Dr Risiyur Nagarajan (Queens Park Health Centre)

Quality Report

Dart Street
London
W10 4LD
Tel: 020 8960 5252
Website: No website

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Dr Risiyur Nagarajan (Queens Park Health Centre) on 7 January 2015. The overall rating for the practice was requires improvement. The full comprehensive report on the 7 January 2015 inspection can be found by selecting the 'all reports' link for Dr Risiyur Nagarajan on our website at www.cqc.org.uk.

This inspection was an announced comprehensive inspection carried out on 3 August 2017 to confirm that the practice had carried out their plan to meet the legal requirements in relation to the breaches in regulations that we identified in our previous inspection on 7 January 2015. This report covers our findings in relation to those requirements and any improvements made since our last inspection.

Overall the practice remains rated as requires improvement.

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

- Although risks to patients were assessed, the systems to address these risks were not implemented well enough to ensure patients were kept safe. For example, we found the processes and management of significant events, patient safety alerts and some aspects of prescription management required improvement.
- Staff demonstrated that they understood their responsibilities with regards safeguarding and we saw that clinical staff had been trained to safeguarding level three. However, non-clinical staff and a phlebotomist had not received safeguarding children training relevant to their role.
- Staff were aware of current evidence based guidance.
- Staff had been trained to provide them with the skills and knowledge to deliver effective care and treatment. However, there were gaps in training which the practice had identified as mandatory, for example, fire safety awareness and information governance.

Summary of findings

- There was evidence of appraisals for all employed staff but the practice did not have a formal induction programme for newly appointed staff.
- Results from the national GP patient survey showed patients were treated with compassion, dignity and respect and were involved in their care and decisions about their treatment.
- Information about services and how to complain was available.
- Patients we spoke with said they found it easy to make an appointment with a named GP and there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.
- The provider was aware of the requirements of the duty of candour. An example we reviewed showed the practice complied with these requirements.

The areas where the provider must make improvement are:

- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.
- 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.

The areas where the provider should make improvement are:

- Consider the infection control lead undertaking enhanced training to support them in this extended role.
- Review the fire evacuation procedure to ensure all staff understand, and continue to understand, the plan in the event of a fire.
- Review the process to regularly check that the shared defibrillator is ready for use at all times.
- Consider keeping a copy of the business continuity plan off site and include the names and contact details of all staff members.
- Continue to monitor patient outcomes in relation to the childhood immunisation and the cervical screening programme.
- Review the use of the urgent two-week referral pathway to ensure all patients within its criteria are being appropriately referred to improve early diagnosis and timely treatment.
- Consider including the long-term sessional GP in the appraisal programme.
- Continue to actively recruit a female GP and a practice nurse to enable patient preferences and outcomes to be met.
- Review how carers are identified and recorded on the clinical system to ensure information, advice and support is made available to them.
- Consider recording verbal complaints to capture all patient feedback in order to identify trends and enable learning.
- Consider developing a practice website.

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?

Requires improvement

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

- Although risks to patients were assessed, the systems to address these risks were not implemented well enough to ensure patients were kept safe. For example, we found the processes and management of significant events, patient safety alerts and some aspects of prescription management required improvement.
- Staff demonstrated that they understood their responsibilities with regards safeguarding and we saw that clinical staff had been trained to safeguarding level three. However, non-clinical staff and a phlebotomist had not received safeguarding children training relevant to their role.
- The practice had adequate arrangements to respond to emergencies and major incidents.

Are services effective?

Requires improvement

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

- Data from the Quality and Outcomes Framework (QOF) showed patient outcomes were comparable to the clinical commissioning group (CCG) and the national average for the majority of the QOF indicators. However, patient outcomes for cervical screening were significantly below local and national averages.
- Staff were aware of current evidence based guidance.
- Clinical audits demonstrated quality improvement.
- Staff had been trained to provide them with the skills and knowledge to deliver effective care and treatment. However, there were gaps in training which the practice had identified as mandatory, for example, fire safety awareness and information governance.
- There was evidence of appraisals for all employed staff but the practice did not have a formal induction programme for newly appointed staff.
- Staff worked with other health care professionals to understand and meet the range and complexity of patients' needs.
- End of life care was coordinated with other services involved.

Are services caring?

Good

The practice is rated as good for providing caring services.

Summary of findings

- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.
- Data from the national GP patient survey showed patients rated the practice comparable to others for several aspects of care. For example, 83% of patients said the last GP they spoke to was good at treating them with care and concern (CCG average 86%; national average 86%).
- Survey information we reviewed showed that patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. For example, 80% of patients said the last GP they saw was good at involving them in decisions about their care (CCG average 83%; national average 82%).
- Information for patients about the services available in the practice was available in several languages aligned to the practice demographic.
- A patient practice leaflet was available but the practice did not have a website.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services.

- The practice understood its population profile and had used this understanding to meet the needs of its population.
- The practice took account of the needs and preferences of patients with life-limiting conditions, including patients with a condition other than cancer and patients living with dementia.
- Patients we spoke with said they found it easy to make an appointment with a named GP and there was continuity of care. For example, 79% of patients usually get to see or speak to their preferred GP (CCG average 59%; national average 56%). Urgent appointments were available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- Information about how to complain was available and evidence from one example reviewed showed the practice responded quickly to issues raised.

Are services well-led?

Requires improvement

The practice is rated as requires improvement for being well-led.

- The practice told us they had a vision to deliver high quality care and promote good outcomes for patients. However, there was no formal written strategy or supporting business plan that detailed the short and long-term development objectives that the practice wanted to achieve.

Summary of findings

- Although the practice had an overarching governance framework which supported the delivery of good quality care, we found some arrangements were not implemented well enough to ensure patients were kept safe.
- There was a clear leadership structure and staff felt supported by management. The practice had policies and procedures to govern activity and held regular practice meetings.
- The practice had a mission statement which was displayed and staff knew and understood the values.
- The partners encouraged a culture of openness and honesty.
- The provider was aware of the requirements of the duty of candour and we saw evidence the practice complied with these requirements.
- The practice proactively sought feedback from staff and patients and we saw examples where feedback had been acted on. The practice engaged with the patient participation group.

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 requires improvement for safe, effective and well-led. The issues identified as requiring improvement overall affected all patients including this population group. However, there was evidence of some good practice.

- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs.
- The practice offered proactive, personalised care to meet the needs of the older patients in its population. For example, the practice liaised with local pharmacies regarding dossette boxes (a pill container and organiser for storing scheduled doses of a patient's medication) and repeat dispensing for this cohort.
- The practice identified at an early stage older patients who may need palliative care as they were approaching the end of life. It involved older patients in planning and making decisions about their care, including their end of life care.
- Older patients were provided with health promotional advice and support to help them to maintain their health and independence for as long as possible. In addition, patients requiring additional support could be referred to a Primary Care Navigator who helped signpost patients to health, social care and voluntary sector services.
- Staff were able to recognise the signs of abuse in older patients and knew how to escalate any concerns.
- The practice held regular multi-disciplinary team meetings with district nurses, community matrons, palliative care team, social services and the mental health team to coordinate and maintain the care of this cohort.

People with long term conditions

Requires improvement

The provider was rated as requires improvement for safe, effective and well-led. The issues identified as requiring improvement overall affected all patients including this population group. However, there was evidence of some good practice.

- GPs had lead roles in long-term disease management and patients at risk of hospital admission were identified as a priority.

Summary of findings

- Performance for diabetes related indicators was comparable to the CCG and national averages. For example, the percentage of patients with diabetes, on the register, in whom the last HbA1c was 64 mmol/mol or less in the preceding 12 months was 77% (CCG average 74%; national average 78%).
- The practice followed up on patients with long-term conditions discharged from hospital and ensured that their care plans were updated to reflect any additional needs.
- There were emergency processes for patients with long-term conditions who experienced a sudden deterioration in health.
- All these patients had a named GP and there was a system to recall patients for a structured annual review to check their health and medicines needs were being met. For those patients with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Requires improvement

The provider was rated as requires improvement for safe, effective and well-led. The issues identified as requiring improvement overall affected all patients including this population group.

- From the sample of documented examples we reviewed we found there were systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances.
- Immunisation rates were below target for standard childhood immunisations.
- Appointments were available outside of school hours and the premises were suitable for children and babies.
- The practice worked with midwives, health visitors and school nurses to support this population group. For example, in the provision of ante-natal, post-natal and child health surveillance clinics.
- The percentage of patients with asthma, on the register, who have had an asthma review in the preceding 12 months that includes an assessment of asthma control was 85% (CCG average 77%; national average 76%).
- The practice's uptake for the cervical screening programme was 48%, which was significantly below the CCG average of 75% and the national average of 81%.

Summary of findings

Working age people (including those recently retired and students)

Requires improvement

The provider was rated as requires improvement for safe, effective and well-led. The issues identified as requiring improvement overall affected all patients including this population group. However, there was evidence of some good practice.

- The needs of these populations had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care, for example, extended opening hours on Monday evening from 6.30pm to 8pm and telephone consultations.
- The practice was proactive in offering online services which included booking appointments and requesting repeat prescriptions.

People whose circumstances may make them vulnerable

Requires improvement

The provider was rated as requires improvement for safe, effective and well-led. The issues identified as requiring improvement overall affected all patients including this population group. However, there was evidence of some good practice.

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

People experiencing poor mental health (including people with dementia)

Requires improvement

The provider was rated as requires improvement for safe, effective and well-led. The issues identified as requiring improvement overall affected all patients including this population group. However, there was evidence of some good practice.

- The practice carried out advance care planning for patients living with dementia.

Summary of findings

- Patients at risk of dementia were identified and offered an assessment.
- The percentage of patients diagnosed with dementia who had had their care reviewed in a face-to-face meeting in the last 12 months was 94% (32 patients) compared with the CCG average of 85% and the national average 84%.
- The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive, agreed care plan documented in the record, in the preceding 12 months was 100% (23 patients) compared with the CCG average of 91% and the national average of 89% and the percentage of patients with schizophrenia, bipolar affective disorder and other psychoses whose alcohol consumption has been recorded in the preceding 12 months was 100% (23 patients) compared with the CCG average 89% and the national average of 89%.
- The practice had a system for monitoring repeat prescribing for patients receiving medicines for mental health needs.
- The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those living with dementia.
- The practice had information available for patients experiencing poor mental health about how they could access various support groups and voluntary organisations.
- The practice had a system to follow up patients who had attended accident and emergency where they may have been experiencing poor mental health.
- Staff interviewed had a good understanding of how to support patients with mental health needs and dementia.

Summary of findings

What people who use the service say

The national GP patient survey results were published in July 2017 for the most recent data. Three hundred and seventy seven survey forms were distributed and 96 were returned. This represented 3% of the practice's patient list and a completion rate of 19%. Results showed that the practice was rated comparable to other for aspects of patient experience.

- 84% of patients described the overall experience of this GP practice as good compared with the CCG average of 85% and the national average of 85%.
- 88% of patients described their experience of making an appointment as good compared with the CCG average of 77% and the national average of 73%.
- 79% of patients said they found it easy to get through to the surgery by phone compared with the CCG average of 84% and the national average of 71%.
- 79% of patients said they usually get to see or speak to their preferred GP compared to the CCG average of 59% and the national average of 56%.
- 74% of patients said they would recommend this GP practice to someone who has just moved to the local area as compared with the CCG average of 81% 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 17 comment cards which were all positive about the standard of care received. Patients told us they felt the practice offered an excellent and efficient service and staff were kind, helpful, caring and treated them with dignity and respect.

We spoke with two patients during the inspection; both of whom were satisfied with the care they received and thought staff were approachable, committed and caring.

Results of the Friends and Family Test (FFT) for the period February to June 2017 based on 20 Reponses showed that 90% of patients were extremely likely to recommend the practice and 10% were likely to recommend the practice. Additional comments from patients included friendly, kind and helpful practice.

Areas for improvement

Action the service MUST take to improve

- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.
- 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.

Action the service SHOULD take to improve

- Consider the infection control lead undertaking enhanced training to support them in this extended role.
- Review the fire evacuation procedure to ensure all staff understand, and continue to understand, the plan in the event of a fire.
- Review the process to regularly check that the shared defibrillator is ready for use at all times.
- Consider keeping a copy of the business continuity plan off site and include the names and contact details of all staff members.
- Continue to monitor patient outcomes in relation to the childhood immunisation and the cervical screening programme.
- Review the use of the urgent two-week referral pathway to ensure all patients within its criteria are being appropriately referred to improve early diagnosis and timely treatment.
- Consider including the long-term sessional GP in the appraisal programme.
- Continue to actively recruit a female GP and a practice nurse to enable patient preferences and outcomes to be met.

Summary of findings

- Review how carers are identified and recorded on the clinical system to ensure information, advice and support is made available to them.
- Consider recording verbal complaints to capture all patient feedback in order to identify trends and enable learning.
- Consider developing a practice website.

Dr Risiyur Nagarajan (Queens Park Health Centre)

Detailed findings

Our inspection team

Our inspection team was led by:

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

Background to Dr Risiyur Nagarajan (Queens Park Health Centre)

Dr Risiyur Nagarajan (Queens Park Health Centre) operates from a purpose-built health centre co-located with two other GP practices and community services. The practice is situated on the ground floor and has access to three consulting room. There is a shared waiting area and a dedicated reception desk.

The practice provides NHS primary care services to approximately 3,000 patients and operates under a General Medical Services (GMS) contract (a contract between NHS England and general practices for delivering general medical services and is the commonest form of GP contract).

The practice is part of NHS West London Clinical Commissioning Group (CCG).

The practice is registered with the Care Quality Commission (CQC) to provide the regulated activities of diagnostic and screening procedures, treatment of disease, disorder or injury and maternity and midwifery services.

The practice staff comprises of a male principal GP totalling eight sessions per week and a long-term sessional male GP five sessions per week. At the time of our inspection the practice did not have a female GP or a practice nurse. The clinical team are supported by a full-time job-share practice manager, a phlebotomist and a team of administration and reception staff.

The practice population is in the second most deprived decile in England. People living in more deprived areas tend to have greater need for health services.

The practice is open between 9am and 6.30pm on Monday, Tuesday, Wednesday and Friday and from 9am to 12.30pm on Thursday. Extended hours appointments are available on Monday from 6.30pm to 8pm. On Thursday afternoons and outside of normal opening hours patients are directed to a GP out-of-hours service or the NHS 111 service.

Why we carried out this inspection

We undertook an announced comprehensive inspection at Dr Risiyur Nagarajan (Queens Park Health Centre) on 7 January 2015 under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The overall rating for the practice was requires improvement. The full comprehensive report on the 7 January 2015 inspection can be found by selecting the 'all reports' link for Dr Risiyur Nagarajan on our website at www.cqc.org.uk.

We undertook a follow-up announced comprehensive inspection of Dr Risiyur Nagarajan (Queens Park Health

Detailed findings

Centre) on 3 August 2017. This inspection was carried out to review in detail the actions taken by the practice to improve the quality of care and to confirm that the practice was now meeting legal requirements.

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 3 August 2017. During our visit we:

- Spoke with a range of staff which included the principal GP, a locum GP, a phlebotomist, the practice manager and reception staff.
- 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.
- Spoke with patients who used the service and reviewed comment cards where patients and members of the public shared their views and experiences of the service.
- Inspected the facilities, equipment and premises.
- Reviewed a wide range of documentary evidence including policies, written protocols and guidelines, recruitment and training records, safeguarding referrals, significant events, patient survey results, complaints, meeting minutes and performance data.

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 living with dementia).

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

Requires improvement

Are services safe?

Our findings

At our previous inspection on 7 January 2015, we rated the practice as requires improvement for providing safe services as the arrangements in respect of the management of medical emergencies and medicine management required improvement.

Although the practice had made improvements and addressed the findings of our previous inspection, at our follow-up inspection on 3 August 2017 we found additional areas of concern in relation to significant events, patient safety alerts and some aspects of prescription management. The practice remains rated as requires improvement.

Safe track record and learning

Although there was a system for reporting and recording significant events this required improvement.

- The practice had an incident management policy which had been reviewed in March 2017. The policy was comprehensive and included examples of what constituted a significant event to guide staff. However, the policy contained out of date information, for example, it referenced significant event reporting being a requirement of the Quality and Outcome Framework (QOF). The organisational indicator (Education 7) which required a practice to undertake a minimum of 12 significant event reviews in the preceding 12 months was retired from QOF from 2013/14.
- The practice had recorded only one significant events for the past 12 months and records showed that prior to that the last significant event had been recorded in 2014. This did not correlate with the comprehensive list of what constituted a significant event outlined in the policy.
- Staff told us they would inform the practice manager of any incidents who would record onto a significant event form. The incident recording form supported the recording of notifiable incidents under the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).
- The practice had not monitored trends in significant events due to the small number recorded.

The practice told us that patient safety alerts and MHRA (Medicines and Healthcare Regulatory Agency) alerts were received via email by the practice manager and disseminated to staff. However, the practice could not demonstrate that they had a process and system in place to ensure all alerts had been received, reviewed, appropriate action taken and shared with staff.

Overview of safety systems and processes

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

- Arrangements for safeguarding reflected relevant legislation and local requirements. Policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. There was a lead member of staff for safeguarding and staff we spoke with knew who this was.
- We observed safeguarding key contact details and referral flowcharts displayed in consultation rooms.
- Staff interviewed demonstrated they understood their responsibilities regarding safeguarding. GPs were trained to child safeguarding level 3. However, none of the non-clinical staff, including the phlebotomist, had undertaken safeguarding children training relevant to their role. All staff had received safeguarding adult training.
- We found that the GPs attended safeguarding meetings when possible or provided reports where necessary for other agencies.
- A notice in the waiting room and in all consulting rooms advised patients that chaperones were available if required. This information was provided in English, Portuguese and Bengali which the practice had identified represented their patient demographic. There was a chaperone policy and guidance accessible to staff. All staff who acted as chaperones were trained for the role and had received an Enhanced 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.

Requires improvement

Are services safe?

- The phlebotomist was the infection prevention and control (IPC) lead with the support of the principal GP. We saw evidence that all staff had undertaken on-line IPC training. However, the lead for IPC had not undertaken any enhanced training to support the responsibilities of the role.
- There was an IPC protocol which included waste management and the safe handling of sharps and spillages. We observed that each consulting room had information displayed on good handwashing techniques, how to deal with a sharps injury and was well equipped with personal protective equipment and waste disposal facilities. All staff we spoke with knew the location of the bodily fluid spill kits and had access to appropriate personal protective equipment when handling specimens at the reception desk. An external IPC audit had been undertaken in February 2016 by the CCG and an internal audit had been undertaken in April 2017 by the IPC lead and the practice manager. We saw evidence that action was taken to address any improvements identified as a result, for example, sharps bins which were not filled to the appropriate level were disposed after three months. On the day of the inspection we observed that sharps waste was managed in line with guidance.

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

- There were processes for handling repeat prescriptions which included the review of high risk medicines. Repeat prescriptions were signed before being dispensed to patients and there was a reliable process to ensure this occurred. However, there was no system in place to monitor that prescriptions had been collected and we noted that there were some prescriptions outstanding collection from 2016.
- Blank prescription forms and pads not in use were stored in a locked cupboard. However, there was no system in place to track their use in line with guidance.
- The practice carried out medicines audits, with the support of the local clinical commissioning group pharmacy teams, to ensure prescribing was in line with best practice guidelines for safe prescribing.
- There were dedicated vaccine storage refrigerators with built-in and secondary thermometers. We saw evidence that the minimum, maximum and actual temperatures were recorded daily. All staff we spoke with knew what action to take should the temperature read under or over the recommended temperature range, which staff had not been able to demonstrate on our inspection of 7 January 2015.

We reviewed six personnel files of all staff including a locum GP file and found appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, evidence of satisfactory conduct in previous employments in the form of references, qualifications, registration with the appropriate professional body and the appropriate checks through the DBS.

Monitoring risks to patients

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

- The premises were managed by NHS Property Estates who provided facilities management for the premises. We saw that risk assessments to monitor safety of the premises such as control of substances hazardous to health, health and safety and legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings) had been carried out.
- There was a health and safety policy available and a health and safety poster located in a staff area which included contact details of responsible individuals within the practice.
- Each clinical room was appropriately equipped and we saw evidence that the equipment was maintained. This included checks of electrical equipment and equipment used for patient examinations. We saw evidence of calibration of equipment used by staff was undertaken annually and was tested in March 2017 and that portable electrical appliances had been checked in August 2016.
- There was a fire alarm warning system, which was tested weekly, and firefighting equipment in place. We saw evidence that these were regularly maintained by an external contractor. The practice had undertaken a fire risk assessment and there was a fire policy in place which was accessible to staff. The practice had identified a fire marshal and staff we spoke with knew who this was and the location of the fire evacuation assembly point. However, staff told us that there had not been a

test fire evacuation drill for more than a year. Furthermore, staff had not undertaken formal fire awareness training which was included in the fire policy and fire risk assessment as a requirement.

- There were arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system to ensure enough staff were on duty to meet the needs of patients. The practice discussed its challenges to recruit a substantive female GP and a practice nurse and we saw evidence that the practice were actively recruiting for a female GP.

Arrangements to deal with emergencies and major incidents

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

- There was an instant messaging system on the computers in all the consultation rooms which alerted staff to any emergency. All staff we spoke with knew how to activate and respond to the alert system.
- There was a shared defibrillator available on the premises which was maintained by NHS Property Estates. We noted that this had been calibrated within the last 12 months; a defibrillator pad was available and in date and it was in working order. However, we were unable to verify on the day of the inspection who checked that this was working on a regular basis as there was no log book available. All staff had received annual basis life support training which included the use of a defibrillator.
- At our previous inspection in January 2015 the practice did not have access to oxygen for use in medical emergencies. At our inspection on 3 August 2017 the practice had oxygen with adult and children's masks available. We saw evidence that there was appropriate signage on the door of the room where it was stored and that it was regularly checked and a log maintained. All staff we spoke with knew the location of the oxygen.
- 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 for major incidents such as power failure or building damage. We saw evidence that the business continuity plan had been activated as a result of a short electricity outage and an IT interruption. However, we noted that the plan did not include emergency contact numbers for staff and a copy was not kept off site. The practice had established a 'buddy' system with its co-located practices but not with any external practices should access to the building be denied.

Requires improvement

Are services effective?

(for example, treatment is effective)

Our findings

At our previous inspection on 7 January 2015, we rated the practice as requires improvement for providing effective services as the arrangements in respect of staff training, consent, clinical oversight when dealing with patient test results, letters, referrals and care plans and patient outcomes required improvement.

Although the practice had addressed and made improvements for the majority of the findings of our previous inspection, at our follow-up inspection on 3 August 2017 we found staff induction and training, and the system to manage two-week wait referrals required improvement. Patient outcomes for cervical screening and childhood immunisations remained lower than the local and national averages. The practice remains rated as requires improvement.

Effective needs assessment

Clinicians we spoke with were aware of relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines.

- The practice had systems to keep all clinical staff up to date. Staff had access to guidelines from NICE and local guidelines and used this information to deliver care and treatment that met patients' needs.

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent published results were 92% of the total number of points available (CCG 92%; national 95%) with 15% clinical exception reporting (CCG 10%; national average 10%). (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). We found that this was a significant improvement from our previous inspection on 7 January 2015 when the practice QOF achievement had been 42% compared to the CCG average of 89% and the national average of 92%.

Data from 2015/16 showed that apart from cervical screening, the practice was not an outlier for QOF (or other national) clinical targets.

Performance for diabetes related indicators was comparable to the CCG and national averages. For example:

- The percentage of patients with diabetes, on the register, in whom the last HbA1c was 64 mmol/mol or less in the preceding 12 months was 77% (CCG average 74%; national average 78%) with a practice exception reporting of 20% (CCG average 12%; national 12%);
- 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 92% (CCG average 76%; national average 78%) with a practice exception reporting of 7% (CCG average 10%; national average 9%);
- The percentage of patients with diabetes, on the register, whose last measured total cholesterol (measured within the preceding 12 months) is 5 mmol/l or less was 85% (CCG average 76%; national average 80%) with a practice exception reporting of 22% (CCG average 11%; national average 13%).

Performance for mental health related indicators was above CCG and national averages. For example:

- The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive, agreed care plan documented in the record, in the preceding 12 months was 100% (23 patients) compared with the CCG average of 91% and the national average of 89% with a practice exception reporting of zero per cent (CCG average 9%; national average 13%);
- The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses whose alcohol consumption has been recorded in the preceding 12 months was 100% (23 patients) compared with the CCG average 89% and the national average of 89% with a practice exception reporting of 4% (CCG average 7%; national average 10%);
- The percentage of patients diagnosed with dementia who had had their care reviewed in a face-to-face meeting in the last 12 months was 94% (32 patients) compared with the CCG average of 85% and the national average 84% with a practice exception reporting of 3% (CCG average 7%; national average 7%).

Requires improvement

Are services effective?

(for example, treatment is effective)

Performance for respiratory-related indicators was comparable to the CCG and national averages. For example:

- The percentage of patients with asthma, on the register, who have had an asthma review in the preceding 12 months that includes an assessment of asthma control was 85% (CCG average 77%; national average 76%) with a practice exception reporting of 3% (CCG average 4%; national average 8%);
- The percentage of patients with chronic obstructive pulmonary disease (COPD) who had a review undertaken including an assessment of breathlessness was 100% (13 patients) compared with the CCG average of 86% and the national average of 90%) with a practice exception reporting of 8% (CCG average 11%; national average 12%);
- The percentage of patients with physical and/or mental health conditions whose notes record smoking status in the preceding 12 months was 98% (CCG average 95%; national average 95%) with a practice exception reporting of 0.9% (CCG average 1.2%; national average 0.8%).

There was some evidence of quality improvement including clinical audit:

- There had been two clinical audits commenced in the last two years, both of which were completed audits where the improvements made were implemented and monitored.
- Findings were used by the practice to improve services. For example, one audit we reviewed was to determine the appropriateness of gynaecological referrals to secondary care to ascertain whether patients could have been appropriately managed in primary care. A random sample of 19 patients showed that all referrals from the practice were appropriate and within NICE or local guideline referral criteria. To ensure this standard was maintained, a second audit was completed. Findings were peer reviewed and benchmark with neighbouring practices to share learning and best practice.

Effective staffing

Although staff had the skills and knowledge to deliver effective care and treatment this required improvement.

- The practice did not have a formal induction programme for newly appointed staff.
- Staff had received training which included safeguarding adults, infection prevention and control and basic life support. However, staff had not received fire safety awareness or information governance training and non-clinical staff and a phlebotomist had not received safeguarding children training relevant to their role.
- The practice could demonstrate how they ensured role-specific training and updating for relevant staff. Staff who administered vaccines could demonstrate how they stayed up to date with changes to the immunisation programmes, for example by access to on line resources.
- The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. This included ongoing support, clinical supervision and facilitation and support for revalidating GPs.
- All employed staff had received an appraisal within the last 12 months. A long-term sessional GP who had been with the practice a number of years was not part of the appraisal programme.

Coordinating patient care and information sharing

At our previous inspection on 7 January 2015 we found there was a lack of clinical oversight when dealing with patient test results, letters, referrals and care plans were not completed collaboratively with patients to reflect their preferences. At our inspection on 3 August 2017 we found that the practice had made improvements and the information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practice's patient record system and their intranet system.

- This included care and risk assessments, care plans, medical records and investigation and test results. The practice operated a 'buddy' system for when clinicians were absent from the surgery.
- From the sample of four documented examples we reviewed we found that the practice shared relevant information with other services in a timely way, for example when referring patients to other services.
- We also saw that care plans were comprehensive and personalised.
- The practice used an IT interface system which enabled patients' electronic health records to be transferred

directly and securely between GP practices. This improved patient care as GPs would have full and detailed medical records available to them for a new patient's first consultation.

However, we noted that the practice did not have an effective system in place to monitor its two-week wait referrals. There was no safety-netting procedure in place to monitor that patients had received an appointment or attended an appointment. Two-week wait referral data showed that the percentage of new cancer cases (among patients registered at the practice) who were referred using the urgent two-week wait referral pathway was 17%, which was lower than the CCG average of 46% and the national average of 49%. This gives an estimation of the practice's detection rate, by showing how many cases of cancer for people registered at a practice were detected by that practice and referred via the two-week wait pathway. Practices with high detection rates will improve early diagnosis and timely treatment of patients which may positively impact survival rates.

Staff worked together and with other health and social care professionals to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. This included when patients moved between services, including when they were referred, or after they were discharged from hospital. Information was shared between services, with patients' consent, using a shared care record. Meetings took place with other health care professionals when care plans were routinely reviewed and updated for patients with complex needs.

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

Consent to care and treatment

At our previous inspection on 7 January 2015 we found that some doctors were unclear about how consent should be obtained and documented and about Gillick competency (determining a child's capacity to consent). At our inspection on 3 August 2017 we found doctors 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 (MCA) 2005. Clinical staff had undertaken MCA training.
- 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.

Supporting patients to live healthier lives

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

- Patients receiving end of life care, carers, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation.
- There was a Primary Care Navigator attached to the practice and could help signpost patients to health, social care and voluntary sector services.
- The practice liaised with local pharmacies regarding dossette boxes (a pill container and organiser for storing scheduled doses of a patient's medication) and repeat dispensing for the elderly and vulnerable patient cohorts.

The practice's uptake for the cervical screening programme was 48%, which was below the CCG average of 75% and the national average of 81% and a finding of our previous inspection on 7 January 2015. The practice told us the lack of a practice nurse and female GP had impacted on its achievement and were actively recruiting a female GP. There was a policy to offer telephone or written reminders for patients who did not attend for their cervical screening test. Furthermore, the practice demonstrated how they encouraged uptake of the screening programme by using information in different languages. There were failsafe systems to ensure results were received for all samples sent for the cervical screening programme and the practice followed up women who were referred as a result of abnormal results. The practice monitored this through audits.

The practice encouraged its patients to attend national screening programmes for bowel and breast cancer.

Requires improvement

Are services effective?

(for example, treatment is effective)

Childhood immunisations were carried out in line with the national childhood vaccination programme. Data for childhood immunisation rates for the vaccinations given to the under two year olds for the period 1 April 2015 to 31 March 2016 were below the target of 90% and ranged from 67% to 86%. Immunisation rates for five year olds ranged from 50% to 86% (CCG average from 62% to 83% and national average from 88% to 94%). The practice recognised that this was an area that improvement and were working to improve these rates through a robust recall system and ongoing active recruitment for a practice nurse.

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.

Good

Are services caring?

Our findings

At our previous inspection on 7 January 2015, we rated the practice as good for providing caring services. At our follow up inspection on 3 August 2017 we also found the practice was good for providing caring services.

Kindness, dignity, respect and compassion

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

- Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- Consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- Reception staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.
- The practice did not have any female clinicians at the time of our inspection.

All of the 17 patient Care Quality Commission comment cards we received were positive about the service experienced. Patients said they felt the practice offered an excellent and efficient service and staff were kind, helpful, caring and treated them with dignity and respect.

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

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

- 87% of patients said the GP was good at listening to them compared with the clinical commissioning group (CCG) average of 89% and the national average of 89%.
- 88% 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 95% 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 CCG average of 86% and the national average of 86%.
- 88% of patients said the nurse was good at listening to them compared with the CCG average of 86% and the national average of 91%.
- 87% of patients said the nurse gave them enough time compared with the CCG average of 88% and the national average of 92%.
- 99% of patients said they had confidence and trust in the last nurse they saw compared with the CCG average of 94% and the national average of 97%.
- 87% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 87% and the national average of 91%.
- 92% of patients said they found the receptionists at the practice helpful compared with the CCG average of 88% 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 and comprehensive.

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:

- 83% of patients said the last GP they saw was good at explaining tests and treatments compared with the CCG average of 87% and the national average of 86%.
- 80% of patients said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 83% and the national average of 82%.

Good

Are services caring?

- 83% of patients said the last nurse they saw was good at explaining tests and treatments compared with the CCG average of 84% and the national average of 90%.
- 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 80% and the national average of 85%.

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

- Staff told us that interpretation services were available for patients who did not have English as a first language. We saw notices in the waiting room written in several languages aligned to the practice demographic informing patients this service was available. Patients were also told about multi-lingual staff who might be able to support them.
- Information leaflets were available in easy read format in the waiting room and these were available in other languages.
- The Choose and Book service was used with patients as appropriate. (Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital.

Patient and carer support to cope emotionally with care and treatment

Patients over 55 years of age requiring support could be referred to a Primary Care Navigator who was attached to the practice and could help signpost patients to health, social care and voluntary sector services.

Information was available to direct carers to the various avenues of support available to them which included signposting through the Primary Care Navigator. The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 27 patients as carers (0.9% of the practice list).

Staff told us that if families had experienced bereavement, their usual GP would 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.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

At our previous inspection on 7 January 2015, we rated the practice as good for providing responsive services. At our follow up inspection on 3 August 2017 we also found the practice was good for providing responsive services.

Responding to and meeting people's needs

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

- The practice offered extended hours on Monday from 6.30pm to 8pm to working patients who could not attend during normal opening hours.
- There were longer appointments available for patients with a learning disability and those requiring an interpreter.
- Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice.
- The practice took account of the needs and preferences of patients with life-limiting progressive conditions. There were early and ongoing conversations with these patients about their end of life care as part of their wider treatment and care planning.
- Same day appointments were available for children and those patients with medical problems that require same day consultation.
- Patients were able to receive travel vaccines available on the NHS as well as those only available privately.
- There were accessible facilities, which included a hearing loop, and interpretation services available.
- The waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for access to consultation rooms and was visible from reception. There was enough seating for the number of patients who attended on the day of inspection.
- Patients had access to baby changing and breast feeding facilities and these were advertised in the waiting room.

Access to the service

The practice was open between 9am and 6.30pm on Monday, Tuesday, Wednesday and Friday and from 9am to 12.30pm on Thursday. Extended hours appointments were offered on Monday from 6.30pm to 8pm. In addition to pre-bookable appointments that could be booked up to two weeks in advance, urgent appointments and telephone consultations were also available for patients that needed them. Patients were able to book appointments on-line which had not been available at our previous inspection.

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.

- 80% of patients were satisfied with the practice's opening hours compared with the clinical commissioning group (CCG) average of 79% and the national average of 76%.
- 79% of patients said they could get through easily to the practice by phone compared to CCG average of 84% and the national average of 71%.
- 87% of patients said that the last time they wanted to speak to a GP or nurse they were able to get an appointment compared with the CCG average of 84% and the national average of 84%.
- 90% of patients said their last appointment was convenient compared with the CCG average of 81% and the national average of 81%.
- 88% of patients described their experience of making an appointment as good compared with the CCG average of 77% and the national average of 73%.
- 79% of patients usually get to see or speak to their preferred GP compared with the CCG average of 59% and the national average of 56%.
- 51% of patients said they don't normally have to wait too long to be seen compared with the CCG average of 59% and the national average of 58%.

Patients told us on the day of the inspection that they were able to get appointments when they needed them.

The practice had a system 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.

Listening and learning from concerns and complaints

The practice had a system for handling complaints and concerns.

Good

Are services responsive to people's needs?

(for example, to feedback?)

- Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England.
- There was a designated responsible person who handled all complaints in the practice.
- We saw that information was available to help patients understand the complaints system. For example, information in the waiting room and complaint form and guidance which contained all up-to-date information in line with guidance.

The practice had recorded no written complaints for a one year period July 2016 to July 2017. The practice did not record verbal complaints. We looked at previous complaints and reviewed one received in January 2016 and found that it had been handled satisfactorily and in a timely manner. We saw evidence of an apology letter to the patient which included further guidance on how to escalate their concern if they were not happy with the response.

Are services well-led?

Requires improvement

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

Our findings

At our previous inspection on 7 January 2015, we rated the practice as requires improvement for providing well-led services.

Although the practice had addressed and made improvements to the majority of the findings of our previous inspection, at our follow-up inspection on 3 August 2017 we found additional concerns and that the overarching governance framework which supported the delivery of quality care required improvement. The practice remains rated as requires improvement.

Vision and strategy

The practice told us they had a vision to deliver high quality care and promote good outcomes for patients. However, there was no formal written strategy or supporting business plan that detailed the short and long-term development objectives that the practice wanted to achieve.

The practice had a mission statement which was displayed and staff knew and understood the values.

Governance arrangements

Although the practice had an overarching governance framework which supported the delivery of good quality care, we found some arrangements were not implemented well enough to ensure patients were kept safe. For example:

- There was limited use of the system for reporting and recording significant events in line with practice procedure.
- There was no formal process in place to track patient safety alerts received and to ensure they had been reviewed, appropriate action taken and shared with staff.
- There was no formal system in place to monitor that repeat prescriptions had been collected by patients.
- The management of blank prescription stationery was not in line with guidance.
- There was no effective safety-netting procedure in place to monitor two-week wait referrals.
- There was no formal induction programme for newly recruited staff.
- The practice could not demonstrate that all staff had received training it had identified as mandatory.
- Patient outcomes for cervical screening and childhood immunisations were below local and national averages.

However, we saw that the practice had structures and procedures and ensured that:

- There was a clear staffing structure and that staff were aware of their own roles and responsibilities.
- A comprehensive understanding of the performance of the practice was maintained and we saw significant improvement on patient outcomes through the Quality and Outcomes Framework (QOF) since our previous inspection on 7 January 2015.
- Clinical audit was used to monitor quality and to make improvements.
- Practice specific policies were implemented and were available to all staff.
- Meetings allowed for lessons to be learned and shared following significant events and complaints.

Leadership and culture

The principal GP and management team told us they prioritised safe, high quality and compassionate care. Staff spoke highly of the GPs and the management team and told us they were approachable and always took the time to listen to all members of staff.

The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment). We saw evidence that the practice had systems to ensure that when things went wrong with care and treatment:

- The practice gave affected people reasonable support, truthful information and a verbal and written apology.
- The practice did not kept written record of verbal interactions.

There was a clear leadership structure and staff we spoke with on the day told us they felt supported by the GPs and the management team.

- The practice held a range of multi-disciplinary meetings including meetings with district nurses and social workers to monitor vulnerable patients. GPs, where required, met with health visitors to monitor vulnerable families and safeguarding concerns.
- Staff told us the practice held regular practice meetings and we saw evidence of minutes.

Are services well-led?

Requires improvement

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

- 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 we spoke with on the day told us they felt respected, valued and supported.

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

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

- The NHS Friends and Family test, complaints, compliments and NHS Choices.
- The patient participation group (PPG) which was active and met quarterly. The PPG members we spoke with told us they submitted proposals for improvements to the practice management team. For example, the installation of an electronic patient call board in the waiting room.
- Staff through appraisals and staff meetings. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: The provider was failing to ensure systems and processes are operated effectively to improve the quality and safety of services: • There was limited use of the system for reporting and recording significant events in line with practice procedure. • There was no formal process in place to track patient safety alerts received and to ensure they had been reviewed, appropriate action taken and shared with staff. • There was no formal system in place to monitor that repeat prescriptions had been collected by patients • The management of blank prescription stationery was not in line with guidance. • There was no effective safety-netting procedure in place to monitor two-week wait referrals. • There was no written strategy or supporting business plan that detailed the short and long-term development objectives. Regulation 17 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing How the regulation was not being met:

This section is primarily information for the provider

Requirement notices

The provider was failing to ensure persons employed in the provision of the regulated activity had received the appropriate support, training, professional development, supervision and appraisal necessary to enable them to carry out the duties.

- There was no formal induction programme for newly recruited staff.
- The practice could not demonstrate that all staff had received training it had identified as mandatory.

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