assessment had a different practice name on it; or were not up to date, for example the safeguarding policy, and were not regularly reviewed.
- A comprehensive understanding of the performance of the practice was maintained with a practice manager from a different practice providing weekly and monthly feedback to the provider regarding QOF targets. The practice were not able to provide minutes of regular practice meetings and there was no evidence of performance meetings being held.
- Three single cycle audits had been conducted, however these had not been completed and the practice could not demonstrate that these had been used to monitor quality and to make improvements to patient outcomes.

There was no effective system for identifying, capturing and managing issues and risks. Significant issues that threatened the delivery of safe and effective care were not always identified or adequately managed. For example;

- Medicine safety alerts had not been actioned since March 2017 as there was not a lead clinician to assign them to.
- The practice were not able to provide documents or a training schedule to show who had received training on safeguarding children and vulnerable adults relevant to their role.
- Staff who acted as chaperones told us they were trained for the role however no evidence was seen and not all staff had received a Disclosure and Barring Service (DBS) check.
- An annual IPC audit had been completed however there were no records to show that action had been taken to address improvements identified as a result.
- There were insufficient processes for handling repeat prescriptions which included the review of high risk medicines.
- Prescription pads were not monitored throughout the practice.
- Appropriate recruitment checks had not been undertaken prior to staff being employed.
- Risk assessments regarding health and safety, fire safety COSHH and legionella had not been carried out or had not been actioned.
- The practice were unable to produce certificates or a training schedule to show that staff received annual basic life support training.
- There was no log of emergency medicines so it was not possible to know whether medicines had been used or were missing.
- The practice were not able to provide documents to show that lessons were learned and shared following significant events and complaints.

Leadership and culture

Management did not have the necessary experience, knowledge, capacity or capability to lead effectively. There was a lack of clarity about authority to make decisions and whether this was at corporate provider or location level. Manager level staff were not supported to provide good quality safe care. A new practice manager had been

Are services well-led?

Inadequate

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

appointed in December 2016 who told us they were being supported by a practice manager from a separate Malling Health location. Staff told us they felt supported by the practice manager.

The practice did not have systems to ensure compliance with the requirements of the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment). There was no evidence of training for staff on communicating with patients about notifiable safety incidents. From the sample of five documented examples we reviewed we found that the practice were not able to demonstrate that they had systems to ensure that when things went wrong with care and treatment affected people were given reasonable support, truthful information and a verbal and written apology. The five significant event analysis forms examined did not refer to whether an explanation or an apology had been offered to patients.

- The practice were not able to provide minutes of any multi-disciplinary meetings to show how they worked 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 a lack of minutes regarding meetings with district nurses and social workers to monitor vulnerable patients and meetings with health visitors to monitor vulnerable families and safeguarding concerns.
- Staff told us that the practice did not hold regular team meetings.
- Minutes of meetings were requested but were not provided other than for two significant event meetings one in 2014 and one in 2015.
- The staff team at the practice were committed to carrying out their role and were observed to be polite and helpful to patients.
- Substantial and frequent staff shortages and poor management of agency or locum staff increased the risk of harm to people who used the service.

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

The practice was not able to demonstrate how it encouraged and facilitated engagement with people who used the service or with the staff team.

The practice had not encouraged feedback from patients and staff.

- The last minutes from a patient participation group (PPG) meeting were published on the practice website in August 2015. There were no documents available to show that the PPG met regularly, carried out patient surveys or submitted proposals for improvements to the practice management team.
- We found seven one star ratings with comments made on NHS Choices since November 2016. The practice had not responded to any of these comments.

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 Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Service users must be protected from abuse and improper treatment **How the regulation was not being met:** There were not systems to ensure processes were established and operated effectively to prevent or mitigate the risk of abuse of patients. This was in breach of regulation 13(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services 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 ensure that sufficient numbers of suitably qualified, competent, skilled and experienced persons were deployed. The registered person was not able to ensure that persons employed by the service provider had received training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform. This was in breach of regulation 18 (1) (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Fit and proper persons employed. **How the regulation was not being met:** The registered person did not ensure that recruitment procedures were established and operated effectively to ensure that persons employed met the requirements of this regulation; the information about candidates set out in Schedule 3 of the regulations had not consistently been confirmed. The registered person did not establish and operate effective systems to check persons employed were registered with the relevant professional body where such registration is required. This was in breach of regulation 19 (2) (4) 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 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 Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Safe care and treatment. The registered person did not ensure there were systems to assess, monitor, manage and mitigate risks to the health and safety of patients who use services. The registered person did not do all that was reasonably practicable to mitigate risk The registered person did not ensure that persons providing care or treatment to service users had the qualifications, competence, skills and experience to do so safely. The registered person did not ensure the proper and safe management of medicines. The registered person did not ensure there were systems for assessing the risk of, and preventing, detecting and controlling the spread of infections, including those that are healthcare associated. This was in breach of regulation 12 (1) (2) (a) (b) (c) (g) (h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good Governance.

This section is primarily information for the provider

Enforcement actions

The registered person was not able to ensure that systems and processes were established and operated effectively to ensure compliance with the requirements in this Part.

The registered person did not do all that was practicable to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activities (including the quality of the experience of the service users in receiving those services).

The registered person did not do all that was practicable to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activities.

This was in breach of regulation 17(1) (2) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.