Care Quality Commission

Drs P Keating & H Appleton

Quality Report

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

Ratings

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

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Drs P Keating and H Appleton on 10 January 2017. Overall the practice is rated as inadequate.

Specifically, we found the practice inadequate for providing safe services and being effective. Improvements were also required for providing caring and well-led services. It was good for providing a responsive service.

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

- Patients were at risk of harm because systems and processes were not in place to keep them safe. For example, the practice had not assessed the risks associated with the absence of oxygen for use in medical emergencies; there were gaps in the system for safeguarding children and adults, the protocol for the handling of high risk medicines was incomplete, risk assessments to determine if staff who act as chaperones required DBS checks had not been completed; and checks to assess additional risks such as infection control, and fire safety and general health and safety were not completed.
- There was very limited or no monitoring of people's outcomes of care and treatment, including no clinical audit. Data showed patient outcomes were notably low when compared to local and national averages, with significantly high exception reporting. Although we saw evidence of completed audits from 2014, we saw no evidence that audits were completed in the last two years.
- The system for managing the learning needs and development of staff through annual appraisal was inconsistent. There was no training programme in place to keep staff up to date and not all staff had completed mandatory training.
- The practice's governance arrangements did not always support the delivery of high-quality person-centred care. For example, the practice had a

number of policies and procedures to govern activity, however record keeping for governance meetings was limited and some policies had not been reviewed in several years.

- Patients were positive about their interactions with staff and said they were treated with compassion and dignity; national surveys identified that patient satisfaction was higher than the local and national average.

The areas where the provider must make improvements are:

- Assess the risks to the health and safety of service users of receiving the care or treatment in respect of the proper and safe management of medicines. Such as ensuring clear protocols are in place for managing the risks associated with high risks medicines.
- Ensure there is an effective programme for identifying the learning needs and development of staff, including a regular programme of staff appraisals and a programme of training is used to monitor training undertaken and training that is required.
- Assess monitor, manage and mitigate risks to the health and safety of service users. This includes effectively managing the risks associated with infection control and fire safety by ensuring annual infection control audits and fire risk assessments; implement a system for risk assessing the need for DBS checks for staff who act as chaperones.
- Ensure effective and sustainable clinical governance systems and processes are implemented to assess, monitor and improve the quality and safety of the services provided. Including; an effective system of managing patient safety alerts; a programme of audits to identify improvement to patient outcomes including completed clinical audits cycles; that clinical systems are used to identify and support vulnerable patients; to ensure there is an effective system for managing patients with long-term conditions and improving patient outcomes.

The areas where the provider should make improvement are:

- Improve governance arrangements within the practice. Including managing complaints and significant events, specifically around the process for reviewing individual complaints and events along with the dissemination of identified learning and outcomes; Implement a system for managing national guidance and implementing a system of formally recording clinical meetings and discussions.
- Improve the uptake in vaccinations for children under the age of two years.
- Implement a system to ensure patients with caring responsibilities are identified and recorded on the patient record system to ensure information, advice and support is made available to them.
- Implement an audit system in relation to the monitoring of prescription pads in accordance with national NHS guidelines.

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

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

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Inadequate

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

- Patients were at risk of harm, for example, the practice did not have a supply of oxygen and had not undertaken a risk assessment to ascertain whether this was safe practice. The practice provided evidence that oxygen was available following the inspection.
- The practice had not undertaken an infection control audit in 2016 and could not demonstrate whether action points from previous audits had been acted upon.
- There was insufficient attention to safeguarding children and vulnerable adults. There was no evidence to demonstrate that staff had received recent safeguarding training, although staff could recognise and respond appropriately if they suspected abuse had occurred; however, vulnerable patients were not flagged on the clinical system.
- There was no evidence to show that arrangements for acting on patient safety alerts enabled safety concerns to be actioned in a timely manner.
- Although we found the practice had a system for managing repeat prescriptions, there was limited guidance or protocols for the prescribing of high risk medicines.
- Although the practice carried out investigations when there were unintended or unexpected safety incidents, there was limited evidence to show that lessons learned were communicated and that safety was improved.

Are services effective?

Inadequate

The practice is rated as inadequate for two populations groups; specifically patients with long-term conditions and patients experiencing poor mental health. The practice is rated as inadequate for providing effective services and improvements must be made.

- Data showed patient outcomes were largely below and in some cases significantly below local and national averages for most indicators. For example:

Summary of findings

- The percentage of patients with COPD who had a review undertaken including an assessment of breathlessness using the Medical Research Council dyspnoea scale in the preceding 12 months was 32% compared to the CCG and national average of 90%.
- The percentage of patients with cancer, diagnosed within the preceding 15 months, who had a patient review recorded as occurring within 6 months of the date of diagnosis was 33% compared to the CCG average of 93% and the national average of 94%.

- Clinical staff had received professional development appropriate for their roles however, we found there was no clear training programme in place and there were gaps in mandatory training provided. For example, in safeguarding adults and children, infection control and basic life support.
- Patient outcomes were hard to identify as no reference was made to audits in the last two years or quality improvement, including no evidence that completed two cycle audits were being used to drive improvements.
- Arrangements to appraise staff had not been followed for the previous two years and the learning needs of staff were not always being identified.
- Childhood immunisation rates for the vaccinations given were lower than the CCG average.

Are services caring?

Requires improvement

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

- Data from the national GP patient survey showed patients rated the practice above the local and national average for all aspects of care. For example, 73% of patients are able to see their preferred GP compared to the CCG average of 52% and the national average of 60%.
- Feedback from comment cards and patients we spoke with indicated patients felt they were treated with compassion, dignity and respect.
- Information for patients about the services available was easy to understand and accessible.
- During our inspection, we saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.
- If families had suffered bereavement, their usual GP contacted them and the practice sent them a sympathy card.

Summary of findings

- No carers were identified at the time of inspection, follow the inspection the practice had identified less than 1% of the patient population as carers.

Are services responsive to people's needs?
The practice is rated as good for providing responsive services.

Good

- Information about how to complain was available and easy to understand and evidence showed the practice responded quickly to issues raised. However, learning from complaints was not always shared with staff.
- Practice staff reviewed the needs of its local population and engaged with the clinical commissioning group to secure improvements to services where these were identified.
- Patients said they found it easy to make an appointment with a named GP and there was continuity of care, with urgent appointments available the same day.
- Routine appointment booking and repeat prescription requests could be made online.
- The practice had good facilities and was equipped to treat patients and meet their needs.
- Data from the national GP survey showed that 91% of patients were satisfied with the practice's opening hours compare to the CCG average of 74% and the national average of 76%.

Are services well-led?
The practice is rated as requires improvement for providing well-led services and improvements must be made.

Requires improvement

- All staff had received inductions but these had not been recorded. Not all staff had received regular performance reviews.
- The practice had a number of policies and procedures to govern activity, but there were gaps in the system for reviewing policies and procedures to ensure they were in line with best practice and national guidance.
- The practice held regular practice meetings; however, records relevant to the running of the practice were not always maintained, for example minutes of clinical meetings.
- The practice recently developed a vision and strategy. Staff were aware of their responsibilities in relation to the vision or strategy however the strategy had not been fully embedded.
- There was a clear leadership structure following recent changes to the management team; staff felt supported by management.
- The practice proactively sought feedback from staff or patients and had an active patient participation group.

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

Requires improvement

The provider was rated as inadequate for providing safe and effective services and requires improvement for providing caring and well-led services. The concerns which led to these ratings apply to everyone using the practice, including this population group.

- Nationally reported data showed that outcomes for patients for conditions commonly found in older people were below the local and national average. For example, The percentage of patients diagnosed with dementia whose care plan has been reviewed in a face-to-face review in the preceding 12 months was 73% compared to the CCG average of 85% and the national average of 84%.
- The practice was responsive to the needs of older people, and offered home visits and urgent appointments for those with enhanced needs.
- We saw evidence the practice participated in multidisciplinary meetings for older patients with complex needs.

People with long term conditions

Inadequate

The provider was rated as inadequate for providing safe and effective services and requires improvement for providing caring and well-led services. The concerns which led to these ratings apply to everyone using the practice, including this population group. The provider was also rated as inadequate for providing effective services for this population group.

- There were errors in the coding of patient information on the clinical system which meant that it was not clear whether patients with long term conditions had had a structured annual review to check their health and medicines needs were being met.
- Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority.
- Longer appointments and home visits were available when needed.
- Performance for patients with long term conditions was below the local and national averages with some conditions being in line with these averages. For example:
  - The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less was 69%

compared to the CCG average of 75% and the national average of 78%. However, the percentage of patients with diabetes, on the register, in whom the last IFCCHbA1c is 64 mmol/mol or less in the preceding 12 months was 73% which was in line with the CCG average but lower than the national average of 78%.

- The percentage of patients with COPD who had a review undertaken including an assessment of breathlessness using the medical research council dyspnoea scale in the preceding 12 months was 32% significantly lower than the CCG and national average of 90%
- The percentage of patients with asthma, on the register, who had an asthma review in the preceding 12 months that includes an assessment of asthma control using the three Royal College of Physicians questions was 44%, significantly lower than the local and national average of 76%.

Families, children and young people

The provider was rated as inadequate for providing safe and effective services and requires improvement for providing caring and well-led services. The concerns which led to these ratings apply to everyone using the practice, including this population group.

- Immunisations rates for children under the age of two years old were lower than local and national averages.
- The practice's uptake for the cervical screening programme was 80%, which was comparable to the CCG average of 80% and the national average of 81%.
- Appointments were available outside of school hours and the premises were suitable for children and babies.
- Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals.

Requires improvement

Working age people (including those recently retired and students)

The provider was rated as inadequate for providing safe and effective services and requires improvement for providing caring and well-led services. The concerns which led to these ratings apply to everyone using the practice, including this population group.

- The practice offered online services as well as a full range of health promotion and screening that reflects the needs for this age group.

Requires improvement

Summary of findings

- The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care.
- Extended hours services were available two evenings during the week.
- Telephone consultations with GPs were available as well on online booking for appointments and repeat prescription requests.

People whose circumstances may make them vulnerable

Requires improvement

The provider was rated as inadequate for providing safe and effective services and requires improvement for providing caring and well-led services. The concerns which led to these ratings apply to everyone using the practice, including this population group.

- Clinical systems were not effectively utilised to identify vulnerable patients.
- Staff knew how to recognise signs of abuse in vulnerable adults and children, although not all staff were up to date with safeguarding training. Staff 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.
- The practice offered longer appointments for patients with a learning disability.
- The practice worked with other health care professionals in the case management of vulnerable patients.

People experiencing poor mental health (including people with dementia)

Inadequate

The provider was rated as inadequate for providing safe and effective services and requires improvement for providing caring and well-led services. The concerns which led to these ratings apply to everyone using the practice, including this population group. The provider was also rated as inadequate for providing effective services for this population group.

- The performance for mental health related indicators was below the local and national averages. For example:
  - The percentage of patients aged 18 or over with a new diagnosis of depression in the preceding 12 months, who had been reviewed not earlier than 10 days after and not later than 56 days after the date of diagnosis was 4% compared to the CCG average of 77% and the national average of 83%.

Summary of findings

- The percentage of patients on lithium levels in the therapeutic range in the proceeding four months was 33% compared to the CCG average of 77% and the national average of 89%.
- The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those with dementia.
- The practice carried out advance care planning for patients with dementia.
- The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations.
- The practice employed an in house counsellor to help support the needs of patient experiencing poor mental health.

Summary of findings

What people who use the service say

The national GP patient survey results were published in July 2016. The results showed the practice was performing above the local and national averages. A total of 279 survey forms were distributed and 122 were returned. This represented 2.7% of the practice's patient list.

- 92% of patients found it easy to get through to this practice by phone compared to the CCG average of 67% and the national average of 73%.
- 85% of patients were able to get an appointment to see or speak to someone the last time they tried compared to the CCG average of 69% and the national average of 76%.
- 91% of patients described the overall experience of this GP practice as good compared to the CCG average of 80% and the national average of 85%.
- 84% of patients said they would recommend this GP practice to someone who has just moved to the local area compared to the CCG average of 73% and the national average of 79%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 30 comment cards which were all positive about the standard of care received. Patients expressed that they felt listened to and cared for by all staff at the practice.

We spoke with four patients during the inspection. All four patients said they were satisfied with the care they received and thought staff were approachable, helpful and caring.

Areas for improvement

Action the service MUST take to improve

- Assess the risks to the health and safety of service users of receiving the care or treatment in respect of the proper and safe management of medicines. Such as ensuring clear protocols are in place for the managing the risks associated with high risks medicines.
- Ensure there is an effective programme for identifying the learning needs and development of staff, including a regular programme of staff appraisals and a programme of training is used to monitor training undertaken and training that is required.
- Assess monitor, manage and mitigate risks to the health and safety of service users. This includes effectively managing the risks associated with infection control and fire safety by ensuring annual infection control audits and fire risk assessments; implement a system for risk assessing the need for DBS checks for staff who act as chaperones.
- Ensure effective and sustainable clinical governance systems and process are implemented to assess, monitor and improve the quality and safety of the services provided. Including; the an efective system of managing patient safety alerts; a programme of audits to identify improvement to patient outcomes including completed clinical audits cycles; clinical systems are used to identify and support vulnerable patients; ensure there is an effective system for managing patients with long-term conditions and improving patient outcomes.

Action the service SHOULD take to improve

- Improve governance arrangements within the practice. Including managing complaints and significant events, specifically around the process for reviewing individual complaints and events along with the dissemination of identified learning and outcomes; Implement a system for managing national guidance and implementing a system of formally recording clinical meetings and discussions.
- Improve the uptake in vaccinations for children under the age of two years.

Summary of findings

- Implement a system to ensure patients with caring responsibilities are identified and recorded on the patient record system to ensure information, advice and support is made available to them.
- Implement an audit system in relation to the monitoring of prescription pads in accordance with national NHS guidelines.

Care Quality Commission

Drs P Keating & H Appleton

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector and included a GP specialist adviser.

Background to Drs P Keating & H Appleton

The Drs P Keating and H Appleton practice is located in Enfield, North London within the NHS Enfield Clinical Commissioning Group. The practice holds a Personal Medical Services contract (an agreement between NHS England and general practices for delivering primary care services to local communities). The practice provides a full range of enhanced services including:

- diagnosis and support for people with dementia
- supporting patients with learning disabilities
- influenza and pneumococcal vaccines
- minor surgery
- rotavirus and shingles immunisation
- unplanned admissions

The practice is registered with the Care Quality Commission to carry on the regulated activities of treatment of disease, disorder or injury, diagnostic and screening procedures, maternity and midwifery services and family planning.

The practice had a patient list size of approximately 4,750 at the time of our inspection. The practice had a higher level of people with a long standing health conditions (58% compared to the CCG average of 52% and the national average of 54%). The practice serves a predominantly White British population (95%). Other prevalent population groups include Polish, Turkish, African, and Black British. At 80 years, male life expectancy is in line with the CCG average of 80 years and the England average of 79 years. At 85 years, female life expectancy is above the CCG average of 84 years and the England average of 83 years.

The practice has fewer patients aged 60 years of age and older compared to an average GP practice in England. The surgery is based in an area with a deprivation score of six out of ten (one being the most deprived). Children and older people registered with the practice have a lower level of income deprivation compared to the local average. Compared to the average GP practice in England, patients at this practice have a lower rate of unemployment.

The staff team at the practice included two GP partners (one male, one female), one female salaried GP, one female practice nurse, one female healthcare assistant, one female phlebotomist (a health care professional that collects blood samples from patients) and one female counsellor and one part-time interim practice manager . At the time of our inspection the practice manager role was vacant; the partners at the practice were actively recruiting to fill the vacancy. The practice had six administrative staff. There were 17 GP sessions and four nurse sessions available per week.

The practice is open between 8.00am and 6.30pm Monday to Friday. GP appointments are available between 8.00am and 12.30pm and between 3.00pm and 6.00pm Monday to Friday. Extended hours appointments are available on Monday from 6.30pm to 7.00pm and Tuesday from 6.30pm to 8.00pm. The surgery is closed on Saturdays, Sundays and bank holidays. Urgent appointments are available each day and GPs also provide telephone consultations for patients. An out of hour's service is provided for patients when the practice is closed. Patients can access the out of

Detailed findings

hour's service by contacting 111. Information on the out of hour's service is provided to patients on the practices answerphone message, through posters in the waiting area and the practice leaflet.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme. This was the first inspection for the practice.

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 10 January 2017.

During our visit we:

- Spoke with a range of staff (two GPs, one practice nurse, one healthcare assistant, one counsellor and two members of the administration team) and spoke with patients who used the service.
- Observed how patients were being cared for and talked with carers and/or family members
- Reviewed personal care and treatment records of patients.
- Reviewed comment cards where patients and members of the public shared their views and experiences of the service.

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

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

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

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

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

Inadequate

Are services safe?

Our findings

Safe track record and learning

The practice had a system in place for reporting and recording significant events. There were six significant events reported in the last 12 months, we reviewed all six events. We found that when things went wrong the practice did not consistently complete reviews and investigations. For example:

- The practice's significant event protocol indicated that a review meeting would be held after the event had been investigated. Staff told us that significant events were discussed at clinical meetings; however, these meetings were not minuted. This meant staff not present at the meetings were unable to see discussions around agreed actions or learning outcomes pertaining to significant events.
- Two of the six significant events we reviewed did not identify any required actions or learning outcomes.
- Staff demonstrated that they understood how to report an event and knew how to access the reporting template.
- We spoke to the lead GP about the system for reviewing significant events and sharing learning with staff. We were told that discussions did take place but the practice recognised that improvements were required to ensure records of actions and learning outcomes were maintained. Immediately following our inspection we were told that a new system had been implemented to ensure all significant events would be reviewed and investigated. We were told that the practice would share all significant events electronically with clinicians through the clinical workflow system. All significant events will continue to be discussed at the monthly clinical meetings and these meetings will now be minuted.

The practice was unable to demonstrate it had a safe system in place to manage patient safety alerts, including those from the Medicines and Healthcare Products Regulatory Agency (MHRA). We were told alerts are received by each clinician through the e-mail system. Staff told us that prior to November 2016 all patient safety alerts were received by the practice manager who distributed hard copies to clinical staff; however, the practice was unable to provide any evidence to demonstrate this process was followed. On the day of our inspection the practice was unable to produce any examples of recent patient safety or MHRA alerts that were relevant to the practice. The partners at the practice told us alerts were discussed at clinical meetings, but they were unable to provide minuted evidence of these discussions.

Overview of safety systems and processes

- We looked at arrangements in place to safeguard children and vulnerable adults from abuse. On the day of inspection, the practice did not have a child protection register in place. In the week following our inspection we were told this register had been established and a meeting had been arranged with local health visitors to review the register which was subsequently populated with five patients. We noted that not all staff had had recent training in safeguarding children and adults. Although we saw evidence that three members of clinical staff were trained to child safeguarding level 3, the practice could not provide evidence to demonstrate that the partner GPs and administration staff were trained to the appropriate level. Following our inspection we were provided with evidence that the partner GPs at the practice had completed child safeguarding level 3 in July 2016. Some staff we spoke with were unable to identify the safeguarding lead at the practice. The computer patient management system used by the practice had the capability to identify vulnerable patients; however, the practice were unable to provide evidence that this was being utilised. Non-clinical and clinical staff were however able to provide meaningful examples of recent safeguarding concerns and actions taken. There was a safeguarding children's policy in place but we noted that it had last been reviewed in December 2013.
- A notice in the waiting room advised patients that chaperones were available if required. The practice had not risk assessed whether staff who acted as chaperones should receive Disclosure and Barring Service (DBS) check DBS. 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 or children or adults who may be vulnerable.
- The practice did maintain appropriate standards of cleanliness and hygiene. We observed the premises to

be clean and tidy. The practice nurse and healthcare assistant shared the role of infection control clinical lead and we saw evidence that they were appropriately trained to carry out this role. The system for managing training records was ineffective and therefore the practice was unable to provide evidence that the GPs and all non-clinical staff were up to date with infection control training. Following our inspection the practice did provide evidence that one of the partner GPs completed infection control training in January 2017. The last annual infection control audit was carried out in 2015; however, the audit did not have an action plan identifying areas for improvement. Staff we spoke with were able to demonstrate an understanding of infection control responsibilities. For example, staff were able to explain how to safely handle clinical specimens and identify the location of spill kits for the cleaning of infectious materials. There was an infection control protocol in place along with a waste management policy which were available to all staff. We saw evidence that these policies were being followed. For example, sharps bins were available in all clinical rooms and clinical waste was securely stored. We noted that there was a cleaning schedule for the practice which was in line with national guidelines on infection prevention and control in general practice.

- Arrangements for managing medicines, including emergency medicines and vaccines (including obtaining, recording, handling, storing, security and disposal) were in place. There were policies in place for repeat prescribing, including high-risk medicines. However, the only high-risk medicine stipulated in the policy was an anticoagulation medicine; no others were referred to. A random check of patient records showed patients were being monitored, but we could not be assured that there was an effective protocol in place to proactively monitor these patients.
- Blank prescription forms and pads were securely stored but there were no systems in place to monitor their use. Patient group directions (PGDs) had been adopted by the practice to allow the nurse to administer medicines in line with legislation. PGDs are written instructions from a qualified and registered prescriber for a medicine including the dose, route and frequency or appliance to be supplied or administered to groups of patients who may not be individually identified before presentation for treatment. The health care assistant was trained to administer vaccines and medicines against a patient specific prescription (PSDs) or direction from a prescriber. PSDs are written instructions signed by a doctor for medicines to be supplied and/or administered to a named patient after the prescriber has assessed the patient on an individual basis.
- We reviewed eight personnel files and found although there was evidence that pre-employment checks had been undertaken.

Monitoring risks to patients

We looked at how risks to patients were assessed and managed.

- There were procedures in place for monitoring and managing some risks to patient and staff safety. The practice did not have an up to date fire risk assessment, had not undertaken regular fire drills and were unable to demonstrate that staff had received fire safety awareness training. The practice nurse maintained copies of her own training and provided us with evidence of fire safety training completed within the previous six months. The practice was unable to provide evidence of other risk assessments in place to monitor safety of the premises such as control of substances hazardous to health and infection control. The most recent risk assessment for legionella had been carried out in 2014. (Legionella is a term for a particular bacterium which can contaminate water systems in buildings). There was a health and safety policy available with a poster in the reception office which identified local health and safety representatives. All electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly.
- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system in place for all the different staffing groups to ensure enough staff were on duty.

Arrangements to deal with emergencies and major incidents

The practice did not have appropriate arrangements in place to respond to emergencies and major incidents at the time of our inspection.

- There was no oxygen available on the premises at the time of our inspection. We were provided with evidence

that oxygen was obtained subsequent to the inspection. The practice had a defibrillator and we saw evidence that emergency equipment was checked regularly. A first aid kit and accident book were available.

- We only saw evidence of basic life support training for one GP at the practice; the practice was unable to provide evidence of basic life support training for the remainder of clinical and non-clinical staff at the practice.
- There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency.
- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and stored securely.
- The practice had a business continuity plan in place for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff.

Inadequate

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Based on data available on patient outcomes, we were not assured that clinical staff could demonstrate they assessed needs and delivered care in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines. There was no system in place to allow the sharing of this information with new or locum staff.

Management, monitoring and improving outcomes for people

We saw limited evidence that the practice used the information collected for the most recent validated Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent published results were 76% of the total number of points available. Exception reporting for many of the clinical domains was significantly higher than the national average for most indicators; including diabetes and mental health. (Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects). On the day of inspection we spoke with the lead GP about the QOF performance for 2015/16 and in particular about the high exception reporting rate. The GP told us they were aware of this and explained that the practice had switched to a new clinical system in 2015 and this had led to coding errors in certain areas, this also coincided with a long period of absence by one of the GP partners. We reviewed QOF performance for the previous three years and noted that exception reporting rates had been in line with local and national averages.

We reviewed several examples of exception reporting for each of these clinical domains and found that patients who did not respond to three reminders for review meetings were reported as exceptions. On the day of our inspection the practice provided evidence that there were no reported exceptions for any clinical domains in the current figures for 2016/17 although this data had not been validated at the time of our inspection.

This practice was an outlier for the majority of QOF (or other national) clinical targets. Data from 2015/16 showed:

- Performance for (COPD) related indicators was below the CCG and national average. For example, the percentage of patients with COPD who had a review undertaken including an assessment of breathlessness using the medical research council dyspnoea scale in the preceding 12 months was 32% compared to the CCG and national average of 90% (exception reporting was 6%).
- Performance for cancer related indicators was below the CCG and national average. For example, the percentage of patients with cancer, diagnosed within the preceding 15 months, who had a patient review recorded as occurring within six months of the date of diagnosis was 33% compared to the CCG average of 93% and the national average of 94% (exception reporting was 40%).
- Performance for asthma related indicators was below the CCG and national average. The percentage of patients with asthma, on the register, who had an asthma review in the preceding 12 months that includes an assessment of asthma control using the three Royal College of Physicians questions was 44%, significantly lower than the local and national l average of 76% (exception reporting was 3%).
- Performance depression related indicators was below the CCG and national average. For example,
- Performance for lithium indicators was below the CCG and national average. For example,
- Performance for diabetes related indicators was in line with the CCG and below the national average. For example, the percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c was 64mmol/mol or less in the preceding 12 months was 73% compared to the CCG average of 73% and the national average of 78% (exception reporting was 13%).
- Performance for mental health related indicators was below the local and national averages. For example, the percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who had a comprehensive, agreed care plan documented in the record, in the preceding 12 months was 80% compared to the CCG average of 92% and the national average of 89% (exception reporting was 57%).

Inadequate

Are services effective?

(for example, treatment is effective)

- Performance for hypertension related indicators was in line with the local and national averages. For example, the percentage of patients with hypertension in whom the last blood pressure reading (measured in the last 12 months) was 150/90 mmHg or less was 78% compared to the CCG average of 81% and the nation average of 83% (exception reporting was 3.2%).
- Performance for dementia related indicators was below the local and national averages. For example, the percentage of patients diagnosed with dementia whose care had been reviewed in a face-to-face review in the preceding 12 months was 73% compared to the CCG average of 85% and the national average of 84% (exception reporting was 58%).

As part of the practice's QOF improvement plan, the GP partner had already tasked the interim practice manager with arranging training around the clinical system for all staff at the practice. We were told that weekly review meetings would be led by a GP partner and these would be used to monitor the progress of improvements to the processes used to recall patients and the subsequent coding of information on the clinical patient management system. Although, at the time of inspection these weekly meetings had not yet commenced.

There was no evidence of quality improvement for the last two years, including clinical audit. We asked the practice to provide us with details of any clinical audits they had undertaken. We were provided with documentation of two full cycle clinical audits completed in 2014 around repeat medication and prescribing. The practice did not have an ongoing audit programme or strategy where they had made continuous quality improvements to patient care in a range of clinical areas as a result of clinical audit.

Effective staffing

We looked at how the practice ensured that staff had the skills, knowledge and experience 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. We saw that this had been followed for the most recently appointed member of staff.
- There was limited evidence to demonstrate that staff had undertaken mandatory training including basic life support and information governance. Following the inspection the practice provided evidence of subscription to an online training provider. We were told that some staff had already completed a number of training modules; however, we were not provided certificates for completed training.
- The learning needs of staff were not consistently identified through a system of appraisals, meetings and reviews of practice development needs. We found that five staff appraisals were overdue and noted that these staff had not been appraised since 2014. We noted that one member of clinical staff had not had an appraisal since they started work for the practice in 2013.

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 in role-specific training programmes attended and completed.

Coordinating patient care and information sharing

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

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

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

Consent to care and treatment

Inadequate

Are services effective?

(for example, treatment is effective)

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. Although staff demonstrated knowledge of the mental capacity act we only saw evidence for the practice nurse this training was up to date. The practice were unable to provide evidence the GPs at the practice were up to date with this training. Following the inspection the practice provided evidence that one of the GP partners completed MCA training in January 2017.
- Although there was a process for seeking consent; this was not yet monitored through regular patient records audits.

Supporting patients to live healthier lives

The practice didn't always identify patients who may be in need of extra support. For example:

- Patients receiving end of life care, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation were signposted to the relevant service; however, the practice had not identified any patients that were carers at the time of inspection.

The practice's uptake for the cervical screening programme was 80%, which was comparable to the CCG average of 80% and the national average of 81%. There was a policy to offer telephone reminders for patients who did not attend for their cervical screening test. The practice demonstrated how they encouraged uptake of the screening programme by using information in different languages and for those with a learning disability and they ensured a female sample taker was available. There were failsafe systems in place to ensure results were received for all samples sent for the cervical screening programme and the practice followed up women who were referred as a result of abnormal results. The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening. Data from 2015/16 showed that practice uptake rates for these screening programmes was comparable to national averages. For example, the uptake rate for breast cancer screening was 76% compared to the national average of 72%.

Childhood immunisation rates for the vaccinations given were below the national average of 90%. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 78% to 90% within the practice. Vaccinations for five year olds ranged from 70% to 89% which was comparable to the CCG rates of 72% to 86% but below the national averages of 88% to 94%.

Patients had access to appropriate health assessments and checks. These included health checks for new patients.

Requires improvement

Are services caring?

Our findings

Kindness, dignity, respect and compassion

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

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

All of the 30 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 felt listened to by all members of staff. Patients also comments that staff were polite, helpful, caring and treated them with dignity and respect.

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

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

- 88% of patients said the GP was good at listening to them compared to the clinical commissioning group (CCG) average of 85% and the national average of 89%.
- 88% of patients said the GP gave them enough time compared to the CCG average of 82% and the national average of 87%.
- 96% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 89% and the national average of 95%.
- 86% of patients said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 81% and the national average of 85%.
- 96% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 84% and the national average of 91%.
- 97% of patients said they found the receptionists at the practice helpful compared to the CCG average of 84% 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.

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

- 85% of patients said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 82% and the national average of 86%.
- 96% of patients said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 84% and the national average of 82%.
- 89% of patients 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 practice provided facilities to help patients be involved in decisions about their care:

Are services caring?

- Staff told us that translation 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. The practice also made use of a translation leaflet that provided medical complaints and symptoms in 15 languages.
- Information leaflets were available in easy read format.

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 were also available on the practice website.

On the day of our inspection the practice had not formally recorded any patients that were carers; the electronic carers register had not been populated. Practice staff told us they were aware of patients who were carers and there was a carer's protocol in place. Following the inspection the practice updated the carers register with 34 patients (less than 1% of the practice list) to ensure they could be easily identified. Written information was available to direct carers to the various avenues of support available to them.

Staff told us that if families had suffered bereavement, 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.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice reviewed the needs of its local population and engaged with the Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. The practice hosted a counsellor to support patients to access support services and offered in-house phlebotomy and minor surgery.

- The practice offered appointments on Monday from 6.30pm – 7.00pm and on Tuesday from 6.30pm – 8.00pm for working patients who could not attend during normal opening hours.
- There were longer appointments available for patients with a learning disability.
- Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice.
- Same day appointments were available for children and those patients with medical problems that require same day consultation. On the day of our inspection we reviewed the appointment system and found that there were three emergency appointments available. Staff told us that even if all emergency appointments have been allocated the partners will not turn away patients who require an urgent appointment.
- Patients were able to receive travel vaccinations available on the NHS and were referred to other clinics for vaccines available privately.
- There were disabled facilities on the ground floor, a hearing loop and translation services available.
- A patient registration form was available for download on the practice website which meant that patients could complete this form at their convenience.

The practice had a policy to allow people to register as temporary patients and the practice website included a form which could be downloaded and completed. The policy allowed a person to be registered as a temporary patient for up to three months and still remain a patient of their permanent GP.

Access to the service

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

- 91% of patients were satisfied with the practice's opening hours compared to the CCG average of 89% and the national average of 78%.
- 92% of patients said they could get through easily to the practice by phone compared to the CCG average of 67% and the national average of 73%.

People told us on the day of the inspection that they were able to get appointments when they needed them. Working patients told us the service was easily accessible however they also said that they could spend an average of 30 minutes in the waiting area for pre-booked routine appointments. Patients told us that when requesting urgent appointments they were always seen by a GP the same day.

The practice had a system in place to assess:

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

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.

The practice was open between 8.00am and 6.30pm Monday to Friday. Appointments were from 8.00am to 12.30pm and 3.00pm to 6.00pm daily. Extended hours appointments were offered two evenings per week on Monday and Tuesday. In addition to pre-bookable appointments that could be booked up to twelve weeks in advance, urgent appointments were also available for people that needed them.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns although there had been issues with maintaining the complaints file since the previous practice manager had left the practice in 2016.

- Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England.
- We saw that information was available to help patients understand the complaints system in the practice leaflets and in the patient waiting area.

Good

Are services responsive to people's needs?

(for example, to feedback?)

We looked at records of three complaints received in the last 12 months which indicated that these had been handled in line with practice procedure. However, the practice was unable to locate the detailed complaints files during our inspection and so could not provide evidence that learning from individual concerns and complaints was used to improve the quality of care. Staff were able to demonstrate an understanding of the practices complaints process and how to support patients who wanted to make a complaint. For example, we reviewed a complaint about a letter being sent to a patient in error, the practice dealt with the complaint in a timely, open and compassionate manner but there was no evidence that learning points had been identified or shared with staff in order to avoid this happening to another patient.

Are services well-led?

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

Our findings

Vision and strategy

The practice's current focus is on improving leadership, filling the practice manager vacancy, providing all staff with in-depth training for the clinical system used at the practice and focusing on QOF performance. For example, the practice are currently working with an interim practice manager to improve governance systems and recruit a permanent practice manager.

The practice's aims and objectives included:

- To provide patients with safe, high quality healthcare in a clean and well equipped environment.
- To offer a flexible service to meet patient choice.
- Working in partnership with other professionals in the care of patients.
- The practice had a mission statement, although this was not on display; staff knew and understood the values.

We spoke with four members of staff and they all demonstrated commitment to the aims and objectives of the practice. We observed them carrying out their roles and responsibilities in keeping with the practices aims and objectives.

The practice did not have a strategy and supporting business plans which reflected the vision and values. Staff at the practice were open and honest with us about this on the day of inspection. The GP partners at the practice identified areas for improvement and staff at the practice demonstrated knowledge of the improvements underway. For example, one of the partners was identified as the QOF lead and planned to hold weekly meetings focusing on improving performance. Although the meetings had not yet taken place at the time of our inspection, staff we spoke to were aware of the plans and their role in improving performance.

Governance arrangements

Governance arrangements did not always operate effectively.

- Practice specific policies were available to all staff but some policies (such as complaints and safeguarding) contained incorrect contact details or referred to lead staff that were no longer employed at the practice.
- There was no system or programme of continuous clinical and internal audit used to monitor quality and to make improvements.
- Risk assessments had not been carried out to ascertain whether staff undertaking chaperone duties required a DBS check.
- Staff were clear of their own roles and responsibilities in relation to significant events and complaints; however, the process around completing investigations and identifying learning outcomes was not consistently managed.
- The practice did have recruitment processes and procedures in place to ensure that recruitment checks were undertaken but staff records had been ineffectively managed for a period of approximately two years which meant that it was not possible to confirm whether these procedures had always been followed. This was identified as an issue by the practice and they were in the process of putting improvements in place, for example a new induction process had been developed prior to the inspection.
- Records had not always been well maintained since 2014. During our inspection staff were locating relevant documents which had been filed incorrectly. For example, one member of staff found a copy of an appraisal from 2015 which had not been placed on their personnel file and other members of staff were able to give credible descriptions of training undertaken in 2015 which had not been recorded. The most recent member of staff recruited had all the necessary recruitment checks in place prior to employment. The practice had taken some measures to improve the management of these files by appointing an experienced member of staff to update the personnel files for all staff. This improvement was led by the recently appointed interim practice manager
- Arrangements to ensure that all staff were appraised annually had not been followed through. In particular we were told that one member of clinical staff had not been appraised at all during their period of employment with the practice. This meant that the learning needs of staff were not consistently identified.

Are services well-led?

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

- There were policies in place which were practice specific but some were overdue for a review to ensure they reflected best practice and national guidelines. For example, child safeguarding and repeat prescribing.

Leadership and culture

The GP partners were visible in the practice and staff told us they enjoyed working in the practice and felt supported. However, GPs recognised that there had been a period when practice management systems had become less effective and this impacted on governance systems. GPs were confident the practice had already begun showing signs of improvement following the practice manager post recently being filled; for instance, a QOF improvement plan was under development and staff training needs had begun to be identified and met. Staff told us that as a team they were committed to driving improvement:

- Staff told us the practice held team meetings approximately every two months and these were formally recorded, we saw evidence of these minutes on our inspection. Clinical meetings were held on a weekly basis, but discussions were not minuted. Staff confirmed that these meetings took place.
- Staff told us there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and felt confident and supported in doing so. Staff also felt confident enough approach the partners as needed and felt the practice maintained an 'open door' policy.
- Staff said they felt respected. All staff were involved in discussions about how to run and develop the practice, and the GP partners encouraged all members of staff to identify opportunities to improve the service delivered by the practice. Staff felt the partners always took the time to listen to their views.

The GP partners were aware of the requirements of the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).This included support training for all staff on communicating with patients about notifiable safety incidents. The partners encouraged a culture of openness and honesty.

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

The practice encouraged and valued feedback from patients. It had gathered feedback from patients through the PPG and surveys. It had an active PPG which included representatives from various population groups; however the practice recognised that more members were required to cover all the patient population groups such as people aged under 25.

The practice (with the PPG) had completed two local surveys in 2014 and 2015. The feedback was very positive and where an issue was identified we saw evidence that the practice took action. For example, the addition of an electronic sign-in screen in reception.

We spoke with one member of the PPG and they were very positive about the role they played and told us they felt engaged with the practice. We also saw evidence that the practice had reviewed results from the national GP survey and noted that these coincided with the findings of the practice's own local surveys both of which demonstrated levels of high patient satisfaction.

The practice had also gathered feedback from staff through informal and formal practice meetings and discussions. Staff told us they felt comfortable giving feedback and discussing any concerns or issues with colleagues and management. They told us they felt involved and engaged in how the practice improved outcomes for both staff and 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 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **How the regulation was not being met:** • The provider failed to operate effective systems and processes to make sure they assess and monitor their service. For example, there was no evidence of quality improvement through a programme of continiuos clinical audits. This was in breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities)

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 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **How the regulation was not being met:** • The provider did not do all that was reasonably practicable to assess, monitor, manage and mitigate risks to the health and safety of service users such as fire safety and annual infection control audits. • The provider did not have a system in place to manage patient safety alerts. • The provider did not ensure DBS checks were in place or risk assessments to ascertain if DBS checks were required for staff undertaking chaperone responsibilities. • The provider did not ensure there was a system in place to identify and support vulnerable children and adults and ensure safeguards were in place. For example, all vulnerable patients should be identified on the clinical system to ensure that staff at the practice are able to carry out safeguarding responsibilities. This was in breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **How the regulation was not being met:** • We found that the provider did not maintain an effective programme for ensuring all staff were up to date with mandatory training. The provider did not consistently identify the learning needs and

This section is primarily information for the provider

Enforcement actions

development of staff as not all staff received annual appraisals and one member of clinical staff had not been appraised since taking up employment with the provider.

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