Dr Saptarshi Saha

Quality Report

Darlaston Health Centre
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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?	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 carried out an announced comprehensive inspection at Dr Saptarshi Saha on 25th May 2016 Overall the practice is rated as inadequate.

We inspected Dr Saha's practice in October 2014. During the inspection we found there were breaches in three regulations. Regulation 17, Good Governance, Regulation 18, Staffing and Regulation 19, Fit and Proper Persons Employed. We rated the practice as requires improvement. Following the inspection the provider sent us an action plan detailing the action taken to ensure compliance with the regulations. We reviewed the action plan as part of the inspection on 25 May 2016.

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. However, documentation did not always demonstrate a thorough investigation and where the practice had closed the learning loop. Patients did not always receive an apology.
- Risks to patients were not always assessed and well managed, for example the practice could not demonstrate an effective system for recording actions following receipt of medicines and healthcare products regulatory (MHRA) alerts.
- Although some audits had been carried out, there was little evidence that audit was used to drive quality improvements to patient outcomes.
- Patients said they were treated with compassion, dignity and respect and they felt involved in their care and decisions about their treatment.
- Patients said they found it easy to make appointments with the GP when they needed one, with urgent appointments available the same day. Requests for home visits were triaged by a GP and mainly passed over to the rapid response team or patients were seen within the practice.

Summary of findings

- The practice had an established system to ensure staff assessed patients' needs and delivered care in line with current evidence based guidance.
- The system to ensure staff had been trained to provide them with the skills, knowledge and experience to deliver effective care and treatment was not thorough enough.
- They had a number of recently updated policies and procedures to govern activity; however they were not fully imbedded.

The areas where the provider must make improvement are:

- Carry out full cycle clinical audits to improve patient outcomes.
- The practice must ensure that internal procedures for responding to nationally recognised guidance for delivering safe care and treatment; including patient safety alerts from the Medicines and Healthcare products Regulatory Agency (MHRA) are followed through to full completion.
- Ensure appropriate risk assessments are in place in the absences of medication not available to respond to medical emergencies.
- Ensure staff receive appropriate training to enable them to carry out their duties effectively.
- Ensure that equipment is suitable for its purpose, properly maintained and used correctly and safely. For example, the practice must ensure that back up systems used to monitor vaccination fridge temperatures are working appropriately.

The areas where the provider should improvement are:

- In the absence of a Patient Participation Group the practice should consider how they collate, discuss and support actions needed to respond to feedback following receipt of views from people who use their service.
- Satisfy themselves that regular checks to the building are carried out and risk assessments relating to the health, safety and welfare of people using the services are completed; with action plans for managing identified risks. For example ensure appropriate fire safety checks are carried out.
- Review the system in place for monitoring the cleaning of the environment to ensure good infection prevent and control.
- Explore how that practice can further identify and support patients who act as carers.
- The practice should send acknowledgement letters to complainants as detailed in their complaints policy. A record of complaints should not be maintained in patient records.
- Report all safety incidents and thoroughly record actions taken ensuring lessons learnt are fully communicated.

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

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

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

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Inadequate

The practice is rated as inadequate for providing safe services.

- There were systems in place for reporting and recording significant events. However following incidents; recording did not demonstrate a thorough investigation or where the practice had closed the learning loop.
- Risks to patients were not always assessed and well managed. For example, there were limited evidence of where actions had been carried out following receipt of safety alerts and the practice did not establish a thorough systems to ensure procedures were followed through.
- The practice had systems and processes in place to keep patients safe and safeguarded from abuse. For example following the inspection the practice provided proof that the safeguarding lead had received training suitable for this role. However due to administration updates safeguarding policies were not available to staff on the day of the inspection.
- Although the practice stored emergency medications the practice had not carried out a risk assessment to mitigate risks for medicines not available within the practice.

Are services effective?

Requires improvement

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

- Our findings at inspection demonstrated that systems were in place to ensure that all clinicians were up to date with both National Institute for Health and Care Excellence (NICE) guidelines and other locally agreed guidelines.
- The systems to enable the practice to assess, monitor and improve the quality and safety of the practice were not robust. For example there was little evidence of where audits drove improvement in patient outcomes.
- Data from the Quality and Outcomes Framework (QOF) showed patient outcomes were comparable to the national average.
- Although there were gaps in training received for some staff members, the practice were able to demonstrate that they were attempting to book specific training for staff.
- There were evidence of appraisals where personal development plans were being discussed.

Summary of findings

- Although the practice worked with other health care professionals to understand and meet patients' needs following hospital discharge there were limited evidence of joint working for palliative care patients.

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 comparable to others for several aspects of care.
- Patients said they were treated with compassion, dignity and respect and they felt involved in decisions about their care and treatment. We saw staff treated patients with kindness, respect, and maintained patient and information confidentiality.
- Private rooms were available for patients who wished to discuss sensitive issues. Information for patients about the services available was easy to understand and accessible.
- The practice was offering support for families who had suffered bereavement, for example the GP offered consultations to discuss support needs and advice on how to access other support services.
- Although the practice identified 60 patients as carers (2% of the practice list), when asked we were told that they were not proactive in offering support or guidance for carers.
- Staff we spoke to told us that a translation service was available and some staff members were multilingual.

Are services responsive to people's needs?

Requires improvement

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

- The practice told us that generally they would not undertake home visits for patients unable to access the practice, for example we were told that non urgent requests were encouraged to attend the practice and urgent requests were passed to the rapid response team (a service that responds to referrals for patients who are not acutely ill but are clinically compromised for example dehydration, fall's or minor head injuries. The team responds within two hours and they set up multi-disciplinary care as appropriate).
- When things went wrong patients did not always received reasonable support and a written apology. Patients were not always told about actions taken to improve processes and prevent reoccurrence.

Summary of findings

- The practice offered a later clinic on Monday evening until 7.30pm for working patients who could not attend during normal opening hours.
- Patients said they found it easy to make an appointment with the GP and felt there was continuity of care, with urgent appointments available the same day.
- The practice had processes for registering patients in vulnerable circumstances however it was not clear that all practice staff were adopting the policy.
- Patients could get information about how to complain in a format they could understand. However the system for managing complaints, investigation, actions taken and sharing learning with the wider team were not thorough enough.

Are services well-led?

Inadequate

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

- There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity however we saw that some policies were not available to staff.
- Arrangements to monitor and improve quality and identify risk were not robust. For example the practice did not establish a programme of continuous audits or an effective system for receiving, sharing and acting on safety alerts.
- The practice had a vision to deliver high quality care and promote good outcomes for patients. Staff we spoke to was clear about the vision and their responsibilities in relation to it.
- The practice held regular general practice meetings however they were no recordings of their clinical meetings.
- Systems for recording notifiable safety incidents and sharing them with staff to ensure appropriate action was taken were not robust.
- The practice sought feedback from patients via their suggestion box, which it acted on. However the practice did not have an active patient participation group (PPG). We saw posters in the reception area encouraging patients to join the PPG, however not all patients we spoke to were aware of this.

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. This is because the concerns identified in relation to how safe, effective, responsive and well-led the practice impacted on all population groups.

- Although the practice offered health checks for patients aged 75 plus, data provided by the practice showed a low uptake. For example 9% received a health check, when asked we were told that there was a low uptake for the follow up appointment therefore they were unable record the health checks as completed.
- Although urgent appointments were available, home visits for patients with enhanced needs were generally passed to the rapid response team. We did not see how non urgent health needs were being met for patients who were housebound. Palliative care patients were seen by the GP.
- Patients identified as frequent attendees at accident and emergency (A&E) departments were invited in to see the GP or practice nurse to review their health needs.
- We saw posters and referral processes in place for those who required support from Age UK and information on dementia support.
- Eighty per-cent of patients diagnosed with dementia had a face to face care review in the past 12 months (01/04/2014 to 31/03/2015) compared to CCG and national average of 84%.

People with long term conditions

Inadequate

The practice is rated as inadequate for the care of people with long-term conditions. This is because the concerns identified in relation to how safe, effective, responsive and well-led the practice impacted on all population groups.

- Nursing staff had lead roles in chronic disease management, for example palliative care and long term conditions. Patients at risk of hospital admission were identified as a priority.
- Performance for diabetes related indicators was above the national average. For example 100%, compared to CCG average of 91% and national average of 89%.
- Longer appointments and home visits were available when needed for palliative care patients.
- Clinical staff conducted structured annual reviews to check patient's health and medicines needs were being met. However

Summary of findings

when asked there was limited evidence of joint working with relevant health and care professionals to deliver a multidisciplinary package of care for patients with the most complex needs.
- The practice did not demonstrate a system for receiving reviewing and acting on hospital correspondence in a timely way, for example blood test results.

Families, children and young people

Inadequate

The practice is rated as inadequate for the care of families, children and young people. This is because the concerns identified in relation to how safe, effective, responsive and well-led the practice impacted on all population groups.

- 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 with a high number of A&E attendances were flagged. Immunisation rates were comparable to national average for all standard childhood immunisations.
- When asked staff was able to tell us how they would ensure children and young people were treated in an age-appropriate way and ensure they were recognised as individuals.
- The percentage of women aged 25-64 whose notes record that a cervical screening test has been performed in the preceding 5 years (01/04/2014 to 31/03/2015) was 86%, compared to CCG average of 81% and national average of 82%.
- Appointments were available outside of school hours and the premises was suitable for children and babies.

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). This is because the concerns identified in relation to how safe, effective, responsive and well-led the practice was impacted on all population groups.

- The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. For example extended services were offered on Monday evenings from 6:30pm to 7:30pm. Patients were able to access appointments with the practice nurse up until 7:20pm.

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- 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. Patients were able to book appointments and request repeat prescriptions online.
- Data provided by the practice showed that 92% of working age patients had their blood pressure recorded in the past 12 months.
- New patient consultations and health checks for 40s to 75 year olds were offered by nurses and health care assistants

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. This is because the concerns identified in relation to how safe, effective, responsive and well-led the practice was impacted on all population groups.

- There were no policies or arrangements to allow people with no fixed address to register or be seen at the practice.
- The practice offered longer appointments for patients with a learning disability. Data provided by the practice showed that 81% had care plans in place, 100% received a medication review and 81% received a face to face review in the last 12 months.
- Although the practice informed some vulnerable patients about how to access various support groups and voluntary organisations, when asked
- Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working and out of hours.

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). This is because the concerns identified in relation to how safe, effective, responsive and well-led the practice was impacted on all population groups.

- 80% of patients diagnosed with dementia had their care reviewed in a face to face meeting in the last 12 months, which is comparable to the national average.

Summary of findings

- 93% of patients with a mental health disorder had a comprehensive, agreed care plan documented in their record in the last 12 months, which was comparable to the national average.
- When asked the practice was unable to evidence how they worked with multi-disciplinary teams in the case management of people experiencing poor mental health.
- The practice carried out advance care planning for patients with dementia. Data provided by the practice showed 88% of patients diagnosed with dementia had care plans in place.
- During our observations we saw posters which sign posted patents experiencing poor mental health to various support groups and voluntary organisations. Data provided by the practice showed that 87% had a care plan in place, 88% received a medication review in the past 12 months.
- The practice had a system in place to follow up patients who had attended accident and emergency where they may have been experiencing poor mental health.

Summary of findings

What people who use the service say

The national GP patient survey results were published on 7 January 2016. The results showed the practice was performing in line with local and national averages for questions around phone access, overall experience and recommendations. However were less favourable towards appointment availability. Four hundred and one survey forms were distributed and 102 were returned. This represented 25% response rate, compared to national average of 38%.

- 74% of patients found it easy to get through to this practice by phone compared to the national average of 73%, and CCG average of 76%.
- 66% of patients were able to get an appointment to see or speak to someone the last time they tried compared to the national average of 76%, and CCG average of 74%.
- 82% of patients described the overall experience of this GP practice as good compared to the national average of 85%, and CCG average of 83%
- 80% of patients said they would recommend this GP practice to someone who has just moved to the local area compared to the national average of 79%, and the CCG average of 76%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received nine comment cards which were positive about the standard of care received. For example patients felt happy with the level of hygiene and the level of service provided. Patients felt that reception staff were very helpful and were able to fulfil their needs.

We spoke with eight patients during the inspection. Patients said they were satisfied with the care they received and thought staff were approachable, committed and caring. For example patients told us that reception staff were always very helpful and pleasant. Patients we spoke to were not confident in how to make a complaint, they felt that they were not asked to comment on their views and were not aware that the practice were seeking to recruit Patient Participation Group (PPG) members. The practice had a low uptake on the friends and families test therefore unable to provide a score.

Areas for improvement

Action the service MUST take to improve

- Carry out full cycle clinical audits to improve patient outcomes.
- The practice must ensure that internal procedures for responding to nationally recognised guidance for delivering safe care and treatment; including patient safety alerts from the Medicines and Healthcare products Regulatory Agency (MHRA) are followed through to full completion.
- Ensure appropriate risk assessments are in place in the absences of medication not available to respond to medical emergencies.
- Ensure staff receive appropriate training to enable them to carry out their duties effectively.
- Ensure that equipment is suitable for its purpose, properly maintained and used correctly and safely. For example, the practice must ensure that back up systems used to monitor vaccination fridge temperatures are working appropriately.

Action the service SHOULD take to improve

- In the absence of a Patient Participation Group the practice should consider how they collate, discuss and support actions needed to respond to feedback following receipt of views from people who use their service.
- Satisfy themselves that regular checks to the building are carried out and risk assessments relating to the health, safety and welfare of people using the services are completed; with action plans for managing identified risks. For example ensure appropriate fire safety checks are carried out.

Summary of findings

- Review the system in place for monitoring the cleaning of the environment to ensure good infection prevent and control.
- The practice should send acknowledgement letters to complainants as detailed in their complaints policy. A record of complaints should not be maintained in patient records.
- Report all safety incidents and thoroughly record actions taken ensuring lessons learnt are fully communicated.

Dr Saptarshi Saha

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector**.** The team included a GP specialist adviser, a practice nurse specialist adviser, a practice manager specialist adviser and an expert by experience.

Background to Dr Saptarshi Saha

Dr Saptarshi Saha Surgery also known as Darlaston Health Centre is located in Walsall, West Midlands situated in a multipurpose modern built NHS building, providing NHS services to the local community. Based on data available from Public Health England, the levels of deprivation (Deprivation covers a broad range of issues and refers to unmet needs caused by a lack of resources of all kinds, not just financial) in the area served by Dr Saptarshi Saha Surgery are below the national average, ranked at two out of 10, with 10 being the least deprived. The practice serves a higher than average patient population aged between zero to 44, and below average of patients aged between 45 and 85 plus.

The patient list is approximately 3,500 of various ages registered and cared for at the practice. Services to patients are provided under a General Medical Services (GMS) contract with the Clinical Commissioning Group (CCG). GMS is a contract between general practices and the CCG for delivering primary care services to local communities.

The surgery has expanded its contracted obligations to provide enhanced services to patients. An enhanced service is above the contractual requirement of the practice and is commissioned to improve the range of services available to patients. These directed enhanced services include, Childhood Vaccination and Immunisation Scheme, Extended Hours Access, Facilitating Timely Diagnosis and Support for People with Dementia, Influenza and Pneumococcal Immunisations, Minor Surgery, Rotavirus and Shingles Immunisation; Unplanned Admissions.

The surgery is registered to deliver regulated activities such as treatment of disease, disorder or injury; maternity and midwifery services; diagnostic and screening procedures.

The surgery is situated on the ground floor of a multipurpose building shared with other health care providers. Parking is available for cyclists and patients who display a disabled blue badge. The surgery has automatic entrance doors and is accessible to patients using a wheelchair.

The practice staffing comprises of one male GP, one practice nurse, one health care assistant, one practice manager, three receptionists and one apprentice receptionist.

The practice is open between 8:30am and 7:30pm on Mondays, 8:30am and 6:30pm on Tuesdays, Wednesdays and Fridays. 8:30am to 12:30pm on Thursdays.

GP consulting hours are from 8:30am to 1:00pm and 4:00pm to 7:30pm on Mondays, 8:30am to 12:30pm and 2:30pm to 6:00pm on Tuesdays, Wednesdays and Fridays; and 8:30am to 12:30pm on Thursdays. Extended consulting hours are offered on Mondays until 7:30pm. The practice has opted out of providing cover to patients in their out of hours period. During this time services are provided by Waldoc.

The practice was previously inspected by CQC on the 3 October 2014 where we rated the practice overall as requires improvement.

Detailed findings

Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The inspection was planned as a follow up to the previous inspection 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 held about the practice and asked other organisations to share what they knew. We carried out an announced visit on 25 May 2016. During our visit we:

- Spoke with a range of staff such as GPs, nurses, health care assistant, receptionists, administrators, managers and spoke with patients who used the service.
- Observed how patients were being cared for.
- Reviewed an anonymised sample of the personal care or treatment records of patients.
- Reviewed comment cards where patients and members of the public shared their views and experiences of the service.

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

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

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

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

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

Inadequate

Are services safe?

Our findings

Safe track record and learning

At the inspection in October 2014 we said that the provider should develop the incident reporting, recording and monitoring process to ensure trends and lessons learnt were captured and shared in order to support learning. There were system in place for reporting and recording significant events. We saw that the practice logged four significant events in the past 12 months however there was limited evidence of learning outcomes to prevent the same thing happening again.

For example:

- Staff told us they would inform the practice manager of any incidents and there were recording forms available on the practice's computer system. The incident forms we viewed had no documentation or recording of investigations or action taken following incidents and limited evidence of shared learning. Although the practice provided evidence of an annual review of incidents the monthly practice meeting minutes we viewed did not demonstrate that significant events were routinely discussed as a standing agenda item. However, when asked staff told us that they received information about the outcomes and learning from incidents via internal memos. We saw a memo regarding the handling of outpatient's medication referral letters however there were limited recording of how the practice had learned from the event. For example, the practice had not recorded the safety concerns which triggered the sending of the memo; and there were limited evidence of where the practice had closed the learning loop. During the last inspection the practice manager recognised the inadequacy on the reporting form and process; however the system were generally unchanged.

Staff were unable to demonstrate that the practice had a thorough system for managing patient safety alerts. We asked for evidence of where the practice had received, reviewed and actioned patient safety alerts. We were told that the GP received National Institute for Health and Care Excellence (NICE) and Medicines and Healthcare products Regulatory Agency (MHRA) alerts via email. We were also told that discussions with the community pharmacist took place weekly and the pharmacist carried out searches following receipt of safety alerts. We saw that the pharmacist identified patients as a result of a safety alert; however there were no recorded evidence of where appropriate actions had been taken.

Overview of safety systems and processes

The practice had systems, processes and practices in place to keep patients safe and safeguarded from abuse, which included:

- Arrangements were in place to safeguard children and vulnerable adults from abuse. These arrangements reflected relevant legislation and local requirements. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. These were not available to staff on the day of the inspection, we were told that this was due to administration updates. During the inspection the provider were unable to demonstrate that staff had completed safeguard training appropriate to their role. However following the inspection the practice provided evidence of completed training. This included evidence of training for the nurse and level 3 training for the safeguard lead. Non-clinical staff demonstrated they understood their responsibilities. The practice nurse also received training on recognising adult domestic violence and the GP attended female genital mutilation (FGM) training. We saw that when safeguarding concerns were raised there were clear documentation of referrals made, communication with Health Visitors and outcomes were documented.
- The chaperoning policy and notices advising patients that chaperones were available in consultation rooms but were not visible in the reception area. Since the last inspection staff acting as chaperones had been trained for the role, when asked staff were able to explain their responsibilities while carrying out chaperoning duties. In the absence of a Disclosure and Barring Service (DBS) check there were no risk assessment completed to ascertain if a DBS were necessary. (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). Following the inspection the practice provided a risk assessment for staff members carrying out chaperoning duties in the absence of a DBS check.
- We observed the premises to be clean and tidy. When asked the practice were unable to provide evidence of

how they ensured standards of cleanliness and hygiene were appropriately maintained. For example the practice provided a copy of an external contractor's general cleaning schedule however cleaning logs had not been completed by the contractors and the practice had not addressed this. We were told that the practice carried out weekly cleaning of their medical equipment, the practice provided records of completed cleaning logs to evidence this. During the last inspection training records did not demonstrate that staff had undertaken infection control training. We were told that training had been planned for two weeks following the initial inspection. The health care assistant (HCA) was the infection control lead. Training records viewed demonstrated that appropriate training had been received to carry out this lead role. We were told that the HCA had attended local infection prevention team updates within the last 12 months to keep up to date with best practice. There were an infection control protocol in place. The practice scored 90 out of a possible 100 following an annual infection control audit carried out by Walsall infection control team. We saw that actions were taken to address any improvements identified as a result.

- We checked vaccination fridges and saw that they were not overstocked, there were good stock rotation; plugs were not accessible and they were clean and tidy. We saw that vaccination fridge temperatures were monitored by data loggers (a battery-operated device or a secure digital card used to continuously record vaccination fridge temperatures, recordings are then downloaded onto a computer). Although on the day of the inspection vaccination fridge temperatures were in recommended range we saw that there were problems with the data logger system. For example we saw times and dates were incorrect and when asked we were not provided with evidence of appropriate actions taken to address the issue.
- The practice were unable to provide inspectors with records to support that all appropriate staff were up to date with the immunisations recommended for staff who are working in general practice, such as Hepatitis B, mumps and rubella (MMR) vaccines. Following the inspection the practice provided evidence of clinical staff immunisations and risk assessments for non-clinical staff had been carried out.
- Although the practice nurse was unavailable during the inspection we were told that the nurse had qualified as an Independent Prescriber, therefore were able to prescribe medicines for specific clinical conditions. We saw evidence of appraisals carried out where the practice nurse received mentorship and support from the GP for this extended role.
- We saw that there were systems in place for the management of prescription stationery and death certificates. Internal processes were in place for handling repeat prescriptions which included the review of high risk medicines. For example; we checked the management of patients on high risk and multiple medication; we saw that medication reviews where being carried out and patients were managed within prescribing guidelines. Patients were coded; alerts were appropriately in place and blood tests were completed when appropriate.
- We saw that the practice used two regular locums. We checked their recruitment files and saw that they had sufficient recruitment checks carried out by an external recruitment agency.
- During the last inspection we noted that the recruitment policy were not sufficient to support the appropriate recruitment of staff. Since the last inspection the provider had recruited an external provider to manage their human resource process. One staff member had been recruited appropriately since our last inspection.

Monitoring risks to patients

Risks to patients were not always assessed and well managed. For example:

- We saw that the general health and safety policy had been reviewed in the last 12 months, we were provided with a completed risk assessment which included evidence of actions taken to review and mitigate risk with the exception of MHRA alert regarding blinds. Following the inspection the practice provided evidence that they had carried out an appropriate risk assessment.
- The practice had up to date fire risk assessments carried out by NHS property services and fire alarms were tested weekly. However when asked we were advised that fire drills have not been carried out for a number of years. The practice did not have a nominated person who took responsibility for fire marshal duties; however

we were told that there were fire marshals located in the shared building. Although not all staff received fire safety training, staff we spoke with were able to explain actions required in the event of a fire.

- Electrical equipment had been checked to ensure they were safe to use and clinical equipment was checked to ensure they were working properly. We saw that the practice had a rolling programme to ensure electrical and medical equipment was tested by professional testing services to ensure they were accurately recording and measuring values.
- The practice had a variety of risk assessments in place to monitor safety of the premises such as control of substances hazardous to health and infection control. At the last inspection the provider was unable to demonstrate that a legionella risk assessment had been completed by the landlord of the property. During this inspection the assessment were still unavailable. However the practice provided evidence where staff had been requesting a copy of the legionella survey and data sheets from the property owners.
- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There were holiday plans in place for all staff members and the practice manager kept a staff rota which were visible in the reception area. We saw that the practice responded accordingly following the departure of a salaried GP, for example we saw that the practice employed two regular locums to cover clinics. We were told that HCA and nurse clinics would be cancelled during annual leave or in the event of staff sickness.

Arrangements to deal with emergencies and major incidents

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

- There was a medical emergency procedure in place and an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency.
- Clinical staff had received basic life support training. In the absence of sufficient training for non-clinical staff the practice were able to evidence that staff were booked onto subsequent training.
- The practice had a defibrillator available on the premises. At the last inspection there had been no risk assessment in the absence of oxygen. At this inspection the practice had oxygen available with adult and children's masks. We saw that the practice stored emergency equipment in an incoherent manner. When asked staff we spoke with told us that the decision to store emergency equipment in different areas of the practice had been based on the advice of experts. A first aid kit and accident book was available.
- Emergency medicines were easily accessible to staff in a secure area of the practice, all staff knew of their location. Since the last inspection a system had been introduces to ensure medication was in date. We saw that the practice had a system in place for checking emergency medicines. However medicines used to treat suspected bacterial meningitis and allergic reactions were not stored within the practice. When asked the GP were unable demonstrate awareness of what medicines were stored and why. For example the practice had injectable chloramphenicol (an antibiotic), however when asked the GP were unaware of this and unable to give a rationale for keeping this medicine. The practice did not carry out a risk assessment to mitigate risks associated with the absence of some emergency medications. Following the inspection the practice provided evidence that they had order all emergency medication.

The practice had a comprehensive business continuity plan in place for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff and contractors.

Requires improvement

Are services effective?

(for example, treatment is effective)

Our findings

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. For example:

- The practice had systems in place to keep all clinical staff up to date. Staff had access to guidelines from NICE and used this information to deliver care and treatment that met patients' needs.
- We saw that care plans followed best practice, for example the GP used electronic templates for chronic disease management which identified long-term conditions, and we saw that reviews were being carried out.
- We saw that prescribing data from Walsall Clinical Commissioning Group (CCG) in the past 12 months showed above average prescribing of hypnotics, anti-depressants and antibiotics, there were no evidence of actions taken to address this.
- We were told that the practice received weekly support from two community pharmacists to ensure prescribing was in line with best practice guidelines for safe prescribing.

There were limited evidence that clinical audits drove quality improvement and we did not see a established clinical audit system in place. For example:

- The practice did not complete a full cycle audit however we were provided with a first cycle audit of patients with diabetes not on statins (medication used to lower blood cholesterol levels). This identified a number of patients which should have been prescribed this medication; we saw that the practice had started to address this. For example patients were called in for a face to face consultation, booked in for a blood test, offered medication and healthy lifestyle advice. The practice had not repeated the audit to assess its impact however we were told that they were planning to carry out a follow up audit.

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 99% of the total number of points available.

This practice was not an outlier for the majority of QOF clinical targets. Data from 2014/15 showed:

- Performance for diabetes related indicators was above the national average. For example 100% compared to CCG average of 91%, and national average of 89%. The practice exception reporting rate for patients diagnosed with diabetes who have been referred to a structured education programme in the preceding 12 months (01/04/2014 to 31/03/2015) was 33% compared to CCG average of 24% and national average of 26%.
- Performance for mental health related indicators was above the national average. For example 93% compared to CCG average of 91% and national average of 88%.
- Females, 50-70 screened for breast cancer within 6 months of invitation was 69%, compared to CCG average of 72% and national average of 73%.
- Females, 50-70 screened for breast cancer in last 36 months was 75%, compared to CCG average of 73% and national average of 72%.

We also saw cancer information, screening posters and leaflets located in the reception area.

Effective staffing

The practice had employed an external human resources (HR) consultant agency to assist with HR related matters and the development of policies and procedures.

- The practice had an induction policy and programme for all newly appointed staff. This covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality.
- At the last inspection the practice were unable to demonstrate that staff had received training relevant to their role for example, infection control, safeguarding and fire training. The provider's action plan stated that all staff had received infection control training and other training gaps would be address by December 2015. Gaps in training remained, for example fire safety and basic life support. The practice were able to demonstrate how they were attempting to book staff

training onto subsequent training. Staff we spoke with told us that they felt their training needs were being identified and they felt supported by management. For example, the health care assistant told us that they had attended training for ear syringing, administration of Vitamin B12 injection and smoking cessation. We were told that the practice nurse were an independent supplementary prescriber therefore took on a greater clinical responsibility, we saw evidence of appraisals where work, performance and training needs were discussed.

- Staff administering vaccines 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 accessing on line resources.
- The learning needs of staff were identified through a system of appraisals and practice meetings. We saw that the practice were attempting to ensure staff had access to appropriate training to meet their learning needs and cover the scope of their work. All staff had received an appraisal within the last 12 months. Staff we spoke with told us that they did not have protected learning time however this had been raised during appraisals and as a result sufficient time would be allocated.

Coordinating patient care and information sharing

The information needed to plan and deliver care and treatment were not always available to relevant staff in a timely and accessible way through the practice's patient record system and their intranet system. For example:

- We were told that correspondence were either received electronically or by paper, the practice used Docman (an electronic document management workflow system used by GPs) for scanned letters. However when asked, the GP were unable to log onto the system, we were told that Docman had recently been installed in May 2016 and staff recently received training however there were teething problems. We asked to see the process for acting on pathology results, we saw that the practice had taken appropriate actions.
- There were evidence of joint work with secondary care to understand and meet the range and complexity of patients' needs following hospital discharge. For example there were systems in place for when patients were discharged from hospital. We were told that the practice nurse contacted patients within 48 hours of discharge. We were told that unplanned admissions were discussed with the practice nurse. Although there were no meeting minutes staff we spoke with told us that discussions were documented in patient notes.
- There were limited evidence of involvement with multi-disciplinary forums, for example we were told that the GP met with Macmillan nurse to discuss palliative care patients, however when asked the practice were unable to provide records of these meetings. During the inspection in October 2014 we also found that these records were not up to date or fully completed.
- 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. Data provided by the practice highlighted that 9% had received a health check. When asked we were told that there were a low uptake of patients who attended follow up appointments therefore the practice were unable record NHS health checks as completed. The low uptake reflected the finding from the inspection in October 2014. We were told that patients were provided with health promotion advice and those who may need extra support were referred to services such as weight management and exercise available through lifestyle UK.

Consent to care and treatment

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

- Some staff we spoke with understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005, however others were unable to clearly explain the process for gaining consent, we were provided with a training matrix which did not include completion of MCA training.
- When providing care and treatment for children and young people, staff we spoke with demonstrated how they carried out assessments of capacity to consent in line with relevant guidance.

Requires improvement

Are services effective?

(for example, treatment is effective)

- Where a patient's mental capacity to consent to care or treatment was unclear we were told that the GP assessed the patient's capacity and, recorded the outcome of the assessment.
- The process for seeking consent was monitored through patient records audits, we saw that there were consent forms in place and used before carrying out minor surgery. The practice were using the Royal College of General Practice (RCGP) approved forms.

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, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation.
- Access to health trainers was available off site and the HCA were trained to deliver smoking cessation advice, we were told that patients were provided with the option of being referred to local QUIT smoking support groups.

The practice's uptake for the cervical screening programme was 86%, which was above the CCG average of 81% and national average of 82%. There was a process in place to offer telephone reminders for patients who did not attend for their cervical screening test. The practice demonstrated how they encouraged uptake of the screening programme by accessing information in different languages and for those with a learning disability and they ensured a female sample taker was available. The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening. Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) was 75%, compared to CCG and national average of 72%. Females, 50-70, screened for breast cancer within 6 months of invitation was 69%, compared to CCG average of 72% and national average of 73%.

Persons, 60-69, screened for bowel cancer in last 30 months (2.5 year coverage, %) was 49%, compared to CCG average of 53% and national average of 58%. Persons, 60-69, screened for bowel cancer within 6 months of invitation was 50%, compared to CCG average of 50% and national average of 55%.

Childhood immunisation rates for the vaccinations given were comparable to CCG averages. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 70% to 100% and five year olds from 97% to 99% compared to CCG average of between 78% to 99% for under two year olds and between 96% and 99% for five year olds.

Good

Are services caring?

Our findings

Kindness, dignity, respect and compassion

We observed 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.
- 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 eight Care Quality Commission comment cards we received were positive about the service experienced and complimentary to staff. Patients said they felt very happy with the service they received and they thought staff were doing their best to fulfil their needs.

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

- 95% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 95% and the national average of 95%.
- 86% of patients said the last GP they spoke to was good at treating them with care and concern compared to the national average of 85%.
- 92% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the national average of 91%.
- 87% of patients said they found the receptionists at the practice helpful compared to the CCG average of 87% and the national average of 87%.

Care planning and involvement in decisions about care and treatment

Patients told us they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them. Patient feedback from the comment cards we received were 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 in line with local and national averages. For example:

- 79% of patients said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 85% and the national average of 86%.
- 83% of patients said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 79% and the national average of 82%.
- 90% of patients said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average of 86% and the national average of 85%.

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

- We saw that the new patient's registration form identified patients who did not have English as their first language. Staff we spoke to told us that translation services were available and some staff members were multilingual.
- Information leaflets were available in easy read format and screens within the reception area had facilities for larger fonts for patients using the electronic signing in system.
- Patients with hearing difficulties and visual impairments were identified; summaries were recorded in patient's records. We were told that the practice accessed linguistic services and utilised internet translation tools. We saw that the practice had a hearing loop in the reception area.

Patient and carer support to cope emotionally with care and treatment

We saw information leaflets and notices available in the patient waiting area which told patients how to access a number of support groups and organisations. For example

Good

Are services caring?

we saw information regarding support for victims of domestic abuse, mental health and debt advice. There were limited information in the reception area available to direct carers to the various avenues of support available to them. The practice's computer system alerted GPs if a patient was a carer, data provided by the practice identified 60 patients as carers (2% of the practice list). Staff we spoke with told us that the practice offered flu vaccinations to carers.

Staff told us that if families had suffered bereavement, the GP contacted them and sent them a sympathy card. We were told that this call was then followed up by a patient consultation at a flexible time and location to meet the family's needs where advice on how to find and access support service were provided.

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

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. For example:

- The practice offered a later clinic on Monday evening until 7.30pm for working patients who could not attend during normal opening hours.
- The practice told us that they had 11 patients with a learning disability. We saw that 81% of patients had a care plan in place, 100% had received a medicines review and 81% received a face to face review within the last 12 months. We were told that longer appointments were available for patients with a learning disability and double appointments for patients who wished to discuss more than one problem.
- The practice had processes for registering patients in vulnerable circumstances however it was not clear that all practice staff were adopting the policy. For example when asked we were told that patients who were homeless were unable to register with the practice. Following the inspection we were provided with the practice procedure for new patient acceptance which included registration of patients in vulnerable circumstances.

Access to the service

The practice was open between 8:30am and 7:30pm on Mondays, 8:30am to 6:30pm on Tuesdays, Wednesdays and Fridays; 8:30am to 12:30pm on Thursdays. Appointments were from 8:30 to 1pm and 4pm to 7:30pm on Mondays, 8:30am to 12:30pm and 2:30pm to 6pm on Tuesdays, Wednesdays and Fridays; 8:30pm to 12:30pm on Thursdays. Extended hours appointments were offered on Mondays from 4pm to 7:30pm. To accommodate patients in employment and school-age children we were told that the nurse offered appointments from 8:30pm and offered later appointments up to 7:20pm. In addition to pre-bookable appointments that could be booked up to three months in advance, urgent appointments were also available for people that needed them.

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

- 78% of patients were satisfied with the practice's opening hours compared to the CCG average of 79% and the national average of 78%.
- 74% of patients said they could get through easily to the practice by phone compared to the CCG average of 76% and the national average of 73%.

The practice had a system in place to assess home visit requests, however when asked the GP told us that the they generally did not complete home visits:

- Home visit requests were triaged by the GP;
- We were told that palliative care patients would be seen at their home.
- With non-urgent requests patients were encouraged to present at the practice.
- Where the GP considered the request to be urgent, these visits were passed to the rapid response team.
- We were told that the practice nurse would visit older patients in their residential home to carry out over 75 checks.
- The provider did not demonstrate how the practice managed house bound patients with non-urgent care needs.

Listening and learning from concerns and complaints

Although the practice had systems in place for handling complaints and concerns the system we reviewed were not thorough enough. We looked at four complaints received in the last 12 months

- The practice complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. There were a designated responsible person who handled all complaints in the practice however we saw that policies were not always being followed.
- We reviewed the practice complaints log and saw that the designated person were not sending acknowledgement letters to the complainant as detailed in the practice complaints policy
- We saw that when receiving and acting on complaints the practice had not established a thorough system for handling and responding to patients. For example patients were not always receiving a written response;

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

we did not see evidence of where patients received reasonable support, a written apology or told about any actions to improve processes to prevent the same thing happening again.

- We were told that verbal complains were being recorded in patient records. In one case we saw that the practice provided feedback to a patient regarding the outcome of a complaint however the practice had no record of the initial complaint on file.
- Although the practice were holding staff meetings to discuss general practice related issues the meetings we reviewed lacked discussions regarding complaints. We saw evidence of one meeting in the past 12 months where the practice discussed an overview of complaints received. Following the inspection the practice provided a copy of a new process for managing complaints, for example we were provided with a complaints acknowledgment, response letter and a complaints checklist.

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 had a vision to deliver high quality care and promote good outcomes for patients however the governance arrangements to support this vision were not well established.

- The practice had a mission statement, staff we spoke to knew and understood the values.
- Staff we spoke with told us the practice visions were to provide high quality care for patients and cater to all their needs. Staff told us they attended meetings where the practice had discussed development of their mission statement.
- The practice had a strategy for the future and supporting business plan which reflected their vision and values.

Governance arrangements

There were limited evidence of an overarching governance framework to supported the delivery of the strategy and good quality care.

- Following the inspection in October 2014 the provider had sent us an action plan detailing actions to be taken to address the areas for improvement. We saw that some areas of the action plan remained incomplete.
- Practice specific policies were implemented and updated. On the day of the inspection we saw that the most recent version of the practice safeguarding policy were not available to staff via the practice shared drive. When asked staff we spoke with told us that the policy had recently been reviewed therefore the updated version had not been uploaded onto the system.
- When asked the practice were unable to provide a programme of continuous clinical and internal audits used to monitor quality and make improvements.
- There were gaps in arrangements for identifying, recording and managing risks, issues and implementing mitigating actions. When asked we were told that the practice had not carried out a risk assessment to mitigate identified risks regarding emergency medication which the practice had decided not to stock.
- We saw that system for managing risks to patients were not thorough enough. We were told that discussions with the community pharmacist took place weekly and searches had been carried out following receipt of safety alerts, however there were no evidence of where the GP had actioned recommendations. For example, we saw that the pharmacist had identified patients on a particular medication; however there were no evidence that an appropriate review of these patients had taken place and the identified medication were still being prescribed.
- We saw evidence of practice meetings being held, we were also told that they held clinical meetings however these meetings were not minuted. We were told that the GP attended meetings with Macmillian nurses to discuss palliative care patients therefore we requested evidence of these meetings however the practice were unable to provide evidence of attendance.
- During the last inspection the management of staff recruitment had not been robust. We reviewed six personnel files to see if improvements had been made. Five of the six files we viewed were of staff employed prior to the inspection in October 2014. Proof of identification were present in only three files. We saw evidence of appropriate checks through the Disclosure and Barring Service (DBS) located in two out of six files. Where DBS checks had not been completed risk assessments were not in place to review and mitigate potential risk. Following the inspection the practice provided risk assessments for staff members in the absence of a DBS check. There were gaps in availability of certificates to confirm qualifications; however registration with the appropriate professional body were located in clinical staff files. We saw that appropriate indemnity insurances were in place for clinical staff. Following the inspection the practice provided copies of safeguarding and infection control training.
- A breach of confidentiality had been reported to the practice and appropriately managed, however information governance were not sufficiently embedded. Although staff we spoke to were able to demonstrate how they were keeping patient information safe and secure; and we saw that consultation rooms were locked when unattended, during the inspection we found a smartcard left in a

Are services well-led?

Inadequate

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

computer. (Smartcards are 'chip and pin' cards which are placed in card readers attached to staffs computers, smartcards allow access to a range of information such as patient care records.

Leadership and culture

The GP were aware of and had some systems in place to ensure compliance with the requirements of the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).This included communicating with patients about notifiable safety incidents. The GP encouraged a culture of openness and honesty. Although the practice had systems in place for when things went wrong with care and treatment the systems were not well embedded or thorough enough. For example:

- Although the practice were providing truthful information to affected people they were not always providing people with information about what to do if they felt the response was unsatisfactory. We saw where a letter of complaint had been received however the practice did not provided a written response. When asked we were told that the practice were recording verbal interactions in patient records.
- Although we saw evidence of a meeting where the practice discussed significant events these meetings were not being held on a regular basis.

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

- Staff told us the practice held team meetings and internal changes were communicated via memo; however clinical meetings were not minuited.
- Staff told us there were an open culture within the practice and they had the opportunity to raise any issues at team meetings and felt confident and supported in doing so.
- Staff said they felt respected, valued and supported, particularly by the GP and management in the practice.

All staff were involved in discussions about how to run and develop the practice, and the management encouraged staff to identify opportunities to improve the service delivered by the practice.

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

The practice actively encourage feedback from patients, the public and staff. For example:

- We saw that the practice had a suggestion box located in the reception area to gather feedback from patients. We were told that patients provided feedback on their experience of not being able to register as a new patient or collect their prescriptions due to not having the correct identification. As a result we were told that the new patient forms now listed identification required and we saw posters in the reception area reminding patients of this.
- During the inspection in October 2014 the provider told us that they had been unsuccessful in recruiting at Patient participation Group (PPG). We saw that there were posters in the reception area encouraging patients to join. At this inspection there were still no PPG group. We saw that posters remained in the reception area which encouraged patients to join. However patients we spoke to on the day of the inspection told us they were not aware that the practice were looking for members to join the PPG. In the absence of an active PPG the practice were unable to provide evidence of how patient feedback had been collated, discussed and actions taken.
- We saw that the practice gathered feedback from staff through staff meetings, appraisals and discussion. Staff we spoke to told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. For example we were told that a new system for ordering medication had been implemented due to staff feedback regarding the number of patients feeling unsettled due to them having to wait for prescriptions to be released.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints **How the regulation was not being met:** The registered person did not assure themselves that staff were following the practice complaints process or current related guidance. For example Complaints were not always acknowledged and there was a lack of evidence of actions taken to prevent similar complaints. The provider had not looked at these over a period of time to identify trends and areas for improvement. This was in breach of regulation 16(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **How the regulation was not being met:** The registered person did not satisfy themselves that staff were operating a robust system for assessing, monitoring and improving the quality and safety of the services provided. For example the clinical audit process to enable the practice to identify where quality and safety were being compromised were not thorough enough. This was in breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **How the regulation was not being met:** The registered person did not ensure compliance with relevant good practice guidance and patient safety alerts. For example the registered person did not establish a system for ensuring actions required following receipt of relevant patient safety alerts, recalls and rapid response reports from the Medicines and Healthcare products Regulatory Agency (MHRA) were followed through to full completion. The registered person did not do all that is reasonably practicable to mitigate risks relating to how the practice responds to medical emergency. For example the practice did not carry out a risk assessments in the absence of some emergency medications. The registered person did not ensure that equipment was suitable for its purpose, properly maintained and used correctly and safely. For example actions had not been taken to ensure that backup systems used to monitor vaccination fridge temperatures were appropriately working. This was in breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
Diagnostic and screening procedures Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **How the regulation was not being met:** The registered person did not ensure that appropriate training were completed to enable staff to carry out duties they were employed to perform. For example, not all staff had received information governance or fire safety training. This was in breach of regulation 18(2) of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.