Dr Sergio De Cesare

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?	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 Dr Sergio De Cesare on 4 and 10 January 2017. The overall rating for the practice was inadequate and the provider was suspended for six months, a care taking practice was allocated to the practice and the practice was placed in special measures. The full comprehensive report on the January 2017 inspection can be found by selecting the 'all reports' link for Dr Sergio De Cesare on our website at www.cqc.org.uk.

This inspection was undertaken following the period of suspension and special measures and was an announced comprehensive inspection on 6 July 2017. Overall the practice is still rated as inadequate.

Our key findings were as follows:

- The practice had a significant events policy. However not all members of staff were able to locate it on the practice's computer system and no events had been recorded even though we were given recent examples of significant events.
- The practice had some policies and protocols but these were not fully embedded in practice and not all staff members were able to locate them.
- The practice had no vulnerable adults or safeguarding children register and not all staff members knew where to access the safeguarding policy. Staff members were unclear of who the safeguarding lead for the practice was and were unclear of the external safeguarding team contacts or when to use them.
- There were no systems to act on and mitigate risks associated with patient safety alerts.
- All staff had completed mandatory training but this had not been embedded into practice.
- Although the practice participated in the Quality and Outcomes Framework (QOF) no data had been submitted and they could not demonstrate how this was being monitored. Therefore the practice was unable to demonstrate outcomes and quality improvement for patients with long term conditions.

Summary of findings

- There had been no audits undertaken since the last inspection, where we were shown one incomplete audit with no evidence of how action led to improvement.
- The process for prescribing repeat medicines did not always include a review of high risk medicines; for example we saw that mesalazine was prescribed without any recent blood tests.
- The practice had a system for monitoring the cold chain; however we found out of date typhoid and nasal flu vaccines in the vaccine fridges.
- Emergency medicines did not include ceftriaxone, (this is used for patients who are allergic to penicillin) and there was no water for injection.
- The practice did not use an interpreting service for patients who did not have English as a first language and did not use their hearing loop.
- There was no practice website, and online services such as appointment booking and prescription requests were not available.
- There were discrepancies about what was classified as a complaint and how these were recorded and responded to.
- Staff who acted as chaperones were trained for the role and had received disclosure and barring service checks; however they were unable to demonstrate that they could carry out the role effectively.
- There was minimal engagement with other providers of health and social care; the practice did not participate in any peer review or multidisciplinary meetings.
- There was no evidence of appraisals or personal development plans.
- The practice had identified none of its patients as a carer.
- The practice told us that they carried out monthly formal practice meetings; however other than a meeting that occurred in response to the inspection announcement, these were not documented, there were no agendas, minutes or noted actions for learning and improvement.
- The business continuity plan was not comprehensive and incomplete and the practice had not secured a buddy practice.
- The practice had a recently formed patient participation group and was in the process of gathering patient feedback.
- We saw that Legionella testing had been carried out.
- All electrical and clinical equipment had been tested and calibrated to ensure that it was fit for purpose and in good working order.
- Patient Group Directions (PGD) had been adopted by the practice to allow nurses to administer medicines in line with legislation. PGD's are written instructions for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment.
- There were systems in place to ensure the regular monitoring of the defibrillator and oxygen in the practice.
- There was a failsafe mechanism for cervical cytology to ensure all test results were received by the practice and all inadequate tests were followed up.

There were also areas of practice where the provider needs to make improvements.

Importantly, the provider must:

- Ensure there is an effective system for identifying, receiving, recording, handling and responding to complaints by patients and other persons in relation to the carrying on of the regulated activity.
- Ensure patients are protected from abuse and improper treatment.
- Ensure care and treatment is provided in a safe way to patients.
- Ensure persons employed in the provision of the regulated activity receive the appropriate support, training, professional development, supervision and appraisal necessary to enable them to carry out the duties.
- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.

Summary of findings

In addition the provider should:

- Ensure that all patients are treated with dignity and respect.
- Maintain appropriate standards of hygiene for premises and equipment.
- Review the system for promoting the availability of chaperones in the practice.
- Consider re-introducing a carers register with processes to identify carers so that sufficient support can be provided to them.

The provider of this service was suspended for six months, a care taking practice was put in place and the practice was placed in special measures in January 2017.

There had been some improvements made but more improvement was needed. The practice remained with a rating of inadequate and in special measures but the suspension was allowed to expire as it was recognised that the practice was unable to effectively bring about the changes required with the care taking practice in place.

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

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

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

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Inadequate

At our previous inspection on 4 and 10 January 2017, we rated the practice as inadequate for providing safe services as the arrangements in respect of the safe management of medicines, safeguarding, risk assessments including fire safety, recruitment processes, learning from incidents and significant events, staff training including chaperoning and infection control were not adequate.

These arrangements had improved when we undertook a follow up inspection on 6 July 2017; however further improvements were required. The practice is still rated as inadequate for providing safe services.

- There was a significant event policy, however not all staff members were able to locate it on the practice's computer system and no events had been recorded even though staff members gave us examples of recent significant events that occurred.
- There was no system to capture and respond to patient safety alerts.
- The process for prescribing repeat medicines did not always include a review of high risk medicines; for example we saw that mesalazine (a medicine used to treat inflammatory bowel disease) was prescribed for a patient who had not had a blood test in the previous 18 months as advised by NICE guidelines.
- The emergency medicines did not include ceftriaxone, (this is used for patients who are allergic to penicillin) and there was no water for injection
- There was insufficient attention to safeguarding children and vulnerable adults. There was a policy that not all staff members were able to locate and had not been fully embedded into practice. Staff members were unaware of who the practice safeguarding lead was or who the external contacts were and there were no safeguarding registers.
- There was a chaperone policy and staff who acted as a chaperone were trained for the role and had recently received Disclosure and Barring Service (DBS) checks. However when asked staff were unclear about how to perform chaperoning duties and told us they would stand outside the curtains during procedures.
- The cold chain was maintained, but we found out of date typhoid and flu nasal spray in the vaccine fridges.

Summary of findings

- The practice carried out an infection control audit, but this was not comprehensive and did not pick up on the patient chairs in the practice not being able to be wiped clean.
- The practice had a fire risk assessment and fire alarms installed. However there was no plan or system in place to ensure that these were regularly checked.
- We saw that Legionella testing had been carried out.
- All electrical and clinical equipment had been tested and calibrated to ensure that it was fit for purpose and in good working order.
- Patient Group Directions (PGD) had been adopted by the practice to allow nurses to administer medicines in line with legislation. PGD's are written instructions for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment.
- There were systems in place to ensure the regular monitoring of the defibrillator and oxygen in the practice.
- There was a failsafe mechanism for cervical cytology to ensure all test results were received by the practice and all inadequate tests were followed up.

Are services effective?

Inadequate

At our previous inspection on 4 and 10 January 2017, we rated the practice as inadequate for providing effective services as the arrangements in respect of limited patient outcomes, alerts from the Medicines and Healthcare Products Regulatory Agency (MHRA), clinical audits, high exception reporting and staff appraisal needed improving.

There had been insufficient improvement when we undertook a follow up inspection on 6 July 2017. The provider is still rated as inadequate for providing effective services.

- Information about patient outcomes was limited as little or no reference was made to audit or quality improvement and there was no evidence that the practice was comparing its performance to others either locally or nationally.
- The practice participated in the Quality Outcomes Framework (QOF); however they had not submitted any data and had no way of measuring performance and quality of care for patients with long term conditions.
- There was minimal engagement with other providers of health and social care and the practice did not participate in any peer review or multidisciplinary meetings.
- There was no evidence of appraisals or personal development plans.

Summary of findings

- Staff were aware of current evidence based guidance but there was no system to ensure that staff remained up to date and were following current guidance.
- End of life care was coordinated with other services involved including the GP out of hours provider.

Are services caring?

Requires improvement

At our previous inspection on 4 and 10 January 2017, we rated the practice as requires improvement for providing caring services as there was less than 1% of patient identified as a carer and there were no translation services available to patients.

When we undertook a follow up inspection on 6 July 2017 we found there was still no translation service available and the number of carer identified had decreased from 14 to zero. The practice is still rated as requires improvement for providing caring services.

- The practice did not offer a translation service; patients were expected to bring a family member or a friend to their appointment to act as a translator.
- The practice had identified none of its patients as a carer and had not considered ways in which they increase the number of patients on their register and provide help and support to them.
- The practice displayed some information about services available to patients.
- Data from the national GP survey showed patients rated the practice positively for care received.

Are services responsive to people's needs?

Inadequate

At our previous inspection on 4 and 10 January 2017, we rated the practice as requires improvement for providing responsive services as the arrangements in respect of reviewing the needs of the local population, offering online services and recording, investigating and learning from complaints needed improving.

There was little improvement when we undertook a follow up inspection on 6 July 2017. The practice is now rated as inadequate for providing responsive services.

- The practice had not reviewed the needs of its local population in the last three years.

Summary of findings

- Although the practice had a high number of working age patients, extended hours appointments were not offered. There was no practice website and patients were unable to book appointments or order repeat prescriptions online.
- The practice was a part of the local HUB which provided GP and nurse appointments to their patients on weekday evenings and weekends when the practice was closed.
- There was a complaints procedure and information advising patients of how to make a complaint. However there were some discrepancies amongst staff members as to what was classified as a complaint and how they were dealt with. There was no shared learning from complaints.
- The practice did not make use of their hearing loop.

Are services well-led?

Inadequate 

At our previous inspection on 4 and 10 January 2017, we rated the practice as inadequate for providing well-led services. This was because there was no shared vision for the practice, no clear leadership arrangements, no policies to govern activity, no formal induction process and staff had not received appraisals. There were issues with non-clinical staff training, there was no patient participation group and the practice did not proactively seek patient feedback. There were no formal practice meetings and the practice did not have a business continuity plan.

These arrangements had improved when we undertook a follow up inspection on 6 July 2017 but further improvement was still required. The practice is still rated as inadequate for providing well led services.

- The lack of fully implemented systems did not support the practice to achieve its vision.
- There was a leadership structure and staff felt supported by management; however not all staff members were aware of which staff led in key areas of practice.
- The practice had some policies and procedures to govern activity but these were not always completed or comprehensive. Not all staff members were able to locate them on the practice's computer system and they had not all been embedded into practice.
- Newly recruited staff members had not received an induction and no staff members had received an appraisal or had a personal development plan in place.

Summary of findings

- The practice told us that they carried out monthly formal practice meetings; however other than a meeting that occurred in response to the inspection announcement, these were not documented. There were no agendas, minutes or noted actions for learning and improvement.
- The practice did not have a completed business continuity plan and had not secured a buddy practice to be used if the premises were not accessible.
- All staff members had received mandatory training relevant to their role but there was no system to ensure that training remained up to date.
- The practice had a newly formed patient participation group formed to seek feedback from patients.

Summary of findings

The six population groups and what we found

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

Older people

Inadequate

The provider was rated as inadequate for safety, effectiveness, responsiveness and being well-led and requires improvement for being caring. The issues identified as being inadequate overall affected all patients including in this population group.

- For patients with the most complex needs, the named GP did not consistently work with the relevant health and social care professionals to deliver a multidisciplinary package of care.
- The practice offered home visits and urgent appointments for patients with enhanced needs.
- The practice did not hold identify any of its patients as a carer.
- Staff were able to recognise signs of abuse but not all staff were aware of how to escalate this.
- The practice did not participate in the unplanned admissions initiative, which aimed to keep older patients out of hospital and well at home.

People with long term conditions

Inadequate

The provider was rated as inadequate for safety, effectiveness, responsiveness and being well-led and requires improvement for being caring. The issues identified as being inadequate overall affected all patients including in this population group.

- Patient outcomes were limited as little or no reference was made to audit or quality improvement and there was no evidence that the practice was comparing its performance to others either locally or nationally.
- The practice participated in the Quality Outcomes Framework (QOF); however they had not submitted any data and had no way of measuring performance and quality of care for patients with long term conditions.
- The GP had the lead role in chronic disease management but patients at risk of hospital admission were not identified.
- Patents had a structured annual review to check that their health and medicine needs were being met. However there was no structured recall system to ensure that all required patients would be invited for an annual review.
- Care plans were informal and not comprehensive.
- For those patients with the most complex needs, the named GP did not consistently work with the relevant health and social care professionals to deliver a multidisciplinary package of care.

Summary of findings

- Longer appointments and home visits were available when needed.

Families, children and young people

Inadequate

The provider was rated as inadequate for safety, effectiveness, responsiveness and being well-led and requires improvement for being caring. The issues identified as being inadequate overall affected all patients including in this population group.

- There were no systems to identify and follow up patients in this group who were living in disadvantaged circumstances and who were at risk.
- The practice told us that their uptake for the cervical screening programme was 70%, which was below the CCG average of 78% and the national average of 81%. There was no policy to offer telephone reminders to patients who did not attend their cervical screening test. The practice could not demonstrate how they encouraged uptake of the screening programme. There were failsafe systems in place.
- Immunisation rates were comparable to CCG and lower than the national averages. For example, childhood immunisation rates for the vaccinations given to five year olds ranged from 65% to 92% compared to the CCG averages of 66% to 89% and the national averages of 88% to 94%.
- Appointments were available outside of school hours.
- Patient Group Directions (PGD) had been adopted by the practice to allow nurses to administer medicines in line with legislation. PGD's are written instructions for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment.

Working age people (including those recently retired and students)

Inadequate

The provider was rated as inadequate for safety, effectiveness, responsiveness and being well-led and requires improvement for being caring. The issues identified as being inadequate overall affected all patients including in this population group.

- The practice had a large number of working age patients but the services available did not reflect that; there was no practice website and patients were unable to book appointments or order repeat prescriptions online.
- The practice did not offer extended hours but was a part of a local HUB which provided weekday evening and weekend appointments with a GP or a nurse.

Summary of findings

- Health promotion advice was offered but there was limited accessible health promotion material available throughout the practice.

People whose circumstances may make them vulnerable

Inadequate

The provider was rated as inadequate for safety, effectiveness, responsiveness and being well-led and requires improvement for being caring. The issues identified as being inadequate overall affected all patients including in this population group.

- The practice did not have a vulnerable adult or safeguarding children register, the practice manager was aware of one at risk child but no other staff members including the GP were aware of this.
- There were no alerts on the clinical system to highlight whether a patient was vulnerable.
- The practice had a register of patients with a learning disability and carried out annual health checks, but there was no system to ensure that all these patients were called for an annual review and no evidence that patients had been discussed as part of a multidisciplinary review.
- Care plans were informal and not comprehensive.
- Not all staff members were sure about how to access safeguarding policies or who the lead was in the practice as well as who the external contacts were.
- All staff members had completed vulnerable adults training.

People experiencing poor mental health (including people with dementia)

Inadequate

The provider was rated as inadequate for safety, effectiveness, responsiveness and being well-led and requires improvement for being caring. The issues identified as being inadequate overall affected all patients including in this population group.

- The practice participated in the Quality Outcomes Framework (QOF); however they had not submitted any data and had no way of measuring performance and quality of care for patients with poor mental health or people with dementia.
- The practice had not worked in multidisciplinary teams in the case management of people experiencing poor mental health.
- The practice did not carry out advanced care planning for patients with dementia.
- The practice did not have systems in place to follow up patients who had attended accident and emergency where they may have been experiencing poor mental health.

Summary of findings

- The GP administered injectable medicines for patients with mental illness but there was no system in place to follow up non-attenders.
- The practice informed patients experiencing poor mental health about support groups and voluntary organisations.

Summary of findings

What people who use the service say

The national GP patient survey results were published in July 2016. The results below show the practice was performing comparably to local and national averages. Three hundred and fourteen survey forms were distributed and 101 were returned. This represented 3% of the practice's patient list.

- 74% 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 71%.
- 84% 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 82% the national average of 84%.
- 78% of patients described the overall experience of this GP practice as good compared to the national average of 85%.
- 79% 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 75% and the national average of 77%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 84 comment cards which were all positive about the standard of care received. There was a recurring theme of friendly caring and caring staff members, however 12 comment cards highlighted long waiting times and four mentioned difficulty in getting through to the practice by telephone.

We spoke with 12 patients during the inspection. All 12 patients said they were satisfied with the care they received and felt involved in decisions and treatment options made about their care. Patients also noted that staff were approachable, committed and caring but some also mentioned difficulty in getting through to the practice by telephone.

Areas for improvement

Action the service MUST take to improve

Importantly, the provider must:

- Ensure there is an effective system for identifying, receiving, recording, handling and responding to complaints by patients and other persons in relation to the carrying on of the regulated activity.
- Ensure patients are protected from abuse and improper treatment.
- Ensure care and treatment is provided in a safe way to patients.
- Ensure persons employed in the provision of the regulated activity receive the appropriate support, training, professional development, supervision and appraisal necessary to enable them to carry out the duties.
- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.

Action the service SHOULD take to improve

In addition the provider should:

- Ensure that all patients are treated with dignity and respect.
- Maintain appropriate standards of hygiene for premises and equipment.
- Review the system for promoting the availability of chaperones in the practice.
- Consider re-introducing a carers register with processes to identify carers so that sufficient support can be provided to them.

Dr Sergio De Cesare

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC lead inspector; the team included a second CQC inspector, a GP specialist advisor, a practice nurse specialist advisor and a practice manager specialist advisor.

Background to Dr Sergio De Cesare

Dr Sergio De Cesare (known locally as Cherry Tree Surgery) is located in a converted terraced house on the borders of Barnet and Haringey and is a part of Barnet Clinical Commissioning Group (CCG). The practice has good transport links and there is free parking on the surrounding roads.

There are approximately 3,300 patients registered at the practice, 40% of patients have a long standing health condition, which is lower than the CCG and national averages of 49% and 54%. The practice also has a higher proportion of patients in paid work or full time education than the national average at 78% compared to the CCG average of 66% and the national average of 62%. Eleven percent of the practice population is aged over 65; this is lower than the CCG average of 14% and the national average of 17%.

The practice provides nine GP sessions per week and two nursing sessions per week. There is a practice manager who is supported by the caretaking practice and three reception/administration staff members.

The practice operates under a General Medical Services (GMS) contract (a contract between NHS England and general practices for delivering general medical services and is the most common form of GP contract).

The practice is open Monday to Friday between 8am and 6:30pm except Thursdays when the practice closes at 1pm to complete administration tasks. Phone lines are answered from 8am and appointment times are as follows:

- Monday 9am to 12pm and 3pm to 5pm
- Tuesday 9am to 11pm and 3pm to 5pm
- Wednesday 9am to 11pm and 2:15pm to 5pm
- Thursday 9:10am to 12:30pm
- Friday 9am to 11am and 3pm to 5pm

The locally agreed out of hours provider covers calls made to the practice whilst the practice is closed including directing patients to services such as 111.

Dr Sergio De Cesare operates regulated activities from one location and is registered with the Care Quality Commission to provide family planning, surgical procedures, treatment of disease, disorder or injury, maternity and midwifery services and diagnostic and screening procedures.

Why we carried out this inspection

We inspected this service as part of our comprehensive programme. This service had previously been inspected in January 2017 and the overall rating for the practice was inadequate. Following the inspection in January 2017 urgent action was taken to suspend the provider for six months, the service was placed in special measures and a caretaking practice was then appointed as the new

provider of services at this location. The full comprehensive report published in May 2017 can be found by selecting the 'all reports' link for Dr Sergio De Cesare on our website at www.cqc.org.uk.

We undertook a further announced comprehensive inspection of Dr Sergio De Cesare on 6 July 2017. This inspection was carried out following a six month period of suspension and special measures to assess whether sufficient improvements had been made.

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations such as NHS England and the caretaking practice to share what they knew. We carried out an announced visit on 6 July 2017. During our visit we:

- Spoke with a range of staff including a GP, a nurse, a practice manager and reception staff members. We also spoke with patients who used the service.
- Reviewed the practice's action plan, which was made as a result of the outcomes of the inspection in January 2017.
- Observed how patients were being cared for in the reception area and talked with carers and/or family members.
- Reviewed a sample of the personal care or treatment records of patients.
- Reviewed comment cards where patients and members of the public shared their views and experiences of the service.
- Looked at information the practice used to deliver care and treatment plans.

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

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

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

- older people
- people with long-term conditions
- families, children and young people
- working age people (including those recently retired and students)
- people whose circumstances may make them vulnerable
- people experiencing poor mental health (including people 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

At our previous inspection on 4 and 10 January 2017, we rated the practice as inadequate for providing safe services as the arrangements in respect of the safe management of medicines, safeguarding, risk assessments including fire safety, recruitment processes, learning from incidents and significant events, staff training including chaperoning and infection control were not adequate.

These arrangements had improved when we undertook a follow up inspection on 6 July 2017; however further improvements were required. The practice is still rated as inadequate for providing safe services.

Safe track record and learning

The system for reporting and recording significant events was not effective.

- There was a significant event policy and recording form available on the practices computer system. This supported the recording of notifiable incidents under the duty of candour. The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment. However not all staff members were able to locate the significant event policy or form on the computer system.
- Staff told us they would inform the practice manager of any incidents and gave examples including a prescription being sent to the wrong pharmacy; however we saw that no significant events had been recorded.
- There were no processes for recording or managing patient safety alerts. We gave staff members the example of the recent cyber-attack safety alert and they could not evidence how they acted upon it.
- The practice was unable to demonstrate how lessons were shared and action taken as a result. We were told that the practice held regular practice meetings, however there were no minutes and no agendas documented.

Overview of safety systems and process

The practice's processes and systems to minimise risks to patient safety were not embedded.

- The practice's safeguarding policy reflected relevant legislation and local requirements, however not all staff members were able to locate the safeguarding policy on the practice's computer system. The policy did not clearly outline who to contact for further guidance if staff had concerns about a patients' welfare and all reception staff members told us that the GP was the current safeguarding lead, when it was in fact the caretaking practice. Although there was an external safeguarding contact list in the reception area, staff members were not aware of this and did not know who to contact in the event that a lead was not available.
- Staff we interviewed told us they would report any safeguarding concerns to the GP. We saw that GPs and the nurse were trained to child safeguarding level three and non-clinical staff were trained to level one.
- The practice did not have a vulnerable adults or child safeguarding register, the practice manager told us that there was one child that should be on the register but the GP was unaware of this.
- Whilst observing the reception area, we saw that a reception staff member gave confidential information to a patients' family member.
- There was a chaperone policy, that was not specific to the practice and not all members of staff were able to locate it on the practice's computer system. All staff members had received chaperone training, however reception staff members told us that they would stand outside the curtains during consultations and there were no chaperone posters in the consultation rooms advising patients that this was available.
- All staff members had received a Disclosure and Barring Service (DBS) check. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).

The practice maintained appropriate standards of cleanliness and hygiene.

- We observed the premises to be clean and tidy. There were cleaning schedules and monitoring systems in place.

- The practice manager was the infection prevention and control (IPC) lead, there was an IPC protocol and staff had received up to dare training. The practice had undertaken an IPC audit but this was not comprehensive and did not highlight that the chairs in the practice were not wipe clean. There was no action plan made as a result of the audit.

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

- There were processes for handling repeat prescriptions, this did not always include a review of high risk medicines; for example we saw that mesalazine (a medicine used to treat inflammatory bowel disease) was prescribed for a patient who had not had a blood test in the previous 18 months as advised by NICE guidelines.
- The practice carried out regular medicines audits with the support of the local clinical commissioning group pharmacy teams with the aim of making sure prescribing was in line with best practice guidelines for safe prescribing. Hand written prescription pads were securely stored in a locked cabinet in the GP consulting room; all other blank prescriptions were kept out of sight but were not securely stored. Patient Group Directions (PGD) had been adopted by the practice to allow nurses to administer medicines in line with legislation. PGDs are written instructions for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment.

Two new reception staff members had been recruited since the inspection in January 2017. We reviewed their personnel files and found appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, evidence of satisfactory conduct in previous employment in the form of references and appropriate checks through the DBS. However these staff members had not completed an induction process.

Monitoring risks to patients

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

- The practice had a health and safety policy but not all reception staff members were able to locate it on the practice's computer system.
- The practice had an up to date fire risk assessment. All staff members had received up to date fire training and there were designated fire marshals within the practice. There was a fire evacuation plan which identified how staff could support patients with mobility problems to vacate the premises. This system was introduced in June 2017 along with the fire risk assessment and installation of a fire alarm system. Testing of the processes had not yet been carried out and the practice manager was unable to provide us with proposed dates or plans for ongoing monitoring and fire alarm testing or fire drills.
- All electrical and clinical equipment was checked and calibrated to ensure it was safe to use and in good working order.
- The practice had a cold chain policy and monitored the temperature of the vaccine fridge daily to ensure that medicines were stored within the optimum temperatures advised by the manufacturers. However although the practice had a policy to check that medicines remained in date, we found an out of date typhoid vaccine in the vaccine fridge in the nurse's room and out of date nasal flu spray in the vaccine fridge in the GP's room.
- The practice had a legionella risk assessment in place, which highlighted that the practice was a very low risk (Legionella is a term for a particular bacterium which can contaminate water systems in buildings).
- There were arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. All staff booked annual leave in advance and there was a rota system to ensure enough staff were on duty to meet the needs of patients.

Arrangements to deal with emergencies and major incidents

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

- There was an instant messaging system on all computers in the practice which alerted staff to any emergency. However, not all staff members we spoke with were aware of this system. There were panic

buttons in all rooms. However, reception staff members showed us a button where they would have to physically get up from their desk and walk over to it in the case of emergency.

- All staff members had received basic life support training. There were emergency medicines available in the consulting room. However, there was no process for monitoring that there were adequate stocks and that these remained in date and diazepam was kept in an unlocked drawer. The practice did not have a supply of ceftriaxone, (this is used for patients who are allergic to penicillin) and there was no water for injection. No risk assessment was carried out to mitigate against the risks of not having supplies of this. We saw that disposable clinical equipment was in date.
- The practice had a defibrillator available on the premises. We saw that this was in good working order. There was oxygen with adult and children's masks however there was no system for monitoring that this was in good working order and we were told that this had never been used.
- The practice's business continuity plan had not been completed and there were discrepancies about where the clinical system back up tapes were stored. The plan stated that tapes not in use would be stored in a locked cabinet, however we saw that one was kept on a shelf in the practice managers' room and another was kept in the practice manager's bag which he took home with him and did not lock away.

Inadequate

Are services effective?

(for example, treatment is effective)

Our findings

At our previous inspection on 4 and 10 January 2017, we rated the practice as inadequate for providing effective services as the arrangements in respect of limited patient outcomes, alerts from the Medicines and Healthcare Products Regulatory Agency (MHRA), clinical audits, high exception reporting and staff appraisal needed improving.

There had been insufficient improvement when we undertook a follow up inspection on 6 July 2017. The provider is still rated as inadequate for providing effective services.

Effective needs assessment

The systems to ensure that clinicians were aware of relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines were not effective.

- There was no system to ensure clinical staff were kept up to date with the latest guidance. Staff had access to guidelines from NICE and used this information to deliver care and treatment that met patients' needs. Staff had the responsibility for ensuring that they kept themselves up to date and there were no systems for monitoring this.
- The practice was unable to demonstrate when asked that they had a process for acting on patient safety alerts. The practice was unable to give any examples of alerts that were relevant or irrelevant to their practice or any action taken even when prompted by the inspection team with known recent relevant safety alerts.

Management, monitoring and improving outcomes for people

Although the practice participated in the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients (QOF is a system intended to improve the quality of general practice and reward good practice), they had not submitted their data as required by NHS England through a system called Calculating Quality Reporting Service (CQRS).

Therefore the practice was unable to demonstrate outcomes and quality improvement for patients with long term conditions or national screening targets such as cytology screening.

The practice was unable to demonstrate quality improvement including clinical audit.

- We were told that there had been no audits undertaken since the last inspection where we were shown one audit that was not a completed and had no evidence of how action led to improvement.
- The practice did not participate in peer review and did not take part in multi-disciplinary meetings. We were told that local benchmarking was provided by the CCG but the practice was unable to tell us how they used this information to inform the services they provided to their patients.

The practice was unable to demonstrate how they monitored information about patient outcomes and use this information to make improvements to patient care.

Effective staffing

Systems in place to monitor staff training and development needs were not effective.

- The practice had an induction programme for all newly appointed staff. This covered topics such as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality. However we saw that this had not been used for newly appointed members of staff.
- Although the nurse was up to date with role specific training, for example cytology and immunisation updates there were no processes in place to monitor this.
- The practice did not have a means of effectively identifying the learning needs of staff. We were told that this happens through general discussions but the practice could not evidence this. We found no completed appraisals on record and no evidence of meetings and reviews of the practice development needs. All staff members had received mandatory training such as basic life support, safeguarding, infection control and chaperoning but the learning had

not fully been embedded into practice. For example, not all staff were aware of who the leads were in the practice and there was no system to highlight when training needed to be updated.

Coordinating patient care and information sharing

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

- This included care and risk assessments, informal care plans, medical records and test results.
- The practice shared relevant information with other services in a timely way when referring patients to other services.
- We noted that there were no alerts on the clinical system to highlight to staff members to patients that were vulnerable such as patients on the palliative care register and patients with learning disabilities.
- The practice had no call or recall system for patients with long term conditions, two patients we spoke with told us they had never been recalled for annual diabetes review.

Staff could not demonstrate how they worked together and with other health and social care professionals to understand and meet the range of complexity of patients' needs and 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. The practice was not a part of any multidisciplinary meetings with other health care professionals where care plans could routinely be reviewed and updated for patients with complex needs.

Consent to care and treatment

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

- Staff understood the relevant consent and decision making requirements of legislation and guidance, including the Mental Capacity Act 2005.
- Where a patient's mental capacity to consent to care or treatment was unclear, the GP or practice nurse assessed the patient's capacity and recorded the outcome of the assessment.
- The process for obtaining consent was recorded in the patient record but there was no process for monitoring this.

Supporting patients to live healthier lives

The practice identified patients who may be in need of extra support. For example:

- Patients with a long term condition, those requiring advice on their diet, smoking and alcohol cessation. Patients were signposted to the relevant service.
- A dietician was available from a local support group and smoking cessation advice was available on the premises.

The practice told us that their uptake for the cervical screening programme was 70%, which was below the CCG average of 78% and the national average of 81%. There was no policy to offer telephone reminders to patients who did not attend their cervical screening test. The practice could not demonstrate how they encouraged uptake of the screening programme and there was a failsafe system in place to ensure that results were received for all samples sent for the cervical screening programme. The practice followed up women who were referred as a result of abnormal results; however the practice did not have a system to monitor inadequate cervical cytology rates.

There were no system for the practice to improve uptake or encourage its patients to attend national screening programmes for bowel and breast cancer screening. However the practice was not an outlier in this area and was comparable to the CCG and national averages. For example 64% of female patients aged 50 to 70 were screened for breast cancer in last 36 months, which was similar to the CCG average of 68% and the national average of 72%. Fifty percent of patients aged 60 to 69 were screened for bowel cancer in last 30 months, which was similar to the CCG average of 49% and the national average of 58%.

We asked practice staff members what their childhood immunisation rates were and we were told that they do not know. Care Quality Commission insight data from 1 April 2015 to 31 March 2016 showed that immunisation rates for children under two years was below the national average ranging from 67% to 73% compared to the national

Inadequate

Are services effective?

(for example, treatment is effective)

average of 90%. Immunisation rates for the vaccinations given to five year olds ranged from 65% to 92% compared to the CCG averages of 66% to 89% and the national averages of 88% to 94%.

Patients had access to appropriate health assessments and checks. These included health checks for new patients and NHS health checks for patients aged 40–74. Appropriate follow-ups for the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.

Requires improvement

Are services caring?

Our findings

At our previous inspection on 4 and 10 January 2017, we rated the practice as requires improvement for providing caring services as there was less than 1% of patient identified as a carer and there were no translation services available to patients.

When we undertook a follow up inspection on 6 July 2017 we found that there was still no translation services available and the number of carers identified had decreased to zero. The practice is still rated as requires improvement for providing caring services.

Kindness, dignity, respect and compassion

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

- Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- We noted that consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- Reception staff knew when patients wanted to discuss sensitive issues or appeared distressed they could offer them a private area to discuss their needs.
- Whilst observing the reception area, we saw that a parent attending the practice 20 minutes late for an appointment for their child aged under two was asked to re-book the appointment without first consulting with the GP. We spoke with the receptionist who then asked the GP whether the child could still be seen to which the GP said yes. We spoke about this with the practice manager who told us that this occurred as it was a routine appointment and was not an emergency booking. The GP informed us that there was an informal policy for reception staff to consult with the GP before turning any patient away due to lateness.

All 84 comment Care Quality Commission comment cards we received were positive about the standard of care given. There was a recurring theme of friendly caring and caring staff members.

We spoke with 12 patients, which included some members of the patient participation group (PPG), they told us they were satisfied with the care provided by the practice and felt that they were always able to get an appointment when needed.

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

- 85% of patients said the GP was good at listening to them compared to the clinical commissioning group average of 88% and the national average of 89%.
- 83% of patients said the GP gave them enough time compared to the CCG average of 84% and the national average of 86%.
- 94% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 94% and the national average of 95%.
- 83% of patients said the last GP they spoke to was good at treating them with care and concern compared to the national average of 86%.
- 94% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the national average of 91%.
- 74% 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.

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

Requires improvement

Are services caring?

- 81% of patients said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 84% and the national average of 86%.
- 77% of patients said the last GP they saw was good at involving them in decisions about their care compared to the national average of 82%.
- 77% of patients said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average of 82% and the national average of 85%.

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

- All staff told us that translation services were not available for patients who did not have English as a first language. Reception staff told us that there was an expectation that patients would bring family or friends to interpret for them. There were no notices in the reception areas informing patients of this. There was no consideration by the practice of patients who did not have English as a first language who presented with a condition that would not be appropriate for a family member or a friend to interpret or for confidentiality issues in terms of giving results.
- There were posters displayed in the reception waiting area advising of services available.

Patient and carer support to cope emotionally with care and treatment

There were a limited number of patient leaflets available in the patient waiting area which told patients how to access support groups and organisations. The practice did not have a website where this information could also be advertised.

During the inspection in January 2017, we saw that the practice's computer system alerted GPs if a patient was a carer and 14 patient carers had been identified (less than 1%). When we carried out the follow up inspection there were no patient carers recorded on the practice's clinical system. The practice had no response to this and was given two days to run searches and let us know whether there had been an error in the system, but we received no further data or information. We saw that there was some information available to direct carers to the various avenues of support available to them and we were told that if identified, carers would be offered the annual influenza vaccine.

Staff told us that if families had suffered bereavement, their usual GP contacted them. 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.

Inadequate

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

At our previous inspection on 4 and 10 January 2017, we rated the practice as requires improvement for providing responsive services as the arrangements in respect of reviewing the needs of the local population, offering online services and recording, investigating and learning from complaints needed improving.

There was little improvement when we undertook a follow up inspection on 6 July 2017. The practice is now rated as inadequate for providing responsive services.

Responding to and meeting people's needs

The practice could not demonstrate how they reviewed the needs of its local population.

- Unlike at the previous inspection, the practice no longer offered extended hours for patients who could not attend the practice during normal working hours.
- We were told there were longer appointments available for patients with a learning disability; however we saw that there was no system for highlighting these patients on the practice's clinical system.
- Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice.
- The practice took account of the needs and preferences of patients with life-limiting progressive conditions. There were early and ongoing conversations with these patients about their end of life care as part of their wider treatment and care planning.
- Same day appointments were accessible for all patients and children and those patients with medical problems that require same day consultation would also be seen by a GP.
- The practice was a part of a local HUB, which provided GP and nursing appointments to patients on weekday evenings and on weekends.
- Patients were able to receive travel vaccines available on the NHS and those only available privately were referred to other clinics.
- There were no translation services available.
- The hearing loop was not connected for use.

Access to the service

The practice was open Monday to Friday between 8am and 6:30pm except Thursdays when the practice closed at 1pm to complete administration tasks. Phone lines were answered from 8am and appointment times were as follows:

- Monday 9am to 12pm and 3pm to 5pm
- Tuesday 9am to 11pm and 3pm to 5pm
- Wednesday 9am to 11pm and 2:15pm to 5pm
- Thursday 9:10am to 12:30pm
- Friday 9am to 11am and 3pm to 5pm

The locally agreed out of hours provider covered calls made to the practice whilst the practice was closed including directing patients to services such as 111.

Due to the use of locum GPs used by the caretaking practice there was no consistent system for how far in advance appointments could be pre-booked. There were same day urgent appointments available for people who needed them. 12 comment cards highlighted long waiting times and four mentioned difficulty in getting through to the practice by telephone.

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

- 70% of patients were satisfied with the practice's opening hours compared to the national average of 76%.
- 74% of patients said they could get through easily to the practice by phone compared to the national average of 71%.

On the day of inspection some patients told us they were no longer able to get an appointment when they needed them since the caretaking practice was put in place.

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.

Reception staff members informed GP's when there was a home visit request. GP's contacted the patient by phone to assess the urgency of need for a home visit. In cases where the urgency of need was so great that it would be

inappropriate for the patient to wait for a GP home visit, alternative emergency care arrangements were made. Clinical and non-clinical staff were aware of their responsibilities when managing requests for home visits.

Listening and learning from concerns and complaints

The system for handling complaints and concerns was not effective.

- The practice had a complaints policy that had not yet been fully embedded into practice procedures. The practice manager was unaware of any contractual obligations relating to complaints handling for GPs in England.
- The practice manager was the lead member of staff in charge of dealing with all complaints in the practice. He informed us that there had been two complaints received since the last inspection, one of which was dealt with by the caretaking practice and one which was dealt with by the practice manager. The complaint dealt with by the practice manager was from a patient who was not happy that they were contacted twice by the practice about the same set of tests result. The practice was not able to demonstrate how learning from this complaint and action taken as a result to ensure that it did not occur again was shared with all relevant members of staff.
- Reception staff members we spoke with gave examples of patient complaints that they wrote on pieces of paper at the request of patients and gave to the practice manager. We saw no records of this. The practice manager told us any complaint that was dealt with within 48 hours would fall outside of the complaints process and was not recorded as such and learning was not shared.
- We saw that information was available to help patients understand the complaints system. There was a complaints leaflet and a complaints poster displayed in the patient waiting area.

Are services well-led?

Inadequate

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

Our findings

At our previous inspection on 4 and 10 January 2017, we rated the practice as inadequate for providing well-led services as there was no shared vision for the practice, there were no clear leadership arrangements, there were no policies to govern activity and there was no formal induction process. Staff had not received appraisals, there were issues with non-clinical staff training, there was no PPG, the practice did not proactively seek patient feedback, there were no formal practice meetings and the practice did not have a business continuity plan.

These arrangements had improved when we undertook a follow up inspection on 6 July 2017 but further improvement was still required. The practice is still rated as inadequate for providing well-led services.

Vision and strategy

The lack of fully implemented systems in the practice did not support the GPs vision to deliver quality care.

- The practice did not have a mission statement and not all staff could demonstrate they understood the practice vision to deliver quality continuity of care.
- There were no strategies or supporting business plans reflecting the vision and values of the practice.

Governance arrangements

The practice's overarching governance framework did not support the delivery of the vision for good quality care. For example:

- Not all staff members were clear of the practices staffing structure especially in relation to the role of the caretaking practice staff members. Staff members were aware of their own roles but not always aware of the roles and responsibilities of other staff members including who led in which clinical areas.
- The practice had some policies and procedures to govern activities; however these were not all complete and comprehensive. The policies were not all embedded into practice and not all staff knew where to locate them on the practice's computer system.
- A comprehensive understanding of the performance of the practice was not maintained. The practice had not submitted their QOF data, public health data or their family and friends test data to the relevant bodies.
- There was no process for a programme of continuous clinical and internal audit to monitor quality and make improvements.
- There were arrangements for identifying risks; however there were not always systems in place for the ongoing monitoring of these.
- All staff had received mandatory training. The learning from this was not always embedded in practice and there was no system in place to ensure staff members remained up to date. For example staff members told us they would stand outside the curtains when undertaking chaperone duties.

Leadership and culture

On the day of inspection the GP explained that due to the small size of the practice premises and the caretaking practice being in place there was limited opportunity for him to be in the practice building to influence change. The GP was unable to demonstrate they had the experience, capacity and capability to run the practice and ensure high quality care. The GP has plans to reduce his clinical sessions by two in order to focus on the management of the practice. The practice manager also had plans to increase their working hours at the practice. Staff told us that the GP was approachable and always took time to listen to all members of staff.

The GP was aware of but had no systems in place to ensure compliance with the requirements of the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment). This included no support training for all staff on communicating with patients about notifiable safety incidents. The GP told us that he encouraged a culture of openness and honesty.

The practice had ineffective systems in place to handle when things went wrong with care and treatment.

- The practice did not keep written records of verbal interactions and written correspondence was not

Are services well-led?

Inadequate

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

always captured. There were discrepancies about what was classified as a complaint and how they were dealt with and learning was not always shared with all relevant staff members.

- There was insufficient documentation of events to establish whether patients were consistently provided with an apology or reasonable support.

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

- We were told that the practice held monthly formal practice meetings. However other than the practice meeting held as a result of the inspection announcement, the practice did not take minutes and there were no documented agendas.
- The practice was not a part of any multidisciplinary meetings with other health and social care professionals where complex and vulnerable patients could be discussed.
- Staff told us that there was an open culture within the practice and they felt comfortable raising any issues.
- Staff told us they felt respected, valued and supported, particularly by the practice manager. All staff we asked said they felt involved in discussions about how to run and develop the practice, and the GP encouraged all members of staff to identify opportunities to improve the service delivered by the practice. However when asked no examples of this were given.

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

The practice had a limited system for receiving feedback from patients and staff:

- Patients through the newly formed patient participation group (PPG), however only two meetings had taken place so far and it was too early for any patient suggestions to be put into place.
- The practice had not submitted any recent data for the NHS friends and family test and they were unable to demonstrate that they were providing patients with the survey forms to complete.
- There was no comment and suggestions box in reception for patients to leave feedback about services.
- We were told that as a result of complaints the number of same day bookable appointments was increased, but there was no documentation to support this.
- The practice could not demonstrate how they gathered feedback from staff members, staff told us they would not hesitate to give feedback, but there were no examples of when they had done this or when they had felt engaged and involved in improving how the practice was run.

Continuous improvement

The practice team could not demonstrate that they were part of local pilot schemes to improve outcomes for patients in the area. There were no completed audit cycles and the practice was not monitoring performance through available means such as QOF.

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 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 had not adequately assessed the risks to the health and safety of patients and done all that was reasonably practicable to mitigate any such risks. In particular:** 1. Systems were not in place to ensure significant events were recognised, recorded and dealt with effectively. There were no planned systems for checking the fire alarm was in good working order and there were no planned fire drills. 2. Processes to ensure that medicines were in date were not effective, we found out of date typhoid and nasal flu in the vaccine fridges. Supplies of diazepam were found in an unlocked cupboard. 3. Processes for prescribing repeat medicines did not always include a review of high risk medicines; for example we saw that mesalazine was prescribed without the patient receiving a blood test in the 18 months prior to the issue of the prescription. 4. You had not submitted any QOF data and had no systems in place to monitor outcomes and improve care and treatment for patients. **Regulation 12 (1), of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014**

This section is primarily information for the provider

Enforcement actions

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 **The Provider had not established adequate systems and processes to ensure compliance with the requirements of the fundamental standards as set out in the Health and Social care Act 2008 (Regulated Activities) Regulations 2014** 1. Policies and procedures to govern activities. were not comprehensive, some staff members were unsure of where to locate some policies and they were not all embedded into practice. 2. Staff had completed mandatory training but this was not embedded into practice for example, staff members stated they would stand outside of the curtains whist carrying out chaperoning duties. There were no systems or processes to ensure staff training was understood and embedded in practice and that all staff members remained up to date with their training. 3. Not all complaints reported to the practice were captured and documented and there was no evidence that these had been dealt with and there was no shared learning. 4. There was no comprehensive or completed business plan, this omission had not been identified by an effective system or process established to ensure compliance with the requirements. **Regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014**