

The Meadows Surgery

Quality Report

The Meadows Surgery
Canal Way
Ilminster
Somerset
TA19 9FE

Tel: 01460 52284

Website: www.themeadowssurgery.co.uk

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

Ratings

Overall rating for this service

Requires improvement



Are services safe?

Requires improvement



Are services effective?

Good



Are services caring?

Good



Are services responsive to people's needs?

Good



Are services well-led?

Requires improvement



Summary of findings

Contents

Summary of this inspection

Overall summary	2
The five questions we ask and what we found	4
The six population groups and what we found	7
What people who use the service say	11

Detailed findings from this inspection

Our inspection team	12
Background to The Meadows Surgery	12
Why we carried out this inspection	12
How we carried out this inspection	12
Detailed findings	15
Action we have told the provider to take	27

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at The Meadows Surgery on 23 May 2017. Overall the practice is rated as Requires Improvement.

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

- The practice offers dispensing services to those patients on the practice list who live more than one mile (1.6km) from their nearest pharmacy.
- The practice participated in a local quality and outcomes framework, Somerset Practice Quality Scheme (SPQS), rather than the Quality and Outcomes Framework (QOF), to monitor practice performance and outcomes for patients. Quality and Outcomes Framework data for 2015/16 showed patient outcomes were at or above average compared to the national average.
- There was an open and transparent approach to safety and a system in place for reporting and recording significant events. However, arrangements for sharing learning and ensuring action was completed were not fully implemented.
- The practice had systems to minimise risks to patient safety with the exception of those relating to some aspects of safety alerts, medicines management, staff training and record keeping.
- Staff were aware of current evidence based guidance. Staff had been trained to provide them with the skills and knowledge to deliver effective care and treatment. However, we found gaps in the records of training.
- Results from the national GP patient survey showed patients were treated with compassion, dignity and respect and were involved in their care and decisions about their treatment.
- Information about services and how to complain was available. Improvements were made to the quality of care as a result of complaints and concerns. However, the practice should ensure learning is shared with staff.
- Patients we spoke with said they found it easy to make an appointment with a named GP and there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.

Summary of findings

- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.
- The provider was aware of the requirements of the duty of candour. Examples we reviewed showed the practice complied with these requirements.

The areas where the provider must make improvement are:

- Ensure care and treatment is provided in a safe way to patients. In particular, ensure there are effective arrangements in place to assess, monitor, manage and mitigate risks in respect of health and safety. These should include systems for addressing Medicines and Healthcare products Regulatory Agency (MHRA) safety alerts; and reviewing patients' medicines.
- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care. In particular, ensure systems are in place to assess, monitor and improve the quality and safety of the service, including those for up to date record keeping, such as for staff training; and for a rolling programme quality improvement, such as completed cycles of clinical audits.

- Ensure sufficient numbers of suitably qualified, competent, skilled and experienced persons are deployed to meet the fundamental standards of care and treatment. In particular, to ensure that staff receive and have a record of appropriate training relevant to their role including in infection prevention and control; and safeguarding adults and children.

The areas where the provider should make improvement are:

- Review arrangements for assessment of the competency of dispensary staff.
- Risk assess the location of the vaccine storage fridge to ensure appropriate infection prevention and control.
- Review arrangements for security of blank prescription stationery when clinical rooms are not in use.
- Review arrangements for communication and records to ensure learning from complaints and incidents is shared and all actions are completed.
- Review arrangements for management & leadership to ensure all staff have clarity of role, these are embedded in teams and adequate capacity and contingency arrangements for absence are in place.

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?

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

Requires improvement



- From the sample of documented examples we reviewed, we found there was an effective system for reporting and recording significant events; lessons were shared to make sure action was taken to improve safety in the practice. When things went wrong patients were informed as soon as practicable, received reasonable support, truthful information, and a written apology. They were told about any actions to improve processes to prevent the same thing happening again.
- The practice had systems, processes and practices to minimise risks to patient safety, however, we found that some were not implemented effectively. These included systems for addressing Medicines and Healthcare products Regulatory Agency (MHRA) safety alerts; security of prescriptions; and reviewing patient's medicines.
- Staff demonstrated that they understood their responsibilities and had received training on safeguarding children and vulnerable adults relevant to their role. However, we found gaps in the records of staff training including in infection prevention and control; and safeguarding adults and children.
- The practice had adequate arrangements to respond to emergencies and major incidents.

Are services effective?

The practice is rated as good for providing effective services.

Good



- Data from the Quality and Outcomes Framework, where this was recorded, showed patient outcomes were at or above average compared to the national average.
- The practice participated in the Dispensary Services Quality System (DSQS) to monitor, audit and improve dispensary services for patients.
- Staff were aware of current evidence based guidance.
- Clinical audits were carried out, however, none were found to be completed cycles of clinical audits that demonstrated quality improvement.
- Staff had the skills and knowledge to deliver effective care and treatment.
- There was evidence of appraisals and personal development plans for all staff.

Summary of findings

- Staff worked with other health care professionals to understand and meet the range and complexity of patients' needs.
- End of life care was coordinated with other services involved.

Are services caring?

The practice is rated as good for providing caring services.

Good



- Data from the national GP patient survey showed patients rated the practice higher than others for several aspects of care.
- Survey information we reviewed showed that patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.
- Information for patients about the services available was accessible.
- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.

Are services responsive to people's needs?

The practice is rated as good for providing responsive services.

Good



- The practice was able to offer dispensing services to those patients on the practice list who lived more than one mile (1.6km) from their nearest pharmacy.
- The practice understood its population profile and had used this understanding to meet the needs of its population. For example, the practice provided sessions on mindfulness techniques to patients in order to address the long waiting times for access to talking therapies services.
- The practice took account of the needs and preferences of patients with life-limiting conditions, including patients with a condition other than cancer and patients living with dementia.
- Patients we spoke with said they found it easy to make an appointment with a named GP and there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- Information about how to complain was available and evidence from seven examples reviewed showed the practice responded quickly to issues raised. However, learning from complaints was not shared with staff and other stakeholders.

Are services well-led?

The practice is rated as Requires Improvement for being well-led.

Requires improvement



Summary of findings

- The practice had a clear vision and strategy to deliver high quality care and promote good outcomes for patients. Staff were clear about the vision and their responsibilities in relation to it.
- There was a leadership structure and staff felt supported by management. The practice had policies and procedures to govern activity and held regular governance meetings. However, it was not clear that there was sufficient management capacity and contingency arrangements for management absence in place to ensure effective leadership.
- A governance framework supported the delivery of the strategy and good quality care. This included arrangements to monitor and improve quality and identify risk. However, some arrangements had not been implemented effectively including those for clinical audits; and reviews of patients' medicines.
- Staff had received inductions, annual performance reviews and attended staff meetings and training opportunities.
- The provider was aware of the requirements of the duty of candour. In seven examples we reviewed we saw evidence the practice complied with these requirements.
- The partners encouraged a culture of openness and honesty. The practice did not have effective systems to ensure all notifiable safety incidents were shared and action was taken.
- The practice proactively sought feedback from staff and patients and we saw examples where feedback had been acted on. The practice engaged with the patient participation group.
- There was evidence of learning and improvement at all levels and staff training was built into staff rotas. However, we found gaps in the records of staff training.
- GPs who were skilled in specialist areas used their expertise to offer additional services to patients.

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

The provider was rated as requires improvement for safety and well-led. The issues identified as requiring improvement overall affected all patients including this population group. There were, however, examples of good practice.

- Staff were able to recognise the signs of abuse in older patients and knew how to escalate any concerns.
- The practice offered proactive, personalised care to meet the needs of the older patients in its population.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs.
- The practice identified at an early stage older patients who may need palliative care as they were approaching the end of life. It involved older patients in planning and making decisions about their care, including their end of life care.
- The practice followed up on older patients discharged from hospital and ensured that their care plans were updated to reflect any extra needs.
- Where older patients had complex needs, the practice shared summary care records with local care services. We saw examples of reviews of patients with complex care needs.
- Older patients were provided with health promotional advice and support to help them to maintain their health and independence for as long as possible. For example, home visit schemes were in place including those provided by emergency care practitioners to avoid hospital admissions.

Requires improvement



People with long term conditions

The provider was rated as requires improvement for safety and well-led. The issues identified as requiring improvement overall affected all patients including this population group. There were, however, examples of good practice.

- Nursing staff had lead roles in long-term disease management and patients at risk of hospital admission were identified as a priority.
- Performance for diabetes related indicators was similar to the clinical commissioning group (CCG) and national averages.

Requires improvement



Summary of findings

- The practice followed up on patients with long-term conditions discharged from hospital and ensured that their care plans were updated to reflect any additional needs. For example, home visits were provided by a pharmacist to review complex medication changes
- There were emergency processes for patients with long-term conditions who experienced a sudden deterioration in health.
- All these patients had a named GP and there was a system to recall patients for a structured annual review to check their health and medicines needs were being met. However, we found a backlog of medicines reviews for some patients. For those patients with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

The provider was rated as requires improvement for safety and well-led. The issues identified as requiring improvement overall affected all patients including this population group. There were, however, examples of good practice.

- From the sample of documented examples we reviewed we found there were systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances.
- Immunisation rates were relatively high for all standard childhood immunisations.
- Patients told us, on the day of inspection, that children and young people were treated in an age-appropriate way and were recognised as individuals.
- The practice provided support for premature babies and their families following discharge from hospital.
- Appointments were available outside of school hours and the premises were suitable for children and babies.
- The practice worked with midwives, health visitors and school nurses to support this population group. For example, in the provision of ante-natal, post-natal and child health surveillance clinics.
- The practice had emergency processes for acutely ill children and young people and for acute pregnancy complications.

Requires improvement



Summary of findings

Working age people (including those recently retired and students)

The provider was rated as requires improvement for safety and well-led. The issues identified as requiring improvement overall affected all patients including this population group. There were, however, examples of good practice.

- The needs of these populations 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 opening hours and Saturday appointments.
- 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.

Requires improvement



People whose circumstances may make them vulnerable

The provider was rated as requires improvement for safety and well-led. The issues identified as requiring improvement overall affected all patients including this population group. There were, however, examples of good practice.

- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice offered longer appointments for patients with a learning disability.
- The practice regularly worked with other health care professionals in the case management of vulnerable patients.
- The practice had information available for vulnerable patients about how to access various support groups and voluntary organisations.
- Staff interviewed knew how to recognise signs of abuse in children, young people and adults whose circumstances may make them vulnerable. They were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

Requires improvement



People experiencing poor mental health (including people with dementia)

The provider was rated as requires improvement for safety and well-led. The issues identified as requiring improvement overall affected all patients including this population group. There were, however, examples of good practice.

Requires improvement



Summary of findings

- The practice offered a series of group sessions for patients on how to use mindfulness techniques to transform stress; and we saw evidence of positive feedback from participants.
- The practice carried out advance care planning for patients living with dementia.
- 56% of patients diagnosed with dementia who had their care reviewed in a face to face meeting in the last 12 months, which is better than the clinical commissioning group (CCG) average of 44% and worse than the national average of 78% and above the national average of .
- The practice specifically considered the physical health needs of patients with poor mental health and dementia. We saw, for example, the practice had a register of patients with enduring mental health conditions that was used to ensure regular monitoring and review.
- The practice had a system for monitoring repeat prescribing for patients receiving medicines for mental health needs.
- The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those living with dementia.
- Patients at risk of dementia were identified and offered an assessment.
- The practice had information available for patients experiencing poor mental health about how they could access various support groups and voluntary organisations.
- The practice had a system to follow up patients who had attended accident and emergency where they may have been experiencing poor mental health.
- Staff interviewed had a good understanding of how to support patients with mental health needs and dementia.

Summary of findings

What people who use the service say

The national GP patient survey results were published on 7 July 2016 and more recent data was not available as a result of the change in the practice's registration from June 2016. The 2016 results showed the practice was performing in line with local and national averages. 214 survey forms were distributed and 106 were returned. This represented 3% of the practice's patient list.

- 91% of patients described the overall experience of this GP practice as good compared with the clinical commissioning group (CCG) average of 89% and the national average of 85%.
- 89% of patients described their experience of making an appointment as good compared with the CCG average of 79% and the national average of 73%.
- 86% of patients said they would recommend this GP practice to someone who has just moved to the local area compared with the CCG average of 83% and the national average of 78%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received thirty nine comment cards which were positive about the standard of care received, with four cards raising some concerns regarding telephone access and waiting times. For example, patients indicated the GPs and staff were caring, empathetic, supportive and professional; and the premises were considered to be safe and hygienic.

We spoke with a representative of the patient participation group (PPG) during the inspection. The PPG said they were satisfied with the care they received and thought staff were approachable, committed and caring. Recent patient feedback for April 2017 via the practice's friends and families test here indicated 100% of the five responding patients would recommend the practice to others.

The Meadows Surgery

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 second CQC inspector, a pharmacist specialist adviser and a second pharmacist specialist adviser.

Background to The Meadows Surgery

The Meadows Surgery was registered as a partnership until the retirement of one of the two partners in June 2016. Dr Austin then registered as an individual provider and continued to operate the practice. The practice serves 3,600 patients and is located in the small town of Ilminster in a rural part of Somerset, some 12 miles south east of Taunton. The modern, purpose built premises are shared with another practice; and offers dispensing services to those patients on the practice list who lived more than one mile (1.6km) from their nearest pharmacy. There is ample parking on site and the regulated activities are carried out at:

The Meadows Surgery

Canal Way

Ilminster

Somerset

TA19 9FE

The patient age distribution is similar to national and Clinical Commissioning Group (CCG) averages. There are slightly fewer patients aged 5 to 39 than the national average; and slightly more male patients aged 55 to 84 years than the national average.

The practice has 55% (2015/16 data) of patients with a long standing health condition, which is similar to the Clinical Commissioning Group (CCG) average of 56% and national average of 53%.

Other Population Demographics:

The percentage of patients in paid work or full time education:

60% (slightly lower than the national average of 63%)

The area is in the fourth less deprived decile in the national index of deprivation.

Index of Multiple Deprivation 2015 (IMD):

16 (lower than the national average of 22)

Income Deprivation Affecting Children (IDACI):

14% (lower than the national average of 20%)

Income Deprivation Affecting Older People (IDAOPI):

12% (lower than the national average 16%)

Average male and female life expectancy for the area is 82 and 86 years respectively, which are both three years more than the national average.

The practice has one GP who is the Individual Provider, supported one salaried GP; who together are equivalent to 1.3 whole time employees. One is male and one is female.

Between them they provide twelve sessions of GP appointments each week, plus extended hours one evening per week.

Detailed findings

There are three practice nurses, whose working hours are equivalent to 1.8 whole time employees (WTE); including one non-medical prescriber who offers the equivalent of 0.6 WTE per week. A fourth practice nurse offers ad hoc locum support. Two health care assistants are employed by the practice with combined hours of 1.2 WTE; along with four staff employed as dispensers. The GPs, nursing team and dispensers are supported by seven management and administrative staff including a practice manager. The practice is also supported by an emergency care practitioner and a clinical pharmacist.

The practice is open from Monday to Friday each week between 8.30am and 6pm, with telephone access from 8am until 6.30pm. Appointments are available typically from 8.30am until 12.30pm and 3.50pm to 5.50pm. Extended hours appointments, known as 'improved access', are offered on Thursday evening from 6.30pm to 7pm with the practice nurse; and alternate Thursdays between 6.30pm and 8pm with a GP and HCA. The dispensary is open Monday to Friday 8.30am to 6pm, except for closure, along with the practice, every Wednesday from 1pm to 2pm for staff training.

The practice operates a mixed appointments system with some appointments available to pre-book and others available to book on the day.

The practice offers online booking facilities for non-urgent appointments and an online repeat prescription service. Patients need to contact the practice first to arrange for access to these services.

The practice has a General Medical Services (GMS) contract to deliver health care services; the contract includes enhanced services such as childhood vaccination and immunisation scheme, facilitating timely diagnosis and support for patients with dementia and minor surgery services. An influenza and pneumococcal immunisations enhanced service is also provided. These contracts act as the basis for arrangements between the NHS Commissioning Board and providers of general medical services in England.

When the practice is closed patients are directed to the NHS 111 service where patients can be referred to Vocare GP Out of Hours service if further clinical advice is required.

This practice along with a number of practices in Somerset Clinical Commissioning Group (CCG) opted out of national QOF arrangements from 2014/15 onwards, in order to

participate in an alternative, locally developed quality scheme (Somerset Practices Quality Scheme – SPQS). This means that reporting on individual clinical indicators will appear lower than practices who have continued to deliver national QOF. This does not mean that there was any drop in the quality of clinical care, practices were continuing to provide care in accordance with NICE guidelines.

Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations, to share what they knew. We carried out an announced visit on 23 May 2017. During our visit we:

- Spoke with a range of staff (including GPs, pharmacist, emergency care practitioner, practice nurses, health care assistants, dispensers and management and administrative staff) and spoke with patients who used the service.
- Observed how patients were being cared for in the reception area and talked with carers and/or family members
- Reviewed a 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.
- Visited all practice locations
- 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:

Detailed findings

- 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.

Are services safe?

Our findings

Safe track record and learning

There was a system for reporting and recording significant events.

- Staff told us they would inform the practice manager of any incidents and there was a recording form available on the practice's computer system. The incident recording form supported the recording of notifiable incidents under the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).
- From the sample of seven documented examples we reviewed we found that when things went wrong with care and treatment, patients were informed of the incident as soon as reasonably practicable, received reasonable support, truthful information, a written apology and were told about any actions to improve processes to prevent the same thing happening again.
- We reviewed safety records, incident reports, patient safety alerts and minutes of meetings where significant events were discussed. The practice carried out a thorough analysis of the significant events.
- The practice did not have effective systems to ensure awareness of all notifiable safety incidents in order to share information with relevant GPs and staff; and ensure appropriate action was taken. This did not ensure care and treatment was provided in a safe way to patients. A protocol for the dissemination of drug alerts, patient safety notices, guidance and formularies had not been fully implemented. Whilst safety alerts, such as those from the Medicines and Healthcare products Regulatory Agency (MHRA), were forwarded to the dispensary who logged these and appropriate action taken; the process to forward alerts relevant to GPs was not implemented effectively. We spoke to practice who provided, within a week of the inspection, evidence that the protocol had been reviewed and updated; and the process was now being fully implemented.
- The practice was supported by a pharmacist who undertook reviews of patients' medicines. However, we found there was a backlog in completing these reviews with, for example, some patients' last medicines review having been completed in 2015. This did not ensure care and treatment was provided in a safe way to patients.

- We saw evidence that lessons were shared and action was taken to improve safety in the practice. For example, we saw a significant event report had been raised regarding a patient with a diagnosis of diabetes that had not been followed up for many months. We saw that learning had been implemented as a result including regular audits of patients with abnormal blood test results; reviews for pre-diagnosed diabetic patients; and the introduction of the House of Care, a scheme to support patients with long term conditions including diabetes.
- The practice also monitored trends in significant events and evaluated any action taken.

Overview of safety systems and processes

The practice had clearly defined and embedded systems, processes and practices in place to minimise risks to patient safety.

- Arrangements for safeguarding reflected relevant legislation and local requirements. Policies were accessible to all staff, however, the practice should ensure contact details on the intranet match those in the policy document. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. There was a lead member of staff for safeguarding. From the sample of five documented examples we reviewed we found that the GPs attended safeguarding meetings when possible or provided reports where necessary for other agencies.
- Staff interviewed demonstrated they understood their responsibilities regarding safeguarding, however, during the inspection we found records did not confirm that all staff had received training on safeguarding children and vulnerable adults; and to act as a chaperone, where relevant to their role. GPs were trained to child protection or child safeguarding level three and where records were available, nurses to level two. We spoke to the practice who provided, within 48 hours of the inspection, evidence that staff would be undertaking training in safeguarding children and adults.
- A notice in the waiting room advised patients that chaperones were available if required. All staff who acted as chaperones were trained for the role and had received a Disclosure and Barring Service (DBS) check.

Are services safe?

(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 advanced nurse practitioner (ANP) was the infection prevention and control (IPC) clinical lead. However, the role was not included in the ANP job description and there was no evidence of ongoing liaison with the local infection prevention teams to keep up to date with best practice. There were Infection Control Policy; and Hand Hygiene Policy and Audit documents available. However, IPC and hand hygiene audits had not been undertaken and only three staff had a record indicating they had received up to date training. We spoke to the practice who undertook an IPC audit during the inspection and provided a copy of the resulting action plan. After the inspection we received confirmation that action was being taken to address the improvements identified as a result of the IPC audit. We were also provided with a copy of a risk assessment regarding the vaccine storage fridge, that was located in the sluice room, to ensure appropriate infection prevention and control; and records confirming that staff training in IPC was being undertaken.

The arrangements for managing medicines, including emergency medicines and vaccines, in the practice minimised risks to patient safety (including obtaining, prescribing, recording, handling, storing, security and disposal).

- There were processes for handling repeat prescriptions which included the review of high risk medicines. Repeat prescriptions were signed before being dispensed to patients and there was a reliable process to ensure this occurred. The practice carried out regular medicines audits, with the support of the local clinical commissioning group pharmacy teams, to ensure prescribing was in line with best practice guidelines for safe prescribing. The practice also had access to a pharmacist through a local federation scheme which was supporting the review of medicines with patients in the practice.

- Blank prescription forms and pads were securely stored and there were systems to monitor their use. However, whilst clinical rooms were locked when not in use, blank prescription forms were accessible within the rooms, for example to contractors on site. The practice should review arrangements to ensure the security of blank prescription stationery when clinical rooms are not in use.
- One of the nurses had qualified as an Independent Prescriber and could therefore prescribe medicines for clinical conditions within their expertise. They received mentorship and support from the medical staff for this extended role.
- Patient Group Directions (PGDs) had been adopted by the practice to allow nurses to administer medicines in line with legislation. All current PGDs were in place, signed by all relevant staff and authorised for use.
- Arrangements were in place for trained staff to administer vaccines and medicines and patient specific prescriptions or directions from a prescriber were produced appropriately.
- The practice had signed up to the Dispensing Services Quality Scheme (DSQS), which rewards practices for providing high quality services to patients of their dispensary.
- There was a named GP responsible for the dispensary and all members of staff involved in dispensing medicines had received appropriate training, or were fully supervised in apprenticeship roles, and undertook continuing learning and development
- Records showed that all members of staff involved in the dispensing process were appropriately qualified and their competence was checked regularly by the lead GP for the dispensary. However, arrangements for competency assessment should be reviewed to ensure involvement of dispensary staff.
- The practice held stocks of controlled drugs (medicines that require extra checks and special storage because of their potential misuse) and had procedures to manage them safely. There were also arrangements for the destruction of controlled drugs.

We reviewed three personnel files and found appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, evidence

Are services safe?

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

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

- There was a health and safety policy available.
- The practice had an up to date fire risk assessment and carried out regular fire drills. There were designated fire marshals within the practice. There was a fire evacuation plan which identified how staff could support patients with mobility problems to vacate the premises.
- All electrical and clinical equipment was checked and calibrated to ensure it was safe to use and was in good working order.
- The practice had a variety of other risk assessments to monitor safety of the premises such as control of substances hazardous to health and infection control and legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings). For example, we saw a Legionella Risk Assessment had been carried out in May 2016.
- There were arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system to ensure enough staff were on duty to meet the needs of patients.

Arrangements to deal with emergencies and major incidents

The practice had 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.
- All staff received annual basic life support training. Emergency medicines were not stored in the treatment rooms but were available from an adjacent, central location in the practice. The practice, within 48 hours of the inspection, reviewed access arrangements for these medicines and placed adrenaline in each treatment room ready for use if needed, for example, when contraceptive devices are fitted and immunisations are given.
- The practice had a defibrillator available on the premises and oxygen with adult and children's masks. A first aid kit and accident book were available.
- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and stored securely.
- The practice had a comprehensive business continuity plan for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff.

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 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.
- The practice monitored that these guidelines were followed through risk assessments, audits and random sample checks of patient records.

Management, monitoring and improving outcomes for people

Since April 2015 the practice has participated in a local quality and outcomes framework, Somerset Practice Quality Scheme (SPQS) rather than the Quality and Outcomes Framework (QOF). (QOF is a system intended to improve the quality of general practice and reward good practice). The SPQS allows GP practices to innovate new ways of integrated working with other providers and pilot new ways of working together across practice groups, whilst continuing to provide assurance of clinical quality. This means that some QOF data does not accurately reflect all aspects of practice performance. The two SPQS work streams are integration and sustainability; and monitoring provides more qualitative information than quantitative data. The practice used the information collected for the SPQS and QOF performance data for some national screening programmes to monitor outcomes for patients.

Published QOF achievement data for 2015/16 was 77% of the total number of points available compared with the clinical commissioning group (CCG) average of 77% and the national average of 95%.

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

- Performance for diabetes related indicators was similar to the CCG and national averages. For example, 84% of patients with diabetes had a record of a dietary review within the last 12 months, compared with the CCG average of 75% and the national average of 82%.

- Performance for mental health related indicators was better than the CCG and worse than the national average. For example, 56% of patients diagnosed with dementia had their care plan reviewed in the last 12 months, compared with the CCG average of 44% and the national average of 78%.

There was evidence of quality improvement including clinical audit:

- There had been four clinical audits commenced in the last two years, however, none of these were completed audits where the improvements made were implemented and monitored. For example, whilst an audit of minor surgery had been carried out in 2015 and repeated in 2016 the audit reports did not compare outcomes for the two years and made no reference to actions or improvements.
- The practice participated in the Dispensing Services Quality Scheme (DSQS) audit which included a patient satisfaction audit regarding meeting the target for completing repeat medication requests within two days. Findings were used by the practice to improve services.

Information about patients' outcomes was used to make improvements, for example we saw evidence of reviews of patients with complex care needs in order to improve the care and support provided through a multi-disciplinary team approach.

Effective staffing

Evidence reviewed showed that staff had the skills and knowledge to deliver effective care and treatment.

- The practice had an induction programme for all newly appointed staff. This covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality.
- The practice could demonstrate how they ensured role-specific training and updating for relevant staff. For example, staff reviewing patients with long-term conditions had been trained.
- Records showed that all members of staff involved in the dispensing process were appropriately qualified and their competence was checked regularly by the lead GP for the dispensary. The practice had completed a Dispensing Services Quality Scheme (DSQS) audit which included competency assessments of the dispensary staff. However, we were told by the dispensary staff that they were not aware that these had been carried out.

Are services effective?

(for example, treatment is effective)

- Staff administering vaccines and taking samples for the cervical screening programme had received specific training which had included an assessment of competence. Staff who administered vaccines could demonstrate how they stayed up to date with changes to the immunisation programmes, for example by access to on line resources and discussion at practice meetings.
- The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. Staff had access to appropriate training to meet their learning needs and to cover the scope of their work. This included ongoing support, one-to-one meetings, coaching and mentoring, clinical supervision and facilitation and support for revalidating GPs and nurses. All staff had received an appraisal within the last 12 months.
- Staff had access to and made use of e-learning training modules and in-house training. However, the practice could not demonstrate that all staff had received training that included safeguarding, infection control and fire safety awareness. For example, some staff had no record of training in infection prevention and control; and safeguarding adults and children, that was relevant to their role. We spoke to the practice who provided, within 48 hours of the inspection, evidence that staff had undertaken or were completing training in safeguarding children and adults; and fire safety. A training event on infection prevention and control was also planned for staff.

Coordinating patient care and information sharing

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

- This included care and risk assessments, care plans, medical records and investigation and test results.
- From documented examples we reviewed we found that the practice shared relevant information with other services in a timely way, for example when referring patients to other services.

Staff worked together and with other health and social care professionals to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. This included when patients moved between services, including when they were

referred, or after they were discharged from hospital. Information was shared between services, with patients' consent, using a shared care record. Meetings took place with other health care professionals on a monthly basis when care plans were routinely reviewed and updated for patients with complex needs.

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

Consent to care and treatment

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

- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005.
- When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance.
- Where a patient's mental capacity to consent to care or treatment was unclear the GP or practice nurse assessed the patient's capacity and, recorded the outcome of the assessment.
- The process for seeking consent was monitored through patient records audits.

Supporting patients to live healthier lives

The practice identified patients who may be in need of extra support and signposted them to relevant services. For example:

- Patients receiving end of life care, carers, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation.
- A dietician was available on the premises and smoking cessation advice was available from a local support group.

The practice's uptake for the cervical screening programme was 77%, which was comparable with the clinical commissioning group (CCG) average of 75% and the national average of 73%. The practice is not an outlier in terms of breast or bowel cancer screening rates.

Childhood immunisations were carried out in line with the national childhood vaccination programme. Uptake rates

Are services effective?

(for example, treatment is effective)

for the vaccines given were comparable with CCG and national averages. For example, rates for the vaccines given to under two year olds were 90% and for five year olds ranged from 70% to 90%.

There was a policy to offer telephone or written reminders for patients who did not attend for their cervical screening test. The practice demonstrated how they encouraged uptake of the screening programme by using 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. There were failsafe systems to ensure results were received for all samples sent for the cervical screening programme and the practice followed up women who were referred as a result of abnormal results.

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.

Are services caring?

Our findings

Kindness, dignity, respect and compassion

During our inspection we observed that members of staff were courteous and very helpful to patients and treated them with dignity and respect.

- Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- 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.
- Patients could be treated by a clinician of the same sex.

Most of the thirty nine patient Care Quality Commission comment cards we received were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect. Four raised some concerns regarding telephone access and waiting times.

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

Results from the national GP patient survey for 2016 showed patients felt they were treated with compassion, dignity and respect. The practice results for its satisfaction scores on consultations with GPs and nurses were in line with local and national averages. For example:

- 86% of patients said the GP was good at listening to them compared with the clinical commissioning group (CCG) average of 92% and the national average of 89%.
- 91% of patients said the GP gave them enough time compared with the CCG average of 90% and the national average of 87%.
- 95% of patients said they had confidence and trust in the last GP they saw compared with the CCG average of 97% and the national average of 95%.

- 83% of patients said the last GP they spoke to was good at treating them with care and concern compared with the CCG average of 88% and the national average of 85%.
- 84% of patients said the nurse was good at listening to them compared with the clinical commissioning group (CCG) average of 94% and the national average of 91%.
- 94% of patients said the nurse gave them enough time compared with the CCG average of 94% and the national average of 92%.
- 94% of patients said they had confidence and trust in the last nurse they saw compared with the CCG average of 98% and the national average of 97%.
- 86% of patients said the last nurse they spoke to was good at treating them with care and concern compared with the CCG average of 93% and the national average of 91%.
- 91% of patients said they found the receptionists at the practice helpful compared with the CCG average of 90% and the national average of 87%.

Care planning and involvement in decisions about care and treatment

Patients told us they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them. Patient feedback from the comment cards we received was also positive and aligned with these views. We also saw that care plans were personalised.

Children and young people were treated in an age-appropriate way and recognised as individuals.

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

- 84% of patients said the last GP they saw was good at explaining tests and treatments compared with the CCG average of 89% and the national average of 86%.
- 79% of patients said the last GP they saw was good at involving them in decisions about their care compared with the CCG average of 86% to the national average of 82%.

Are services caring?

- 91% of patients said the last nurse they saw was good at explaining tests and treatments compared with the CCG average of 92% and the national average of 90%.
- 80% of patients said the last nurse they saw was good at involving them in decisions about their care compared with the CCG average of 88% and the national average of 85%.

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. Patients were also told about multi-lingual staff who might be able to support them.
- 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. Support for isolated or house-bound patients included signposting to relevant support and volunteer services.

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified ninety two patients as carers (2.6% of the practice list). A member of staff acted as a carers' champion to help ensure that the various services supporting carers were coordinated and effective. For example, the champion worked with others employed in similar roles in other local GP practices and with a local carers support agency to organise events for carers. Written information was available to direct carers to the various avenues of support available to them. Older carers were offered timely and appropriate support. For example, carers were offered health checks and flu vaccinations.

Staff told us that if families had experienced bereavement, their usual GP contacted them or sent them a sympathy card. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

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

- The practice provided sessions on mindfulness techniques to patients in order to address the long waiting times for access to talking therapies services. This was provided by a GP at the practice through evening group sessions and we saw evidence of positive feedback from patients who had attended. For example, sessions helped patients to transform stress through building resilience, using heart rate variability, breathing and coherence.
- The practice offered extended hours each Thursday evening for working patients who could not attend during normal opening hours.
- There were longer appointments available for patients with a learning disability.
- Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice.
- The practice took account of the needs and preferences of patients with life-limiting progressive conditions. There were early and ongoing conversations with these patients about their end of life care as part of their wider treatment and care planning.
- Same day appointments were available for children and those patients with medical problems that require same day consultation.
- The practice sent text message reminders of appointments and test results.
- Patients were able to receive travel vaccines available on the NHS as well as those only available privately/ were referred to other clinics for vaccines available privately.
- There were accessible facilities, which included a hearing loop, and interpretation services available.
- The practice building included a lift providing access to the upper floor.
- Other reasonable adjustments were made and action was taken to remove barriers when patients find it hard to use or access services.

- The practice has considered and implemented the NHS England Accessible Information Standard to ensure that disabled patients receive information in formats that they can understand and receive appropriate support to help them to communicate.
- The lead GP visited older patients in three local residential and care homes each week. This included patients registered at other GP practices who received a report including suggestions to improve patient health, care and welfare.

Access to the service

The practice and pharmacy was open between 8.30am and 6pm Monday to Friday, with closure for staff training between 1pm and 2pm each Wednesday. Telephone access was available from 8am to 6.30pm Monday to Friday. Appointments were typically from 8.30am to 11am every morning and 3.50pm to 6pm daily. Extended hours appointments, known as 'improved access', are offered on Thursday evening from 6.30pm to 7pm; and alternate Thursdays between 6.30pm and 8pm. In addition to pre-bookable appointments that could be booked up to six weeks in advance, urgent appointments were also available for patients that needed them.

Results from the national GP patient survey 2016 showed that patient's satisfaction with how they could access care and treatment was comparable to or better than local and national averages.

- 81% of patients were satisfied with the practice's opening hours compared with the clinical commissioning group (CCG) average of 79% and the national average of 76%.
- 92% of patients said they could get through easily to the practice by phone compared with the CCG average of 79% and the national average of 73%.
- 90% of patients said that the last time they wanted to speak to a GP or nurse they were able to get an appointment compared with the CCG average of 88% and the national average of 85%.
- 95% of patients said their last appointment was convenient compared with the CCG average of 94% and the national average of 92%.
- 89% of patients described their experience of making an appointment as good compared with the CCG average of 79% and the national average of 73%.

Are services responsive to people's needs?

(for example, to feedback?)

- 86% of patients said they don't normally have to wait too long to be seen compared with the CCG average of 62% and the national average of 58%.

Patients told us on the day of the inspection that they were able to get appointments when they needed them. We saw that urgent appointments were available on the day of the inspection and routine appointments with a GP or nurse were available within one week.

A home visits service had been established with eight other local federation practices and were provided by three emergency care practitioners employed by the practices. The practice had a system to assess:

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

This was done, for example, by telephoning the patient or carer in advance to gather information to allow for an informed decision to be made on prioritisation according to 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. Clinical and non-clinical staff were aware of their responsibilities when managing requests for home visits.

Listening and learning from concerns and complaints

The practice had a system for handling complaints and concerns.

- Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England.
- 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. For example, there were posters displayed and a summary leaflet was available in the waiting area.

We looked at seven complaints received in the last 12 months and found that they had been handled satisfactorily, in a timely way with openness and transparency. However, there was no record that learning was shared with relevant staff or that any analysis of trends and action taken was carried out as a result to improve the quality of care.

Are services well-led?

Requires improvement 

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

Our findings

Vision and strategy

The practice had a vision to deliver high quality care and promote good outcomes for patients.

- The practice had a mission statement which was displayed in the waiting areas and staff knew and understood the values.
- The practice had a clear strategy and supporting business plans which reflected the vision and values and were regularly monitored.

Governance arrangements

The practice had some governance arrangements to support the delivery of the strategy and good quality care. However, we found that a number of processes that were not fully implemented to ensure the provision of good quality care. For example:

- There was a clear staffing structure and most staff were aware of their own roles and responsibilities. GPs and nurses had lead roles in key areas. However, we found that the roles within the nursing team were not fully embedded, for example, in relation to infection prevention and control.
- Practice specific policies were implemented and were available to all staff. These were updated and reviewed regularly. However, we found the policy on safeguarding children did not contain up to date details, for example, to match key contacts on the practice intranet; and was awaiting approval by the main GP.
- An understanding of the performance of the practice was maintained. Practice meetings were held monthly which provided an opportunity for staff to learn about the performance of the practice. We saw the meetings structure allowed for lessons to be learned and shared following incidents, significant events and complaints. However, evidence from minutes of meetings did not confirm that learning was shared or that actions were completed.
- There were ineffective arrangements in place to assess, monitor, manage and mitigate risks to the health and safety of service users. These included systems for addressing Medicines and Healthcare products Regulatory Agency (MHRA) safety alerts; and reviewing patient's medicines.

- The practice did not have effective systems for recording keeping. For example, to demonstrate that all staff had received and had a record of appropriate training relevant to their role, including up to date training in infection control; and safeguarding adults and children.
- The practice did not have a programme of continuous clinical audits to monitor quality and to make improvements. For example, none of the four clinical audits that had been carried out were full cycle audits and did not demonstrate improved outcomes for patients.

Leadership and culture

Leadership is provided by the practice management team comprising the lead GP, who is registered as an individual provider, and a part time practice manager. There is no deputy practice manager although some cover for absence is provided by a medical secretary. On the day of inspection the management demonstrated they had the experience and capability to run the practice and provide good quality care. Staff told us the management were approachable and took the time to listen to all members of staff. However, the lead GP had limited capacity to ensure sufficient time was available to reflect upon and provide the leadership and governance role. For example, the lead GP worked nine out of ten potential sessions during normal surgery hours, plus one evening session, each week. This presents a risk in the ability of the practice to provide sufficient and sustainable capacity for effective leadership and governance.

The provider was aware of and had 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). This included support training for all staff on communicating with patients about notifiable safety incidents. The management encouraged a culture of openness and honesty. From the sample of seven documented examples we reviewed we found that the practice had systems to ensure that when things went wrong with care and treatment:

- The practice gave affected people reasonable support, truthful information and a verbal and written apology.
- The practice kept written records of verbal interactions as well as written correspondence.

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

Are services well-led?

Requires improvement 

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

- The practice held and minuted a range of multi-disciplinary meetings including meetings with district nurses and social workers to monitor vulnerable patients. GPs, where required, met with health visitors to monitor vulnerable families and safeguarding concerns.
- Staff told us the practice held regular team or whole practice meetings every month. Minutes were comprehensive and were available for practice staff to view.
- Staff told us there was an open culture within the practice and they had the opportunity to raise any issues at team meetings.
- Staff said they felt respected supported by the management in the practice. All staff were involved in discussions about how to run and develop the practice, and the management encouraged all members of staff to identify opportunities to improve the service delivered by the practice.
- the NHS Friends and Family test, complaints and compliments received. We saw examples of letters of thanks and compliments from patients.
- staff through staff meetings, appraisals and general discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged to improve how the practice was run.

Continuous improvement

There was a focus on continuous learning and improvement at all levels within the practice. The practice team was forward thinking and part of local pilot schemes to improve outcomes for patients in the area. The practice had established and delivered innovative group sessions on mindfulness techniques to patients in order to address the long waiting times for access to talking therapies services.

The practice participated in the Somerset Practice Quality Scheme (SPQS), including federation working with other local practices. For example, services for patients included those focusing on frailty; management of long term conditions, including the use of the House of Care scheme; and home visit services by emergency care practitioners and pharmacists. We saw evidence that the home visit services were reducing emergency admissions and optimising medication use for patients. The dispensary participated in the Dispensary Services Quality System (DSQS) to monitor, audit and improve dispensary services for patients.

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

The practice encouraged and valued feedback from patients and staff. It proactively sought feedback from:

- patients through the patient participation group (PPG) and through surveys and complaints received. The PPG met regularly, carried out patient surveys and submitted proposals for improvements to the practice management team. For example, the PPG had worked with the practice management to improve patient access and promote triage arrangements. The PPG also meet as friends of the surgery and have raised funds to purchase equipment including a defibrillator, ECG monitor and play equipment for the waiting area.

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	<p>Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment</p> <p>How the regulation was not being met:</p> <p>There was no proper and safe management of medicines. In particular:</p> <ul style="list-style-type: none">• suitable systems were not in place for addressing MHRA safety alerts and recalls; and reviewing patient's medicines. <p>This was in breach of regulation 12(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.</p>
Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	<p>Regulation 17 HSCA (RA) Regulations 2014 Good governance</p> <p>How the regulation was not being met:</p> <p>The registered person had systems or processes in place that operated ineffectively in that they failed to enable the registered person to maintain securely such records as necessary to be kept in relation to persons employed in the carrying on of the regulated activities. In particular:</p> <ul style="list-style-type: none">• there was ineffective record keeping in relation to staff training. <p>The registered person had systems or processes in place that were operating ineffectively in that they failed to enable the registered person to assess, monitor and improve the quality and safety of the services provided. In particular:</p> <ul style="list-style-type: none">• there were ineffective arrangements for quality improvement, such as clinical audits and re-audits.

This section is primarily information for the provider

Requirement notices

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

Regulated activity

Diagnostic and screening procedures
Family planning services
Maternity and midwifery services
Surgical procedures
Treatment of disease, disorder or injury

Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing

How the regulation was not being met:

The service provider had failed to ensure that persons employed in the provision of regulated activities received such appropriate support, training, professional development, supervision and appraisal as was necessary to enable them to carry out the duties they were employed to perform. In particular:

- not all persons employed received appropriate training, relevant to their role, including in infection prevention and control; and safeguarding adults and children.

This was in breach of regulation 18(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.