Meanwhile Garden Medical Centre

Quality Report

Meanwhile Garden Medical Centre, Unit 5, 1-31
Elkstone road, London,
W10 5NT
Tel: 0208 960 5620

Date of inspection visit: 7 July 2015
Date of publication: 08/10/2015

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

Ratings

Overall rating for this service	Inadequate
Are services safe?	Inadequate
Are services effective?	Inadequate
Are services caring?	Requires improvement
Are services responsive to people's needs?	Inadequate
Are services well-led?	Inadequate

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Meanwhile Garden Medical Centre on 7 July 2015. Overall the practice is rated as inadequate.

Specifically we found the practice inadequate for providing safe, effective, responsive and well-led services and requires improvement for providing caring services. It was also inadequate for providing services for older people, people with long term conditions, families, children and young people and requires improvement for working age people (including those recently retired and students) and people whose circumstances may make them vulnerable, and good for people experiencing poor mental health (including people with dementia).

Our key findings were as follows:

- Patients were at risk of harm because inadequate systems were in place to keep patients safe including those for incident reporting, safeguarding, recruitment, infection control and medicine management.
- Systems were not in place to monitor safety and respond to risk.
- There was insufficient assurance to demonstrate patients received effective care and treatment. The National Institute for Health and Care Excellence (NICE) guidance was not always followed, clinical performance was not monitored and clinical audit not carried out to evaluate and improve outcomes for patients.
- The majority of patients said they were treated with compassion, dignity and respect.
- There was limited engagement with local commissioners to discuss service improvements.
- Patients reported positively in terms of access to appointments.
- The practice did not actively engage with patients and staff to seek feedback.

Summary of findings

- Leadership was fragmented and there was no clear leadership structure in place.

The areas where the provider needs to make improvements are;

Importantly, the provider **must:**

- Introduce robust procedures for reporting, recording, acting on and monitoring significant events, incidents and near misses, ensure learning is shared with all staff and safety alerts received by the practice are acted on where appropriate. Ensure robust systems are in place for safeguarding children and adults.
- Ensure staff receive appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out their duties they are employed to perform including providing clinical care and treatment in line with national guidance and guidelines.
- Ensure recruitment arrangements include all necessary employment checks for all staff and document all recruitment and employment information in staff files.
- Ensure all vaccine fridges are temperature monitored and daily temperature checks recorded.
- Establish effective systems, including monitoring and regular audit of practice, to meet current guidance to ensure infection prevention and control measures are met and the cleanliness and hygiene of the practice is maintained and assured. Introduce a legionella risk assessment and related management schedule.
- Implement a system to monitor health and safety in the practice including risk assessments for fire and the general environment. Provide staff with fire safety training and carry out regular fire drills to test the fire evacuation procedures.
- Provide access to an automated external defibrillator (AED) or carry out a risk assessment to assess the risk of not having access to this equipment.
- Develop a business continuity plan to ensure continuity of services in the event of a major disruption to the service.
- Proactively monitor the Quality and Outcomes Framework (QOF) performance to steer practice activity and carry out clinical audit to drive improvement in patient outcomes.
- Ensure there are formal governance arrangements in place including systems for assessing and monitoring risks and the quality of the service provision. Ensure staff have appropriate policies and guidance to carry out their roles in a safe and effective manner which is reflective of the requirements of the practice. Clarify the leadership structure and ensure there is leadership capacity to deliver all improvements. The service must seek and act on feedback from staff, patients and external agencies on the services provided and evaluate and improve their practice in respect of this information.

In addition the provider **should:**

- Develop a website as an additional means to provide information about the practice to patients.
- Provide more detailed information on the practices' complaints procedure including external organisations patients can contact.
- Schedule in longer appointment slots for more vulnerable patients.
- Repair the light cord in the disabled toilet.
- Ensure patients are sufficiently involved in decisions about their treatment and care.
- Ensure patients are treated with care and concern by all staff.

On the basis of the ratings given to this practice at this inspection, I am placing the provider into special measures. This will be for a period of six months. We will inspect the practice again in six months to consider whether sufficient improvements have been made. If we find that the provider is still providing inadequate care we will take steps to cancel its registration with CQC.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Inadequate

The practice is rated as inadequate for providing safe services and improvements must be made. Staff were not clear about reporting incidents, near misses and concerns. Although the practice carried out investigations when things went wrong, lessons learned were not communicated and so safety was not improved. Patients were at risk of harm because systems and processes were implemented in a way that did not keep them safe. Areas of concern included safeguarding, recruitment, infection control, medicine management, monitoring safety and responding to risk and contingency planning.

Are services effective?

Inadequate

The practice is rated as inadequate for providing effective services and improvements must be made. Data showed that care and treatment was not always delivered in line with recognised professional standards and guidelines. Patient outcomes were hard to identify as little or no reference was made to audits and there was limited evidence that the practice was comparing its performance to others; either locally or nationally. There was minimal engagement with other providers of health and social care. There was limited recognition of the benefit of an appraisal process for staff and little support for any additional training that may be required. Basic care and treatment requirements were not met.

Are services caring?

Requires improvement

The practice is rated as requires improvement for providing caring services, as there are areas where improvements should be made. Data showed that patients rated the practice lower than others for some aspects of care. The majority of patients said they were treated with compassion, dignity and respect. However, not all felt cared for, supported and listened to. Information for patients about the services was available but not everybody would be able to understand or access it.

Are services responsive to people's needs?

Inadequate

The practice is rated as inadequate for providing responsive services and improvements must be made. The practice had not reviewed the needs of its local population. There was limited engagement with the Clinical Commissioning Group (CCG) to discuss service improvements. Patients were generally satisfied with the appointment system although they sometimes had to wait a long time to be seen. Information about how to complain was available for patients but it did not explain the process properly.

Summary of findings

Are services well-led?

Inadequate 

The practice is rated as inadequate for being well-led and improvements must be made. It did not have a clear vision and strategy. Staff we spoke with were not clear about their responsibilities in relation to the vision or strategy. There was no clear leadership structure and staff were not proactively supported by management. The practice had a number of policies and procedures to govern activity, but these had not been reviewed consistently. There was little evidence of practice meetings and issues were discussed informally. The practice had not proactively sought feedback from staff or patients and did not have a patient participation group (PPG). Staff told us they had not received regular performance reviews and did not have clear objectives.

Summary of findings

The six population groups and what we found

We always inspect the quality of care for these six population groups.

Older people

Inadequate

The practice is rated as inadequate for the care of older people.

The practice had a lower than national average number of older patients. The percentage over 75 years was 5.9% and over 85 years was 1.1% (National average 7.6% and 2.2% respectively).

The practice had some initiatives in place to meet the needs of older patients. For example the practice had signed up to the unplanned admissions Enhanced Service (a programme designed to improve the coordination of care for patients with complex needs and avoid unnecessary hospital admissions). The practice had developed care plans for 37 patients over 70 years of age in the previous year for the Enhanced Service.

A GP link worker employed by the practice carried out home visits to older patients and provided blood pressure, weight and medication checks, and helped with their social needs. However there was no evidence of competency or training for the GP link worker and the practice had not completed a criminal check via the Disclosure and Barring Service (DBS) to ensure they were of suitable character to carry out this role.

The practice's Quality and Outcomes Framework (QOF) performance in 2013/14 for palliative care indicators was 50%, which was 38% below the CCG average and 46.7% below the national average.

People with long term conditions

Inadequate

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

The percentage of patients at the practice with a long standing health condition or with health related problems in daily life were 54% and 59.1%. These were similar or higher than the England averages of 54% and 48.8%. However, the practices' QOF performance in the management of long-term conditions had declined over the previous two years. For example, performance for diabetes related indicators in 2013/14 was 68.4%, (18% below the CCG average and 21.7% below the national average) and performance for chronic obstructive pulmonary disease related indicators was 67.7%, (21.7% below the CCG average and 27.5% below the national average). In 2014/15 performance for diabetes indicators had declined to 45%, (a decline of 23.4% on the previous

Summary of findings

year) and performance for chronic obstructive pulmonary disease related indicators was 60%, (a decline of 7.7% on the previous year). Performance for asthma related indicators was 62%, (a decline of 38% on the previous year).

Families, children and young people

Inadequate

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

The practice had a lower number of children aged 0 to four years compared to the national average (4.4% compared to 6%) and a lower number of children aged five to 14 years (9.9% compared to 11.4%). The percentage of children aged under 18 years was lower than the national average (13.2% compared to 14.8%). The practice provided some services for this population group including mother and baby clinics and child health/immunisations. The practice's performance for 2013/14 was mixed for childhood immunisation rates. For example, vaccinations given to under one year olds ranged from 83% to 90% and two year olds from 73% to 96% which were above the CCG averages. Vaccinations for five year olds ranged from 60% to 85% which were either comparable to or below CCG averages.

Working age people (including those recently retired and students)

Requires improvement

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

The percentage of patients in paid work or full time education was 53.7% which was below the national average of 60.2%. The practice did not offer extended hours in the evenings however extended hours were available on Saturday mornings for this population group. Walk-in appointments were available if the patient was registered with the male GP partner. Repeat prescriptions could be requested online and also appointments however there was no website for working age patients to access information about the practice online.

People whose circumstances may make them vulnerable

Requires improvement

The practice is rated as requires improvement for the care of people whose circumstances may make them vulnerable.

The practice had a learning disabilities register and all eight patients on the register had received an annual health check. However the practice did not offer any other additional services for vulnerable people.

Summary of findings

Access to translation services were available for patients if they were needed however this did not include access to British Sign Language (BLS) services for those patients hard of hearing or services for those who were blind.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia).

The practice had 33 patients on the dementia register and all patients had received an annual health check. The practices' performance in 2013/14 for mental health related indicators was similar to the national average. For example; the percentage of patients with poor mental health who have a care plan and the percentage that have been reviewed in the preceding twelve months.

Summary of findings

What people who use the service say

We spoke with five patients who used the service. We reviewed 37 completed comment cards where patients and members of the public shared their views and experiences of the service. We reviewed the national GP patient survey 2015 where 85 patients out of 449 responded to the survey (19% completion rate). Evidence from all these sources showed patients were satisfied with how they were treated by the practice and that was with compassion, dignity and respect. Patients were also satisfied with access to appointments however they did say the wait after their appointment time to be seen by the GP was often longer than 15 minutes. Patient feedback was less positive in terms of care planning and involvement in decisions about care and treatment and support to cope emotionally with care and treatment, where the practice scored below the Clinical Commissioning Group (CCG)/national averages in the national patient survey.

Areas for improvement

Action the service MUST take to improve

- Introduce robust procedures for reporting, recording, acting on and monitoring significant events, incidents and near misses, ensure learning is shared with all staff and safety alerts received by the practice are acted on where appropriate. Ensure robust systems are in place for safeguarding children and adults.
- Ensure staff receive appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out their duties they are employed to perform including providing clinical care and treatment in line with national guidance and guidelines.
- Ensure recruitment arrangements include all necessary employment checks for all staff and document all recruitment and employment information in staff files.
- Ensure all vaccine fridges are temperature monitored and daily temperature checks recorded.
- Establish effective systems, including monitoring and regular audit of practice, to meet current guidance to ensure infection prevention and control measures are met and the cleanliness and hygiene of the practice is maintained and assured. Introduce a legionella risk assessment and related management schedule.
- Implement a system to monitor health and safety in the practice including risk assessments for fire and the general environment. Provide staff with fire safety training and carry out regular fire drills to test the fire evacuation procedures.
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- Develop a business continuity plan to ensure continuity of services in the event of a major disruption to the service.
- Proactively monitor the Quality and Outcomes Framework (QOF) performance to steer practice activity and carry out clinical audit to drive improvement in patient outcomes.
- Ensure there are formal governance arrangements in place including systems for assessing and monitoring risks and the quality of the service provision. Ensure staff have appropriate policies and guidance to carry out their roles in a safe and effective manner which is reflective of the requirements of the practice. Clarify the leadership structure and ensure there is leadership capacity to deliver all improvements. The service must seek and act on feedback from staff, patients and external agencies on the services provided and evaluate and improve their practice in respect of this information.

Action the service SHOULD take to improve

- Develop a website as an additional means to provide information about the practice to patients.
- Provide more detailed information on the practices' complaints procedure including external organisations patients can contact.
- Schedule in longer appointment slots for more vulnerable patients.
- Repair the light cord in the disabled toilet.

Summary of findings

- Ensure patients are sufficiently involved in decisions about their care and treatment.
- Ensure patients are treated with care and concern by all staff.

Meanwhile Garden Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector and the team included a second CQC inspector, a GP Specialist Advisor and a Practice Manager Specialist Advisor who were granted the same authority to enter registered persons' premises as the CQC inspectors.

Background to Meanwhile Garden Medical Centre

Meanwhile Garden Medical Centre is situated at Unit 5, 1-31 Elkstone Road, London, W10 5NT. The practice provides primary medical services through a General Medical Services (GMS) contract to approximately 2893 patients in West London (GMS is one of the three contracting routes that have been made available to enable commissioning of primary medical services). The practice is part of the NHS West London Clinical Commissioning Group (CCG) which comprises 51 GP practices. The ethnicity of the practice population is mainly white with a higher than national average number of patients between 20 and 60 years of age. Life expectancy is 81 years for males and 85 years for females which is above the national average. The local area is the second most deprived in the West London CCG (people living in more deprived areas tend to have greater need for health services).

The practice team consists of a male GP partner (1 WTE), a female GP partner (1 WTE) a practice manager (0.75 WTE), a practice nurse (0.75 WTE), a GP link worker (0.5 WTE), two reception/administration staff (0.75 and 0.8 WTE) and a locum practice manager (the practice manager is recently in post and is temporarily supported by the locum who is the former practice manager).

The GP partners work autonomously and have their own patient lists. The practice has two separate reception windows and waiting areas.

The practice offers a number of clinics/services including mother and baby clinics, child health and immunisations, joint injections, smoking cessation and substance misuse clinics.

The service is registered with the Care Quality Commission to provide the regulated activities of diagnostic and screening procedures, treatment of disease, disorder and injury, surgical procedures, family planning and maternity and midwifery services.

The practice opening hours are Monday to Friday 8:00 to 18:30 apart from Thursday where the practice closes at 13:00. The practice also opens from 9:00 to 12:00 on Saturdays. The practice closes for lunch between 13:00 and 14:00. The practice has opted out of providing out-of-hours services to their own patients and directs patients to the NHS 111 service and a local NHS Walk-in Centre.

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. This inspection was

planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, and to look at the overall quality of the service.

How we carried out this inspection

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 are provided for specific groups of people and what good care looks 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)

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 7 July 2015. During our visit we spoke with a range of staff including two GPs, the practice nurse, a practice manager, two reception staff and spoke with five patients who used the service. We reviewed 37 completed comment cards where patients and members of the public shared their views and experiences of the service.

Inadequate

Are services safe?

Our findings

Safe track record

The practice did not prioritise safety and utilise information from reported incidents, national patient safety alerts and complaints from patients to identify risks and improve patient safety. There was no clear system or processes in place for the reporting of significant events, incidents and near misses and the practice's significant events procedures had not been reviewed since 2011. Staff were aware of their responsibilities to raise concerns but were not always clear on what constituted an incident in their practice.

Practice meetings were not held to review and monitor risks. There were no meeting minutes available to evidence that significant events, incidents, patient safety alerts and complaints were discussed amongst practice staff to demonstrate a safe track record and the locum practice manager told us practice meetings had not occurred for a number of years.

The practice made available to us significant event records from 2009 to 2012, however records from 2012 to present were minimal. We were told that the reason for the lack of records was that very few incidents had occurred during this time period. The practice was only able to show us two significant events which had been recorded and investigated for GP appraisal purposes. The female GP partner and nurse told us that often concerns were recorded in patient records. We found the practice's safety track record was inconsistent and there was no clear system in place for staff to follow.

Learning and improvement from safety incidents

The practice did not have a clear process in place for reporting, recording and monitoring significant events (SEAs) and incidents, and where SEAs had been reported, action taken to prevent recurrence had not been completed or was not immediate. Two of the SEAs we reviewed were situations of high medical risk. For example, one SEA we reviewed was a prescribing error where a patient continued to be prescribed warfarin after they had finished attending anti-coagulation clinics. The practice took action to stop the warfarin medication, the patient was informed and aspirin prescribed. It was recorded on the significant event form that an audit of patients on warfarin was to be conducted to ensure they were attending anti-coagulation clinics. However, there was nothing recorded to show the audit had been carried out or the results used to improve patient safety. A second SEA we reviewed was where a locum GP failed to arrange a follow-up appointment for a patient with serious illness in the absence of their regular GP. The significant event form stated that the GP referred the patient immediately on return from leave. However, we found actions to prevent recurrence were not implemented until a significant event review six months later where it was stated that locum GPs had been instructed to action urgent results immediately.

Significant events were not a standing item on the practice meeting agenda and dedicated meetings were not held to review actions from past significant events and complaints. There was some evidence of shared learning from significant event reviews, however the learning was not shared widely with all practice staff.

National patient safety alerts were received by practice staff electronically. Staff we spoke with were able to give examples of recent alerts that had been received. For example we were given an example of an alert from the Medicines and Healthcare products Regulatory Agency (MHRA) alerting the practice to the risk of cardiovascular disease with high dose Ibuprofen. However, although staff received safety alerts, there was no system in place to ensure they were acted on and therefore important safety alerts could be potentially missed.

Reliable safety systems and processes including safeguarding

The practice had some systems to manage and review risks to vulnerable children, young people and adults however they were not robust. We looked at training records which showed that the clinical staff had received child protection training to Level 3. However we found no evidence of child protection training for reception staff which is recommended to Level 1. There was also no evidence of safeguarding vulnerable adults training for any staff. We asked a cross-section of staff about their safeguarding knowledge. Staff had a basic understanding of different types of abuse and how to recognise the signs of abuse in older people, vulnerable adults and children. They were also aware of how to contact the relevant agencies in working hours and out of normal hours. Contact details for both the child protection team and safeguarding adults

team were easily accessible. The practice did not have policies for safeguarding however they used the Pan-London Multiagency guidelines and had a safeguarding protocol.

Staff we spoke with were not always clear on who the safeguarding leads were and who to speak with in the practice if they had a safeguarding concern. For example, the male GP partner told us the practice manager was the safeguarding lead whereas other staff told us it was the female GP partner.

There was evidence of some engagement in local safeguarding procedures and working with other relevant organisations including health visitors and the local authority however examples were limited. For example, we saw evidence of a safeguarding adults strategy meeting to discuss an older patient found neglected in their home. The meeting was attended by the GP link worker employed by the practice, local authority safeguarding team, social worker and family of the patient. However, the meeting had not been attended by either GP partner.

There was a chaperone policy, however there were no notices displayed offering patients the option of having a chaperone during consultations/intimate examinations (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). The practice nurse told us that she usually provided chaperoning duties and reception staff would carry out the role if the nurse was not available. Staff were able describe the basic role of a chaperone, however staff told us they had not received any formal training to carry out this role. The practice could not provide evidence of criminal record checks via the Disclosure and Barring Service (DBS) for the nurse or reception staff acting as a chaperone (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 locum practice manager assured us a criminal record check had been completed for the nurse and he would send us the DBS certificate the day after our inspection, however we did not receive it. He also confirmed that it was not practice policy to carry out criminal record checks on reception staff despite them carrying out chaperoning duties on occasion when the nurse was not available and there were no risk assessments in place.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found most were stored securely and were only accessible to authorised staff. Records showed fridge temperature checks were carried out which ensured medication was stored at the appropriate temperature. The practice nurse was responsible for the monitoring of medicines and was able to describe the action to take in the event of a potential failure. Although all the vaccines were stored appropriately in fridges in the nurse's room we found an overspill fridge in a separate consultation room containing flu vaccines. We found that the fridge did not have a temperature monitor and the nurse was unsure if they were stored within the correct temperature range. The nurse made immediate arrangements to dispose of the vaccines and we advised the practice to contact Public Health England who recommended the fridge be disposed of and replaced with a new one.

Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations. The nurses used Patient Group Directions (PGDs) to administer vaccines and other medicines that had been produced in line with legal requirements and national guidance and we saw examples of these which were in date.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Both blank prescription forms for use in printers and those for hand written prescriptions were handled in accordance with national guidance and kept securely at all times.

Cleanliness and infection control

We observed the premises to be clean and tidy. The practice used a professional cleaning company to clean the practice and the practice manager told us a substantial clean had taken place prior to our inspection. Although the practice appeared clean the practice was not able to provide evidence of written protocols, procedures or checklists that the cleaners followed and therefore could not provide assurances that adequate standards were maintained. Most patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control although one patient

commented that the toilets were often unhygienic. We also found that the privacy curtains in the consultation rooms were not disposable and there were no records to show that they were regularly cleaned. The locum practice manager told us that disposable curtains had been ordered which arrived on the day of our inspection.

The practice had an infection control policy that set out the standards to follow. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these to comply with the practice's infection control policy. There was also a protocol for needle stick injury and staff knew the procedure to follow in the event of an injury. Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms.

The practice nurse was the lead for infection control and told us she had received infection control training. However there were no records to confirm this, or that other staff had received infection control training appropriate to their role. Staff we interviewed confirmed they had not received any infection control training. We also found that no infection control audits had been completed since 2011 to assess and monitor infection control standards and therefore the practice could not provide assurances that adequate standards were maintained.

The practice did not have a policy for the management, testing and investigation of legionella (a bacterium which can contaminate water systems in buildings), the practice was not carrying out regular checks to reduce the risk of infection to staff and patients and no legionella risk assessment was in place. The locum practice manager confirmed the risks associated with legionella bacteria had not been assessed.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date which was within the last year. We saw evidence of calibration of relevant equipment; for example weighing scales, spirometers, blood pressure measuring devices and the fridge thermometer.

Staffing and recruitment

The practice had a recruitment policy in place that set out the necessary recruitment checks the practice would undertake on staff prior to employment however it was not followed by the practice.

The practice was unable to provide evidence of criminal record checks through the Disclosure and Barring Service (DBS) for the practice nurse, two regular locum GPs and a GP link worker. The locum practice manager assured us that criminal record checks had been completed for these staff and told us he would send us evidence the day after our inspection. However we only received evidence of a DBS check for one locum GP. We also found no evidence of written references for any staff working at the practice.

Staff told us about the arrangements for planning and monitoring the number and mix of staff needed to meet patients' needs. Locum GPs covered the regular GPs annual leave and there was suitable cover for the practice nurse. Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe.

Monitoring safety and responding to risk

There were some systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice including medicine management and dealing with emergencies and equipment. The practice also had a health and safety policy however there was no evidence of health and safety risk assessments including fire, legionella, general health and safety and no risk register or log to monitor risks. The locum practice manager confirmed that no health and safety risk assessments had been carried out.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all staff had received update training in basic life support in the current year. Emergency equipment was available including access to oxygen, resuscitation masks and a first aid kit. All staff knew the location of this equipment and records confirmed that

Inadequate

Are services safe?

it was checked regularly. The practice did not have an automated external defibrillator (used in cardiac emergencies) and had not undertaken an assessment of the risks of not having this equipment.

Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis, epilepsy and hypoglycaemia. Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

There was no business continuity plan in place to deal with a range of emergencies that may impact on the daily operation of the practice and no buddy arrangements with other local practices. The practice had not carried out a fire risk assessment to identify, assess and mitigate risks associated with fire. Staff had not received fire safety training and regular fire drills were not practised to rehearse fire evacuation procedures.

Inadequate

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. However from discussions with the GPs we found these were not always followed when prescribing statins (statins are medicines prescribed to lower cholesterol). For example, NICE guidance recommends simvastatin as first line therapy for elevated cholesterol. The guidance recommends that patients on simvastatin experiencing muscle pain have their levels of Creatine Kinase (CK) measured and switched to alternative medication if elevated (increased levels of the CK enzyme correlate with muscle damage). However, the female GP partner told us they measured CK levels prior to prescribing a statin and put patients on an alternative to simvastatin if CK levels indicated it which was not in accordance with NICE guidelines.

We discussed with the GPs and nurse how NICE guidance was received into the practice. They told us that they were informed of updates via email. However, there was no evidence to show new guidance was discussed amongst the clinicians as no clinical meetings were held and staff were unable to provide examples of where clinical updates had been discussed, implications for the practice's performance and patients identified, and change implemented.

We saw the agenda of a recent network learning forum meeting which GPs from local practices attended to participate in educational sessions to improve clinical knowledge. However it was not clear if the GP partners had attended these meetings.

Management, monitoring and improving outcomes for people

The practice was unable to show evidence that clinical audits had been undertaken to evaluate and improve outcomes for patients. We saw examples of data collection which included data on referrals to secondary care musculoskeletal services. The data was collected and submitted to the clinical commissioning group (CCG) along with similar referral data from other practices, where it was collated and the results presented and discussed at locality meetings. However, we did not see evidence of clinical audits where results were discussed, evaluated and change instituted within the practice. There was no evidence of clinical audits linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). (QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). There was no evidence that clinical audit was used to drive improvements in the quality of patient care.

The practice did not use the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. This practice was an outlier for a number of QOF clinical targets; It achieved 72.8% of the total QOF target in 2013/14, which was below the CCG average of 89% and the national average of 93.5%. Specific examples to demonstrate this included:

- Performance for diabetes related indicators was 68.4%, which was 18% below the CCG average and 21.7% below the national average.
- Performance for palliative care indicators was 50%, which was 38% below the CCG average and 46.7% below the national average.
- Performance for chronic obstructive pulmonary disease related indicators was 67.7%, which was 21.7% below the CCG average and 27.5% below the national average.
- Performance for the primary prevention of cardiovascular disease related indicators was 30.7%, which was 45.1% below the CCG average and 57.3% below the national average.

The practice achieved 63.7% of the total QOF target in 2014/15, a decline of 9.1% on the previous year. Comparators to the CCG/national average were not available however performance in a number of clinical indicators were significantly lower than the previous year. Specific examples to demonstrate this included:

- Performance for diabetes related indicators was 45%, a decline of 23.4% on the previous year.
- Performance for asthma related indicators was 62%, a decline of 38% on the previous year.
- Performance for chronic obstructive pulmonary disease was 60%, a decline of 7.7% on the previous year.

Inadequate

Are services effective?

(for example, treatment is effective)

The practice was aware that QOF performance was not in line with CCG or national figures, however the GPs were unable to provide an explanation for this or provide examples of action plans to facilitate improvement. The GP partners did not collaborate to improve QOF performance and only completed QOF work for their own registered patients.

The practice participated in local benchmarking through membership of the CCGs commissioning learning set (CLS). Benchmarking is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area. This benchmarking data showed the practice had outcomes that were comparable to other services in the area in terms of referral rates to secondary care. We also found that outpatient attendances and prescribing rates were similar to expected compared to national figures.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and found that staff were not up to date with attending mandatory courses. Staff had completed training in basic life support in the previous twelve months. However, evidence of training in infection control, fire safety, chaperoning and safeguarding vulnerable adults was lacking for all staff. We also found no evidence of safeguarding children training for non-clinical staff. We noted that the male GP partner had special interests in methadone prescribing, joint injections and cardiology. However, the GP had not updated their knowledge of cardiology since 2012. All GPs were up to date with their yearly continuing professional development requirements and all either have been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

The practice was unable to provide evidence of annual appraisals that identified learning needs and from which action plans were documented. The practice nurse told us she had received an appraisal in the previous year however it was not available for us to review. The locum practice manager told us appraisals were not carried out for non-clinical staff. Our interviews with staff showed that the practice was not proactive in providing training and funding for relevant courses. We found there were no job descriptions for the practice nurse or GP link worker that outlined their roles and responsibilities and no evidence that these staff were trained to fulfil their duties.

Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and manage those of patients with complex needs. It received blood test results, X ray results, and letters from the local hospital including discharge summaries and the 111 service both electronically and by post. However we found evidence that locum GPs did not always arrange urgent follow-up appointments when the regular GPs were on leave and the practices' locum checklist we reviewed instructed locums not to refer patients unless it was an emergency or suspected cancer. For a standard referral patients would have to wait to be re-seen by their regular GP. The practice did not hold multidisciplinary team meetings at the practice to discuss patients with complex needs.

Information sharing

The practice used an electronic system to communicate with other providers including referrals, which were often made through the Choose and Book system. (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). The practice also used referral forms which were faxed or scanned into the computer system.

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record to coordinate, document and manage patients' care. All staff were trained on the system, and commented positively about the system's safety and ease of use.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. Clinical staff we spoke with had a basic knowledge of the legislation but were not able to describe how it should be implemented correctly. For example, when carrying out smear tests for patients with a learning disability, the nurse told us she would involve family members or carers rather than first assessing the patient's capacity to consent.

Inadequate

Are services effective?

(for example, treatment is effective)

Clinical staff we spoke to could demonstrate a basic understanding of the Gillick competency test. (These are used to help assess whether a child under the age of 16 has the maturity to make their own decisions and to understand the implications of those decisions).

Health promotion and prevention

The practice offered a health check to all new patients registering with the practice and NHS health checks to all its patients aged 40 to 75 years. Health checks had also been carried out for all patients on the learning disability and dementia registers in the previous twelve months.

The practices' QOF performance for cervical screening indicators in line with the national average, for example; the percentage of women aged 25 or over and who have not attained the age of 65 whose notes record that a cervical screening test has been performed in the preceding 5 years was 82%.

The practice ran smoking cessation clinics on a weekly basis however there was no data available to show the success rate of this service. The practices' QOF performance for smoking related indicators was 52.2% in 2013/14, 36.8% below the CCG average and 41.5% below the national average. The practice also encouraged its patients to attend national screening programmes for bowel cancer and breast cancer screening.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. The practice's performance for 2013/14 was mixed for childhood immunisation rates. For example, vaccinations given to one year olds ranged from 83% to 90% and two year olds from 73% to 96% which were above the CCG averages. Vaccinations for five year olds ranged from 60% to 85% which were either comparable or below CCG averages.

Requires improvement

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. Information was only available from the national patient survey 2015 as the practice had not carried out annual satisfaction surveys.

The evidence from the national patient survey showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the national patient survey showed that 87% of respondents rated the practice as 'good' compared to the CCG average of 86% and national average of 85%. The practice was also at or above average for its satisfaction scores on consultations with doctors and nurses. For example:

- 94% said the GP was good at listening to them compared to the CCG average of 89% and national average of 89%.
- 89% said the GP gave them enough time compared to the CCG average of 85% and national average of 87%.
- 96% said they had confidence and trust in the last GP they saw compared to the CCG average of 95% and national average of 96%
- 88% said the nurse was good at listening to them compared to the CCG average of 86% and national average of 91%.
- 88% said the nurse gave them enough time compared to the CCG average of 87% and the national average of 92%.
- 94% said they had confidence and trust in the last nurse they saw compared to the CCG average of 94% and the national average of 97%.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 37 completed cards and the majority were positive about the service experienced. Patients said they felt the practice offered a good service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. Three comments were less positive but there were no common themes to these. We also spoke with five patients on the day of our inspection. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We saw that consultation / treatment room doors were usually closed during consultations and that conversations taking place in these rooms could not be overheard. However, we noted that on one occasion during our inspection the nurse's room door was left open and patients could overhear conversations between the nurse and a patient.

We saw that reception staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. Additionally, 93% of respondents to the national patient survey said they found the receptionists at the practice helpful compared to the CCG average of 86% and national average of 87%.

There was no visible notice in the patient reception area stating the practice's zero tolerance for abusive behaviour however it was outlined in the patient leaflet.

Care planning and involvement in decisions about care and treatment

The national patient survey information we reviewed showed patients had mixed responses to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice below average for three out of four questions asked;

- 94% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 86% and national average of 86%.
- 79% said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 81% and national average of 81%.
- 78% said the last nurse they saw was good at explaining tests and treatments compared to the CCG average of 83% and the national average of 90%.
- 73% said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average of 79% and the national average of 85%.

The five patients we spoke with on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they

Requires improvement

Are services caring?

felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. Patient feedback on the comment cards we received was also positive and aligned with these views.

Staff told us that translation services were available for patients who did not have English as a first language to ensure they were involved in decisions about care and treatment.

Patient/carer support to cope emotionally with care and treatment

The patient survey information we reviewed showed the practice scored below average about the emotional support provided by staff. For example:

- 84% said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 86% and national average of 85%.
- 82% said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 87% and national average of 90%.

The patients we spoke with on the day of our inspection and the comment cards we received were positive about emotional support. These highlighted that staff responded compassionately when they needed help and provided support when required. For example, one patient told us she had developed a serious illness and the GPs and nurses had been very supportive. Patients did not comment on bereavement support provided by practice staff.

Inadequate

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice was unable to demonstrate a clear understanding of the needs of the local population. The practice had not met with the Public Health team from the local authority and the clinical commissioning group (CCG) to discuss the implications and share information about the needs of the practice population identified by the Joint Strategic Needs Assessment (JSNA) to help focus services offered by the practice (The JSNA pulls together information about the health and social care needs of the population in the local area).

We saw some evidence of engagement with the CCG to discuss service improvements to meet the needs of the local population however these were within the wider context of commissioning learning sets (CLSs) run by the CCG. During these learning sessions ideas for new services or improvements to existing ones were discussed however these were few. For example, CLS meeting minutes we reviewed showed the practice had engaged with the CCG with regard to new referral services and weekend GP access services.

The practice had signed up to the unplanned admissions Enhanced Service (a programme designed to improve the coordination of care for patients with complex needs and avoid unnecessary hospital admissions). For the year 2014/15 the practice had care plans in place for 37 patients over 70 years of age although it was not clear if the practice had met the 2% target.

The practice had not carried out patient satisfaction surveys other than those required for GP appraisal and there was no active patient participation group (PPG) although it was noted that the practice was in the process of establishing one and this was evidenced from partners meeting minutes we reviewed. The practice currently had a suggestion box as the only means for patients to post comments and feedback about the service. The practice were unable to provide examples of improvement made to the service as a result of patient feedback.

Tackling inequity and promoting equality

The practice had not recognised the needs of different groups in the planning of its services. For example, it was not practice policy to schedule longer appointment times for patients with learning disabilities or other vulnerable groups and where patients needed longer appointments the GPs ran over. Access to translation services were available if they were needed however this did not include access to British Sign Language (BLS) services for the blind, or deaf services for those patients hard of hearing.

The premises were not specifically designed to meet the needs of disabled patients however services were based on the ground floor with level access to the reception/waiting rooms and consultation rooms. The ground floor toilets had been modified for disabled access however we found the light cord was cut and therefore out of reach of those patients who were wheelchair bound. There was enough space in the waiting areas to accommodate wheelchairs and prams to help maintain patients' independence. Overall the facilities required upgrading.

There was a male GP partner and a female GP partner in the practice. New patients could choose if they preferred a male or female GP as their regular GP and there was a facility to switch GP if they so wished.

The practice had not provided equality and diversity training for staff and staff had minimal understanding of equality and diversity issues. Staff told us that they did not have any patients who were of "no fixed abode" but would see someone if it was an emergency.

Access to the service

The practice opening hours were Monday to Friday 8:00 to 18:30 apart from Thursday where the practice closed at 13:00. The practice also opened from 9:00 to 12:00 on Saturdays and was closed on Sundays. Appointments could be booked throughout the practice's opening hours but not between 13:00 and 14:00 when the practice was closed for lunch. There was a morning walk-in service run by the male GP partner and the female GP partner ran a pre-bookable appointment system and six appointments slots a day allocated for patients who present on the day with emergency conditions. Appointments were available in the afternoons with both partners. Routine appointments could be booked two days in advance and urgent appointments were available the same day. The practice offered telephone consultations, and home visits including visits to a local nursing home. The practice did not have a patient website although appointments and repeat prescriptions were accessible online.

Inadequate

Are services responsive to people's needs?

(for example, to feedback?)

Information was available to patients about appointments in the patient leaflet. This included how to arrange urgent appointments and home visits and how to book routine appointments. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients in the patient leaflet including the NHS direct 111 service, and a local NHS walk-in centre.

It was not practice policy to schedule longer appointment for those who needed them such as older patients, those experiencing poor mental health, and patients with a learning disability. We were told although longer appointments were not scheduled in, the GP ran over if necessary to ensure patients' needs were accommodated.

The national patient survey information we reviewed showed patients on the whole responded positively to questions about access to appointments and generally rated the practice well in these areas although patients usually had a long wait to be seen. For example:

- 83% were satisfied with the practice's opening hours compared to the CCG average of 79% and national average of 75%.
- 80% described their experience of making an appointment as good compared to the CCG average of 79% and national average of 73%.
- 46% said they usually waited 15 minutes or less after their appointment time compared to the CCG average of 65% and national average of 65%.
- 89% said they could get through easily to the surgery by phone compared to the CCG average of 85% and national average of 83%

Patients we spoke with were satisfied with the appointments system and said it met their needs. They confirmed that they could see a doctor on the same day if they felt their need was urgent. However, we did note that patients could not choose whether they had walk-in access to their GP or appointment only access as it depended on which GP partner was their regular doctor.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. The practice manager handled all complaints in the practice.

We saw that limited information was available to help patients understand the complaints system which was partially provided in the patient leaflet. The information was not comprehensive and did not contain a detailed procedure for patients to follow.

We looked at three written complaints received in the last twelve months and found they were satisfactorily handled and dealt with in a timely way. However, we found no evidence that complaints were discussed amongst the practice team to ensure all staff were able to learn and contribute to determining any improvement action that might be required.

Are services well-led?

Inadequate

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

Our findings

Vision and strategy

The practice did not have a clear vision and there was no business plan or strategy in place to deliver high quality care and improve outcomes for patients. Staff were not aware of a practice vision and did not know their responsibilities in relation to it. Staff we spoke with said they had not been involved in developing a vision for the practice.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the practice. However not all staff we spoke with knew where to find these. We looked at a number of these policies and procedures and found that they were not always reviewed annually. We also found that key policies and procedures were missing for example those for methadone prescribing. We looked at the whistleblowing policy which was reviewed in December 2014 and found that staff had not signed a cover sheet which was in place for staff to confirm that they had read the policy and were aware of any updates.

There was no clear leadership structure with named members of staff in lead roles. From our discussions with the locum practice manager it was clear that the GP partners worked autonomously. We were told the GPs had made a decision to operate a 'personal list' system on the basis that they believed their patients prefer to be able to see 'their own doctor' when they attended. However, this meant the GP partners did not work collaboratively and therefore leadership was fragmented and incoherent.

There was no evidence that the GPs took an active leadership role for overseeing that the systems in place to monitor the quality of the service were consistently being used and were effective. For example, neither of the GP partners or the practice manager were proactively monitoring Quality and Outcomes Framework performance (QOF). The QOF data for this practice showed performance had declined considerably over the previous three years, from 94% in 2012/13 to 64% in 2014/15. QOF data was not discussed at meetings or action plans produced to maintain or improve outcomes. The GPs only completed QOF work for their own registered patients and did not work collaboratively.

There was also no programme of clinical audits in place to monitor quality and systems to identify where action should be taken. Evidence from other data from sources, including incidents and complaints were not used to identify areas where improvements could be made. Additionally, there were no processes in place to review patient satisfaction and that action had been taken, when appropriate, in response to feedback from patients or staff.

The practice had not identified, recorded and managed risks. It had not carried out risk assessments to monitor health and safety risks within the practice. There were no risks assessments for fire, legionella, general health and safety and no risk register or log to monitor risks. There were no infection control audits to assess and monitor infection control standards. We saw no evidence from partners meeting minutes that performance, quality and risks had been discussed.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example recruitment and sickness policies which were in place to support staff. Staff we spoke with were not always clear on these policies and where to locate them. For example a whistleblowing policy was available to staff, however not all staff were aware of the procedure to follow if they had suspicions of malpractice by other staff members.

Leadership, openness and transparency

The partners in the practice were visible in the practice and staff told us that they were usually approachable. Staff we spoke with said they were not involved in discussions about how to run the practice and how to develop the practice.

There were no minutes to show that team meetings were held regularly. The locum practice manager told us team meetings had not been held for the previous five years. We were told partners meetings were held monthly, however meeting minutes were only available for one meeting held in June 2015. Staff said there was an open culture within the practice and they had the opportunity to raise any issues informally and felt confident in doing so. There were no team away days however staff said they felt respected and valued by the GP partners.

Seeking and acting on feedback from patients, public and staff

Are services well-led?

Inadequate

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

There was no formal process in place to obtain feedback from patients and act on it. The practice had not carried out patient satisfaction surveys other than those required for GP appraisal and there was no patient participation group (PPG) at the time of our inspection. The practice was conducting the NHS friends and family test and had a suggestion box at reception. The locum practice manager told us that the practice was in the process of establishing a PPG which would be active by August 2015. There was no evidence that the practice had reviewed its' results from the national GP patient survey to see if there were any areas that needed addressing.

There was little evidence that the practice had gathered feedback from staff. There were no annual staff surveys, staff away days or whole practice meetings where staff could feedback to the practice. The locum practice manager said that feedback was usually gathered informally.

Management lead through learning and improvement

The practice supported staff to maintain their clinical professional development however it was up to them to request it. There was no evidence that regular appraisals took place or that staff had personal development plans that identified their training needs. We were told that the new practice manager needed to assess her own training needs and make a request to the GP partners.

The practice had not completed reviews of significant events and other incidents and shared with staff at meetings and away days to ensure the practice improved outcomes for patients.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment How the regulation was not being met: Service users were not protected from abuse and improper treatment because robust procedures and processes were not in place to make sure service users were protected from abuse. Non-clinical staff had not received training in safeguarding children and no staff had received training in safeguarding adults or chaperoning. Staff were not up to date with the principles of the Mental Capacity Act 2005 and associated legislation. Regulation 13 (1) (2)

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed How the regulation was not being met: Service users were not protected against unsafe treatment because criminal record checks had not been completed on all staff including the nurse, GP link worker, a locum GP and reception staff who carried out chaperoning duties. There was also a lack of written references for any staff. Regulation 19 (1) (a)

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: Service users were not protected from receiving unsafe care and treatment because action was not always taken to prevent the recurrence of serious incidents and where action was taken it was not always immediate. Infection control standards were not monitored, cleaning schedules were not in place and staff had not received training in infection control. Staff had not received training in fire safety, safeguarding adults and chaperoning and evidence of staff qualifications and competency relating to their specific role were in some cases absent. Flu vaccines were not always stored appropriately and therefore posed significant risks to patient safety. Regulation 12(1) and (2) (a) (b) (c) (g) (h)

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17: Good governance How the regulation was not being met: There were a lack of systems and processes in place to assess, monitor and mitigate risk in relation to health, safety and welfare of service users and others who may be at risk. There was no clear process for reporting, recording, investigating and monitoring incidents and near misses and no contingency planning to manage risks to service users in the event of a major disruption to the service. There was no system in place to ensure

This section is primarily information for the provider

Enforcement actions

safety alerts were disseminated and acted on promptly. There was no program of clinical audit to evaluate and improve outcomes for service users and no oversight of clinical performance.

There was no formal process to seek feedback from service users about the service they received. There was no clear leadership structure in place and the provider had no vision or strategy for the practice. The practices' policies were not always reviewed annually and some key policies were absent. Records and documentation relating to staff recruitment, training, appraisal and staff meetings were missing.

Regulation 17 (1) and (2) (a) (b) (d) (i)(ii) (e) (f)