Grove Medical Centre

Quality Report

The Grove
Church Road
Egham
Surrey
TW20 9QN
Tel: 01784 433159
Website: www.thegrovemedicalcentre.co.uk

Date of inspection visit: 23 August 2017
Date of publication: 02/11/2017

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?	Requires improvement
Are services caring?	Good
Are services responsive to people's needs?	Requires improvement
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 Grove Medical Centre on 10 May 2016. The overall rating for the practice was requires improvement. The full comprehensive report on the 10 May 2016 inspection can be found by selecting the 'all reports' link for Grove Medical Centre on our website at www.cqc.org.uk.

A subsequent focussed inspection was undertaken on 20 January 2017. The overall rating for the practice remained requires improvement but rated inadequate for being well led. A warning notice was served in relation to the good governance of the practice, Regulation 17.

This inspection was undertaken as an announced comprehensive inspection on 23 August 2017. Overall the practice is now rated as inadequate. Specifically, the practice was rated as inadequate in safe and well led, requires improvement in effective and responsive and good in caring

Our key findings were as follows:

- Staff recruitment checks did not always ensure that evidence was held on file for their employment history and not all staff had references obtained for them.
- Medicine alerts were not acted upon and no evidence was seen that patients were identified as being at potential risk. Patients taking high risk medications were not monitored effectively.
- Although the practice carried out investigations when there were unintended or unexpected safety incidents, lessons learned were not communicated effectively and so safety was not improved. For example there were three significant events featuring wrongly scanned patient information.
- There was insufficient attention to safeguarding vulnerable adults. The practice had different policies in place for this issue which had different information contained within each.
- Non clinical staff had not undertaken training in adult safeguarding.
- Exception reporting for cervical screening was high at 19% and no explanation was given for this(Exception reporting is the removal of patients from QOF

Summary of findings

calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects).

- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.
- Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.
- Data from the national GP patient survey published July 2017 showed patients rated the practice higher than others for some aspects of care.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- No complaint information was displayed within the reception or waiting room area on the day of inspection but information was available on the practice website. Responses to complaints did not follow the practice's complaint policy.
- The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group was active but patients spoken to on the day of inspection were not aware of the group or how to contact it.
- Governance arrangements for the oversight and management of risk had not been sufficiently improved leaving a risk of potential harm to patients and staff. For example, the gas safety certificate had expired in March 2017 and this had been identified within the fire risk assessment undertaken in May 2017, yet it remained unresolved at the time of the inspection in August 2017.
- Risk assessments that had been completed had outstanding actions remaining. For example, corrective pipe work to comply with the legionella risk report of May 2016 was still unresolved and documented in the legionella risk assessment of August 2017.
- While we saw that the provider had taken some action against the warning notice issued in respect of Regulation 17, insufficient progress had been made to manage processes effectively.
- The practice met the warning notice in respect of the management of tracking prescription forms throughout the practice.

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

Importantly, the provider must ensure:

- That recruitment procedures are established and operating effectively to ensure only fit and proper persons are employed. Information relating to Schedule Three must be available for each person employed. .
- Safe care and treatment must be provided in a safe way to patients, including the proper and safe management of medicines.
- That staff employed by the practice must receive appropriate training to enable them to carry out the duties they are employed to perform. In particular adult safeguarding training for non-clinical staff.
- That the practice establishes and operates effectively an accessible system for identifying, receiving, recording, handling and responding to complaints.
- That systems and processes are established and operated effectively to ensure good governance. Including assessing, monitoring and improving the quality of service provided. For example, reviewing the management of significant events. Assessing, monitoring and mitigating risk relating to the health, safety and welfare of patients and staff. For example, reviewing the management of safety assessments, fire risk assessments, Legionella assessments and gas safety.

In addition the provider should:

- Review access to appointments in line with patient feedback.
- Review the management of the cleaning of the practice to ensure that areas of concern are adequately addressed.

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

Summary of findings

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

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

- Staff were clear about reporting incidents, near misses and concerns. Although the practice carried out investigations when there were unintended or unexpected safety incidents, lessons learned were not communicated effectively and so safety was not improved. For example, we saw that the same significant event had happened three times, meaning the practice had not managed or learnt from the original event.
- Patients were at risk of harm because systems and processes had weaknesses. For example adult safeguarding concerns were not recorded as alerts on the patient system for those concerned on the day of inspection.
- Recruitment checks did not always ensure that evidence was held on file for staff employment histories and not all staff had references obtained for them.
- There was insufficient attention to safeguarding vulnerable adults. The practice had different policies in place for this issue which had different information contained within each.
- Medicine alerts were not acted upon and no evidence was seen that patients were identified as being at potential risk. Patients taking high risk medications were not monitored effectively.
- The systems, process and practices for managing medicines do not keep patients safe. Opportunities to prevent or minimise risk were missed.
- There was a health and safety policy available. However, the practice had not undertaken any health and safety risk assessments at the time of inspection.

Are services effective?

Requires improvement

The practice is rated as requires improvement for providing effective services, as there are areas where improvements must be made.

- Data from the Quality and Outcomes Framework (2015/16) showed patient outcomes were at or above average compared to the national average. For example, The percentage of patients diagnosed with dementia whose care plan had been reviewed in a face-to-face review in the preceding 12 months was 95% compared to a national average of 84%.

Summary of findings

- Data showed 93% of women aged 25-64 had recorded that a cervical screening test had been performed in the preceding five years compared to the national average of 81%. However, the exception reporting was very high at 19% compared to a national average of 6.5% and no evidence was available that documented the reason for this level of non-attendance.
- Non clinical staff had not undertaken training in adult safeguarding.
- There was evidence of appraisals and personal development plans for all staff.
- Staff worked with other health care professionals to understand and meet the range and complexity of patients' needs.

Are services caring?

Good

The practice is rated as good for providing caring services.

- Data from the national GP patient survey published July 2017 showed patients rated the practice higher than others for some aspects of care. For example, 93% of patients say the last GP they saw or spoke to was good at giving them enough time compared to the local CCG average of 87% and a national average of 86%.
- Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.
- Information for patients about the services available was accessible.
- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.

Are services responsive to people's needs?

Requires improvement

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

- Practice staff reviewed the needs of its local population and engaged with the NHS England South East Area Team and clinical commissioning group to secure improvements to services where these were identified. For example there were fewer emergency appointments, though more pre-bookable appointments, available in the summer months as it had been identified there was less demand for this during this time.
- Feedback from patients reported that access to a named GP and continuity of care was not always available quickly, although urgent appointments were usually available the same

Summary of findings

day. The national GP patient survey identified that 34% of respondents stated that they always or almost always see or speak to the GP they prefer compared to the local CCG average of 53% and a national average of 56%.

- The practice had good facilities and was well equipped to treat patients and meet their needs.
- No complaint information was displayed within the reception or waiting room area on the day of inspection but information was available on the practice website. Responses to complaints did not follow the practice's complaint policy.
- The practice offered two urgent appointment lists. One in the morning from 10am until 12pm and another in the afternoon from 5.30pm.
- The practice undertook telephone consultations from 2pm for patients who may not be able to, or did not need to, visit the practice.
- The practice facilitated a fortnightly diabetic clinic attended by a specialist diabetic nurse to assist in managing patients with complex needs

Are services well-led?

Inadequate

The practice is rated as inadequate for being well-led, as there are areas where improvements must be made.

- The practice had a vision and a strategy but not all staff were aware of this and of their responsibilities in relation to it.
- There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings. The practice did have a specific policy for significant events but the lessons from these were not adequately embedded throughout the practice. For example, we saw that lessons had not been learnt adequately after a significant event where documents had been incorrectly scanned and stored. The same event then happened a further two times.
- The practice had a business continuity plan which at the time of inspection had been reviewed and contact details added where appropriate. However, it was not known by all partners how this plan could be accessed remotely.
- The provider was aware of and complied with the requirements of the duty of candour. The partners encouraged a culture of openness and honesty. The practice had systems in place for notifiable safety incidents and ensured this information was shared with staff to ensure appropriate action was taken

Summary of findings

- The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group was active but patients spoken to on the day of inspection were not aware of the group or how to contact it.
- Governance arrangements for the oversight and management of risk had not been sufficiently improved leaving a risk of potential harm to patients and staff. For example, the gas safety certificate had expired in March 2017 and identified within the fire risk assessment undertaken in May 2017, yet remained unresolved at the time of the inspection in August 2017.
- The practice showed evidence they were now providing patients with the required information to allow them to escalate a complaint if they remained dissatisfied. However, the practice was not complying with their own complaints policy and while the practice stated that complaints information was available on the television screen in the waiting area we did not see this when viewing the screen at the time of inspection. Complaints were not routinely discussed at partner or clinical meetings.
- Risk assessments that had been completed had outstanding actions remaining. For example, corrective pipe work to comply with the legionella risk report of May 2016 was still unresolved and documented in the legionella risk assessment of August 2017.

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 safe and well led services, requires improvement for providing effective and responsive services and good for providing caring services. The issues identified as inadequate and requiring improvement overall affected all patients including this population group. There were, however, examples of good practice.

- The practice offered proactive, personalised care to meet the needs of the older people in its population.
- The practice was responsive to the needs of older people, and offered home visits and urgent appointments for those with enhanced needs.
- The practice offered longer appointments for patients with complex conditions.
- Patients with an agreed care plan who may be at risk of hospital admission had these shared on a computer system that could be accessed by the ambulance service and the Out of Hours provider.
- The practice had worked with local pharmacists to ensure that any electronic prescription requests were delivered directly to the patient if they had mobility issues.

People with long term conditions

Inadequate

The provider was rated as inadequate for safe and well led services, requires improvement for providing effective and responsive services and good for providing caring services. The issues identified as inadequate and requiring improvement overall affected all patients including this population group. There were, however, examples of good practice.

- Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority.
- A community nurse specialist in diabetes held a half day clinic each fortnight at the practice.
- One practice nurse and two GPs held the Warwick certificate for Diabetes care.
- The practice could undertake mini-spirometry for patients who might be at risk of chronic obstructive pulmonary disease (COPD).
- Monthly palliative care meetings were held which were attended by GPs, a palliative care nurse, practice nurse and district nurses.

Summary of findings

• Data from 2015/16 showed the percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who had a comprehensive, agreed care plan documented in the record, in the preceding 12 months was 93% compared to the local CCG average of 92% and the national average of 89%.

• Longer appointments and home visits were available when needed.

• Patients with long-term conditions had a named GP and 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

Inadequate

The provider was rated as inadequate for safe and well led services, requires improvement for providing effective and responsive services and good for providing caring services. The issues identified as inadequate and requiring improvement overall affected all patients including this population group. There were, however, examples of good practice.

• There were systems in place 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 attendances. Immunisation rates were relatively high for all standard childhood immunisations.

• There was regular liaison with a health visitor, who attended the monthly practice primary health care team meeting, to review those children who were considered to be at risk of harm.

• Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this.

• Data showed that the percentage of women aged 25-64 whose notes recorded that a cervical screening test had been performed in the preceding five years was 93% compared to the local CCG average of 80% and the national average of 81%. However, the practice did have high exception reporting for this area which had not been investigated to identify reasons why patients had not attended the practice for this procedure.

• Appointments were available outside of school hours and the premises were suitable for children and babies.

• We saw positive examples of joint working with midwives and health visitors

Summary of findings

• Appointments were available each weekday from 5.30pm which were particularly useful for school students who might wish to seek a consultation for health issues that had emerged during the school day.

Working age people (including those recently retired and students)

Inadequate

The provider was rated as inadequate for safe and well led services, requires improvement for providing effective and responsive services and good for providing caring services. The issues identified as inadequate and requiring improvement overall affected all patients including this population group. There were, however, examples of good practice.

• The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care.

• The practice was proactive in offering online services as well as a full range of health promotion and screening that reflected the needs for this age group.

• Telephone consultations were available each day from 2pm for patients who might not be able to visit the practice.

• Appointments to see a GP or nurse were available each Saturday morning from 8am to 11am.

• Electronic prescriptions and direct email access to GPs were available for patients.

• Patients could access test results online and GP messages where relevant.

People whose circumstances may make them vulnerable

Inadequate

The provider was rated as inadequate for safe and well led services, requires improvement for providing effective and responsive services and good for providing caring services. The issues identified as inadequate and requiring improvement overall affected all patients including this population group. There were, however, examples of good practice.

• The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability.

• The practice offered longer appointments for patients with a learning disability.

• The practice regularly worked with other health care professionals in the case management of vulnerable patients.

Summary of findings

• The practice was able to support carers in the form of a carer's allowance of £300 from the local authority. The Patient Participation Group (PPG) assisted the practice in determining who the allowance could be given to following an application process.

• The practice informed vulnerable patients about how to access various support groups and voluntary organisations.

• Staff knew how to recognise signs of abuse in vulnerable children though not all staff had been trained in safeguarding vulnerable adults. Staff were aware of their responsibilities regarding information sharing and the documentation of safeguarding concerns.

People experiencing poor mental health (including people with dementia)

Inadequate 

The provider was rated as inadequate for safe and well led services, requires improvement for providing effective and responsive services and good for providing caring services. The issues identified as inadequate and requiring improvement overall affected all patients including this population group. There were, however, examples of good practice.

• 95% of patients diagnosed with dementia had had their care reviewed in a face to face meeting in the last 12 months, which is better than the national average of 85%.

•Data from 2015/16 showed that the percentage of patients with schizophrenia, bipolar affective disorder and other psychoses whose alcohol consumption has been recorded in the preceding 12 Months was 93% which is comparable to the national average of 89%.

• The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those with dementia.

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

• The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations.

• The practice had a system in place to follow up patients who had attended accident and emergency where they may have been experiencing poor mental health.

• Staff 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. The results showed the practice was generally performing better than local and national averages. 276 survey forms were distributed and 112 were returned. This represented approximately 1% of the practice's patient list.

• 60% of patients who responded found it easy to get through to this practice by phone compared to the national average of 71%.

• 91% of patients who responded were able to get an appointment to see or speak to someone the last time they tried compared to the national average of 84%.

• 88% of patients who responded described the overall experience of this GP practice as good compared to the national average of 85%.

• 86% of patients who responded said they would recommend this GP practice to someone who has just moved to the local area compared to the national average of 77%.

We spoke with eight patients including one member of the patient participation group (PPG). They told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. Comments highlighted that staff responded compassionately when they needed help and provided support when required. However, two patients mentioned that getting routine appointments could require waiting some weeks and no patients spoken to knew that the PPG existed. Patients were not aware how to make a complaint if they needed to. The friends and family test (FFT) results from June 2017 showed 105 responses of which 101 indicated that they were extremely likely, or likely, to recommend the practice to others.

Areas for improvement

Action the service MUST take to improve

- That recruitment procedures are established and operating effectively to ensure only fit and proper persons are employed. Information relating to Schedule Three must be available for each person employed. .
- Safe care and treatment must be provided in a safe way to patients, including the proper and safe management of medicines.
- That staff employed by the practice must receive appropriate training to enable them to carry out the duties they are employed to perform. In particular adult safeguarding training for non-clinical staff.
- That the practice establishes and operates effectively an accessible system for identifying, receiving, recording, handling and responding to complaints.
- That systems and processes are established and operated effectively to ensure good governance. Including assessing, monitoring and improving the quality of service provided. For example, reviewing the management of significant events. Assessing, monitoring and mitigating risk relating to the health, safety and welfare of patients and staff. For example, reviewing the management of safety assessments, fire risk assessments, Legionella assessments and gas safety.

Action the service SHOULD take to improve

- Review access to appointments in line with patient feedback.
- Review the management of the cleaning of the practice to ensure that areas of concern are adequately addressed.

Grove Medical 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 second CQC inspector, a GP specialist adviser, a practice nurse specialist adviser and a practice manager specialist adviser.

Background to Grove Medical Centre

Grove Medical Centre is located in a residential area of Egham and provides general medical services to approximately 14,041 patients.

There are three GP partners (two male and one female) and three salaried GPs. The GPs are supported by three female practice nurses, two healthcare assistants, a team of receptionists, administrative staff, a practice manager, a deputy practice manager and an assistant practice manager.

Data available to the Care Quality Commission (CQC) shows the practice serves a higher than average number of patients who are aged between 35 and 54 years of age when compared to the national average. The number of patients aged 60 to 79 is slightly lower than average. The number of registered patients suffering income deprivation (affecting both adults and children) is below the national average.

The practice is open Monday to Friday between 8am and 6.30pm. Extended hours appointments are offered every Saturday morning from 8am to 11am with appointments available to see either a GP or a nurse. Appointments can be booked over the telephone, online or in person at the surgery. Patients are provided information on how to access an out of hour's service by calling the surgery or viewing the practice website.

The practice runs a number of services for its patients including; chronic disease management, new patient checks, smoking cessation, phlebotomy, 24 hour blood pressure monitoring, travel vaccines and advice.

Services are provided from one location. Grove Medical Centre, The Grove, Church Road, Egham, Surrey, TW20 9QN.

The practice has a General Medical Services (GMS) contract with NHS England. (GMS is one of the three contracting routes that have been available to enable commissioning of primary medical services). The practice is part of NHS North West Surrey Clinical Commissioning Group. Out of hours care is accessed by contacting NHS111.

The practice has been inspected on two previous occasions. In May 2016 we rated the practice as "Requires improvement" and served requirement notices for improvement. A subsequent inspection in January 2017 rated the practice as still requiring improvement but inadequate for being well led and a warning notice was issued.

The full comprehensive report on the May 2016 inspection and January 2017 inspection can be found by selecting the 'all reports' link for Grove Medical Centre on our website at www.cqc.org.uk.

Detailed findings

Why we carried out this inspection

We undertook a comprehensive inspection of Grove Medical Centre on 10 May 2016 under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The practice was rated as requires improvement for providing safe, effective and well led services.

We undertook a follow up inspection of Grove Medical Centre on 20 January 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. The practice was subsequently rated as requiring improvement for providing safe and effective services and inadequate for providing well led services.

We also issued a warning notice to the provider in respect of good governance and informed them that they must become compliant with the law by 25 May 2017. The full comprehensive report on the May 2016 inspection and the January 2017 inspection can be found by selecting the 'all reports' link for Grove Medical Centre on our website at www.cqc.org.uk.

We undertook a further announced comprehensive inspection of Grove Medical Centre on 23 August 2017 to ensure improvements had been made and to assess whether 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 23 August 2017.

During our visit we:

- Spoke with a range of staff including partner GPs and a salaried GP, practice nurses, administrative staff, the assistant practice manager and the practice manager.
- Spoke with patients who used the service.
- Observed how patients were being cared for in the reception area and talked with carers and/or family members
- Reviewed an anonymised sample of the personal care or treatment records of patients.
- 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 May 2016 and, we rated the practice as requires improvement for providing safe services as the arrangements in respect of risk management and prescription form safety were not adequate. We completed a further inspection on 20 January 2017 where the practice had not improved and remained rated as requires improvement for the same issues.

These arrangements had not significantly improved when we undertook a follow up comprehensive inspection on 23 August 2017. The provider is now rated as inadequate for providing safe services.

Safe track record and learning

There was a system for reporting and recording significant events. However, we saw evidence that lessons were not always learnt. For example the same significant event had been repeated three times.

• Staff told us they would inform the practice manager of any incidents and there was a recording form available on the practice's computer system. The incident recording form supported the recording of notifiable incidents under the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).

• From the sample of 16 documented examples we reviewed we found that when things went wrong with care and treatment, patients were informed of the incident as soon as reasonably practicable, received reasonable support, truthful information, a written apology and were told about any actions to improve processes to prevent the same thing happening again.

• We reviewed safety records, incident reports, patient safety alerts and minutes of meetings where significant events were discussed. The practice carried out an analysis of the significant events but evidence was seen that showed that lessons from significant events were not adequately learned from as there had been three incidents of scanning patient documents into the wrong patient notes. Another incident identified 58 documents had been wrongly processed. On the day of inspection errors were seen in relation to documents not being managed correctly within the GPs workflow area.

.**Overview of safety systems and process**

The practice had systems, processes and practices in place to minimise risks to patient safety. Evidence was seen that these were not adequate in keeping patients safe.

• Arrangements for safeguarding did not reflect relevant legislation and local requirements. Policies were accessible to all staff and were stored in three locations. The policies were different depending on what document was accessed and one safeguarding policy seen had incomplete information in relation to who should be contacted and the contact number to do so. There was a lead member of staff for safeguarding.

• Staff interviewed demonstrated they understood their responsibilities regarding safeguarding and had received training on safeguarding children. Non clinical staff at the time of inspection had not been trained in adult safeguarding but the practice had shown they had purchased online training for staff following the inspection. GPs and nurses were trained to child protection or child safeguarding level three.

• A notice in the waiting room advised patients that chaperones were available if required. All staff who acted as chaperones were trained for the role and had received a Disclosure and Barring Service (DBS) check. (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 standards of cleanliness and hygiene.

• We observed the premises to be clean and tidy. There were cleaning schedules and monitoring systems in place. However, evidence was seen that the monthly checks on the standards of cleaning between March 2017 and July 2017 documented consistently the need for cleaning to be improved in relation to dusting and the standard of vacuuming.

• A practice nurse was the infection prevention and control (IPC) clinical lead who liaised with the local infection prevention teams to keep up to date with best practice. There was an IPC protocol and staff had received up to date training. Annual IPC audits were undertaken and we saw evidence that action was taken to address any improvements identified as a result.

Inadequate

Are services safe?

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

- There were processes for handling repeat prescriptions which did not include the review of high risk medicines; evidence was seen that high risk medicines were repeatedly prescribed without required blood test information to ensure safe prescribing.

The repeat prescription box, at the time of inspection, was emptied quarterly and contained prescription forms that were two months old. Five of these prescriptions had been reissued which could have resulted in a patient obtaining two courses of medication. Information was received following the inspection that indicated that a new policy had been initiated at the practice to prevent this situation arising by ensuring the box was emptied on a monthly basis.

- No evidence was available at the time of inspection to show that medicine alerts from the Medicines & Healthcare products Regulatory Agency (MHRA) were acted upon by the practice. No searches on the patient system had been undertaken to identify patients that might have been affected.
- The practice carried out regular medicines audits, with the support of the local clinical commissioning group pharmacy teams, to ensure prescribing was in line with best practice guidelines for safe prescribing.
- Blank prescription forms were securely stored and there were systems to monitor their use.
- Patient Group Directions had been adopted by the practice to allow nurses to administer medicines in line with legislation. Health care assistants were trained to administer vaccines and medicines and patient specific prescriptions or directions from a prescriber were produced appropriately.

We reviewed three personnel files and found that not all appropriate recruitment checks had been undertaken prior to employment. For example, not all staff had references on file or had their full employment histories, including reasons for any employment gaps on file. Qualifications, registration with the appropriate professional body and the appropriate checks through the DBS were on file.

Monitoring risks to patients

There were procedures for assessing, monitoring and managing risks to patient and staff safety but these were not adequately managed.

• There was a health and safety policy available. However, the practice had not undertaken any health and safety risk assessments.

• The practice had an up to date fire risk assessment and carried out regular fire drills. There were designated fire marshals within the practice. There was a fire evacuation plan which identified how staff could support patients with mobility problems to vacate the premises. However the gas safety certificate for the practice was out of date in March 2017 and documented in the May 2017 fire risk assessment. At the time of the inspection the certificate of safety had not been completed.

• All electrical and clinical equipment was checked and calibrated to ensure it was safe to use and was in good working order.

• The practice had a variety of other risk assessments to monitor safety of the premises such as control of substances hazardous to health and infection control and legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings). However, there was one action outstanding from the legionella assessment of May 2016 which had not been resolved and was documented again as needing attention in the new assessment of August 2017.

•There were arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system to ensure enough staff were on duty to meet the needs of patients.

Arrangements to deal with emergencies and major incidents

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

• There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency.

• All staff received annual basic life support training and there were emergency medicines available in the treatment room.

Inadequate

Are services safe?

• The practice had a defibrillator available on the premises and oxygen with adult and children's masks. A first aid kit and accident book were available.

• Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and stored securely.

• The practice had a comprehensive business continuity plan for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff. However, not all staff knew how to access this information.

Requires improvement

Are services effective?

(for example, treatment is effective)

Our findings

At our previous inspections in May 2016, we rated the practice as requires improvement for providing effective services as the arrangements in staff training were not adequate. The practice had not improved when we completed a follow up inspection in January 2017 and was still rated as required improvement.

These arrangements had not significantly improved when we undertook a follow up inspection on 23 August 2017. The provider also did not ascertain the reason why they had a high exception rate for cervical screening at the time of this inspection. The provider is still rated as requires improvement for providing effective services.

Effective needs assessment

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

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

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

Management, monitoring and improving outcomes for people

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 99.1% of the total number of points available compared with the clinical commissioning group (CCG) average of 96.3% and national average of 95.3%.

The practice had high exception reporting rate for the percentage of women aged 25-64 whose notes record that a cervical screening test had been performed in the preceding five years. The practice's exception rate was 19% against a CCG average of 6.4% and a national rate of 6.5%

(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). The practice did not know why there was such a high level of exception reporting at the time of inspection but information was subsequently supplied which illustrated how patients were now contacted to ascertain the reason they had not undertaken the procedure.

Data from 2015/16 showed:

• Performance for diabetes related indicators similar to the CCG and national averages. For example, the percentage of patients with diabetes, on the register, in whom the last blood

pressure reading (measured in the preceding 12 months) was 140/80 mmHg or less was 77% compared to the CCG average of 79% and a national average of 78%.

• Performance for mental health related indicators was similar to the CCG and national averages. For example, the percentage of patients with schizophrenia, bipolar affective disorder and other

psychoses who had a comprehensive, agreed care plan documented in the record, in the preceding 12 months was 93% compared to the CCG average of 92% and a national average of 89%.

There was evidence of quality improvement including clinical audit:

• There had been two clinical audits commenced in the last two years, both of these were completed audits where the improvements made were implemented and monitored.

•Findings were used by the practice to improve services. One audit had been in relation to the treatment of urinary tract infections to ensure that best practice was being undertaken.

Effective staffing

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

• The practice did not have documentation outlining an induction programme for all newly appointed staff though an unrecorded process was in place.

Requires improvement

Are services effective?

(for example, treatment is effective)

• The practice could demonstrate how they ensured role-specific training and updating for relevant staff. For example, for those reviewing patients with long-term conditions..

• Staff administering vaccines and taking samples for the cervical screening programme had received specific training which had included an assessment of competence. Staff who administered vaccines could demonstrate how they stayed up to date with changes to the immunisation programmes, for example by access to on line resources and discussion at practice meetings.

• The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. Staff had access to appropriate training to meet their learning needs and to cover the scope of their work. This included ongoing support, one-to-one meetings, coaching and mentoring, clinical supervision and facilitation and support for revalidating GPs and nurses. All staff had received an appraisal within the last 12 months.

• Staff received training that included: safeguarding, fire safety awareness, basic life support and information governance. Staff had access to and made use of e-learning training modules and in-house training. However, non-clinical staff had not been trained in adult safeguarding at the time of inspection. Evidence was submitted following the inspection detailing that online training for these staff had been purchased.

Coordinating patient care and information sharing

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

• This included care and risk assessments, care plans, medical records and investigation and test results.

• We reviewed patient care records and found that the practice shared relevant information with other services in a timely way, for example when referring patients to other services.

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

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

Consent to care and treatment

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

• Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005.

• When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance.

• Where a patient's mental capacity to consent to care or treatment was unclear the GP or practice nurse assessed the patient's capacity and, recorded the outcome of the assessment.

• The process for seeking consent was monitored through patient records audits.

Supporting patients to live healthier lives

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

• Patients receiving end of life care, carers, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation.

The practice's uptake for the cervical screening programme was 93%, which was better than the CCG average of 80% and the national average of 81%. 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. However, the practice exception reporting rate for this area was 19% compared to the CCG average of 6.4% and national average of 6.5%. At the time of inspection the practice did not know why their exception

Requires improvement

Are services effective?

(for example, treatment is effective)

reporting was so high. Following the inspection the practice had initiated a policy of contacting patients who had not responded to the letters of invitation for this procedure. A GP was also undertaking cervical screening but at the time of inspection did not maintain a log recording these so the practice was unable to ascertain what percentage of procedures undertaken were classed as inadequate. Information was sent by the practice following the inspection that a log had been started.

The practice also encouraged its patients to participate in national screening programmes for bowel and breast cancer screening. For example, 72% of women aged between 50 and 70 had attended screening for breast cancer which was similar to the CCG average of 71% and the national average of 73%. Bowel cancer screening was similar to the local and national averages, at 51% compared with the CCG average of 53% and the national average of 56%.

Childhood immunisations were carried out in line with the national childhood vaccination programme. Information seen on the day of inspection showed high uptake rates for the vaccines given. For example, rates for the vaccines given to under two year olds were 94% and five year olds was 98%.

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 10 May 2016, we rated the practice as 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.

• Patients could be treated by a clinician of the same sex.

We spoke with eight patients including one member of the patient participation group (PPG). They told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. Comments highlighted that staff responded compassionately when they needed help and provided support when required. However, two patients mentioned that getting routine appointments could require waiting some weeks and no patients spoken to knew that the PPG existed. Patients were not aware how to make a complaint if they needed to.

Results from the national GP patient survey published in July 2017 showed patients felt they were treated with compassion, dignity and respect. The practice was above average for its satisfaction scores on consultations with GPs and nurses. For example:

• 96% of patients who responded said the GP was good at listening to them compared with the clinical commissioning group (CCG) average of 91% and the national average of 89%.

• 93% of patients who responded said the GP gave them enough time compared to the CCG average of 87% and the national average of 86%.

• 96% of patients who responded said they had confidence and trust in the last GP they saw compared to the CCG average of 96% and the national average of 95%

• 94% of patients who responded said the last GP they spoke to was good at treating them with care and concern compared to the national average of 86%.

• 98% of patients who responded said the nurse was good at listening to them compared with the clinical commissioning group (CCG) average of 92% and the national average of 91%.

• 98% of patients who responded said the nurse gave them enough time compared with the CCG average of 93% and the national average of 92%.

• 99% of patients who responded said they had confidence and trust in the last nurse they saw compared with the CCG average of 98% and the national average of 97%.

• 98% of patients who responded said the last nurse they spoke to was good at treating them with care and concern compared to the national average of 91%.

• 83% of patients who responded said they found the receptionists at the practice helpful compared with the CCG average of 86% and the national average of 87%.

Care planning and involvement in decisions about care and treatment

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

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

Results from the national GP patient survey 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:

Good

Are services caring?

• 92% of patients who responded said the last GP they saw was good at explaining tests and treatments compared with the CCG average of 88% and the national average of 86%.

• 89% of patients who responded said the last GP they saw was good at involving them in decisions about their care compared to the national average of 82%.

• 95% of patients who responded said the last nurse they saw was good at explaining tests and treatments compared with the CCG average of 91% and the national average of 90%.

• 89% of patients who responded said the last nurse they saw was good at involving them in decisions about their care compared to the national average of 85%.

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

• We were told that interpretation services were available for patients who did not have English as a first language. However, not all staff were aware of this.

• Information leaflets were available in easy read format.

• The Choose and Book service was used with patients as appropriate. (Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital.

Patient and carer support to cope emotionally with care and treatment

Patient information leaflets and notices were available in the patient waiting area which told patients how to access a number of support groups and organisations. Information about support groups was also available on the practice website. Support for isolated or house-bound patients included signposting to relevant support and volunteer services.

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 275 patients as carers (approximately 2% of the practice list). The practice was able to facilitate a carer's support grant being awarded of £300 to carers following an application process. These applications were discussed anonymously with the PPG before approval of the grant was made. Written information was available to direct carers to the various avenues of support available to them.

Staff told us that if families had experienced 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 or by giving them advice on how to find a support service.

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

At our previous inspection on 10 May 2016, we rated the practice as good for providing responsive services but there were areas of complaint management that needed improving in relation to patient's who remained dissatisfied or escalate their complaint. This area had been resolved when we undertook out focussed inspection on 20 January 2017.

However, when we undertook a comprehensive follow up inspection on 23 August 2017 the arrangements in respect of recording, investigating and learning from complaints needed improving. The practice is now rated as requires improvement 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 a Saturday morning from 8am until 11am for working patients who could not attend during normal opening hours. Appointments were available with either a GP or a nurse.

• There were longer appointments available for patients with a learning disability.

• Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice.

• The practice took account of the needs and preferences of patients with life-limiting progressive conditions. There were early and ongoing conversations with these patients about their end of life care as part of their wider treatment and care planning.

• Same day appointments were available for children and those patients with medical problems that require same day consultation.

• The practice sent text message reminders of appointments and test results.

• Patients were able to receive travel vaccines available on the NHS as well as those only available privately.

• There were accessible facilities, which included a hearing loop, and whilst we were told interpretation services were available not all staff were aware of this.

• There were disabled facilities within the practice and the practice could accommodate those patients with limited mobility or who used wheelchairs.

Access to the service

The practice was open between 8am and 6.30pm Monday to Friday. Appointments were from 8am to 12pm every morning and 2pm to 6.30pm daily. Extended hours appointments were offered every Saturday morning between 8am and 11pm and patients could choose to see either a GP or a nurse. In addition to pre-bookable appointments that could be booked up to four weeks in

advance, urgent appointments were also available for patients that needed them.

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

• 70% of patients who responded were satisfied with the practice's opening hours compared to the national average of 76%.

• 60% of patients who responded said they could get through easily to the practice by phone compared to the national average of 71%.

• 91% of patients who responded 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%.

• 81% of patients who responded said their last appointment was convenient compared with the CCG average of 79% and the national average of 81%.

• 70% of patients who responded described their experience of making an appointment as good compared with the CCG average of 70% and the national average of 73%.

• 58% of patients who responded said they don't normally have to wait too long to be seen compared with the CCG average of 58% 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.

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

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.

The duty GP triaged the requests for home visits by viewing the information recorded at the time of the request and allocated visits to other GPs as required to encourage continuity of care. 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 in place for handling complaints and concerns, however this was not always followed.

- Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. However, we saw that the practice did not follow their complaint procedure.
- 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 on the practice website and within the practice leaflet but the leaflet was not available at reception on the day of inspection.
- On the day of inspection we did not see information available within the reception or waiting area that informed patients of how to complain if they wanted, however the practice told us this was available on the television screen. Information was sent following the practice that illustrated that this had been resolved.
- Complaints were not routinely discussed at partner or clinical meetings.
- Not all outcomes were recorded in relation to the complaint following the final response letter.

We looked at three complaints received since our last inspection and found these were dealt with in a timely way. However, The practice did not follow their own complaints procedure which indicated that patients would be offered a face to face meeting. There was no evidence that these had been offered.

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 initial inspection on 10 May 2016, we rated the practice as requires improvement for providing well-led services as there were improvements needed within their governance structure in relation to areas of risk management.

We undertook a focussed inspection on 20 January 2017 and found that insufficient progress had been made in these areas. We issued a warning notice in respect of these issues.

We undertook a comprehensive follow up inspection of the service on 23 August 2017 and found that improvements were still required in these areas. The practice is still rated as inadequate for being well-led.

Vision and strategy

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

• The practice had a mission statement though this was not displayed and not all staff knew and understood the values.

Governance arrangements

The practice had a governance framework but this did not support the delivery of the strategy or good quality care.

• There was a clear staffing structure and that staff were aware of their own roles and responsibilities. GPs and nurses had lead roles in key areas.

• Practice specific policies were implemented and were available to all staff. However, in the area of adult safeguarding, there were different policies held in separate areas, which contained conflicting information.

• A comprehensive understanding of the performance of the practice was maintained. Practice meetings were held monthly which provided an opportunity for staff to learn about the performance of the practice.

• A programme of continuous clinical and internal audit was used to monitor quality and to make improvements.

• There was not an effective system in place for identifying, capturing and managing issues and risks. For example the practice had not undertaken health and safety inspections and there was still an outstanding issue raised during the legionella risk assessment of May 2016 still not resolved and documented again in the risk assessment undertaken in August 2017.

• We saw evidence from minutes of a meetings structure that allowed for significant events to be discussed but lessons were not effectively learned from these, for example, the practice had documented three separate significant events all in relation to the mis-scanning of patient documents. Complaints were not routinely discussed at either partner or clinical meetings.

Leadership and culture

Areas were identified where strong leadership was required to ensure an effective and consistent approach to all issues was adopted by practice management. These issues included management of complaints, staff recruitment, significant events management, staff training and acting upon issues identified within risk assessments. Our findings from this inspection indicated the management team lacked the capacity to oversee the changes required to meet the regulatory breaches previously identified. The lack of change in some areas therefore placed patients and staff at risk particularly in regard of health and safety. These included:

- Not all relevant employment checks had been completed prior to the starting of employment.
- Actions that were required following risk assessments had not been undertaken.
- A significant events policy that whilst ensured issues were discussed the lessons from these were not addressed in a manner that enabled them to become embedded.
- Staff had undergone the majority of their expected training but no non-clinical staff had been trained in adult safeguarding on the day of inspection.
- The provider had reviewed their complaints procedure as required following our initial inspection and had provided the appropriate signposting information to patients should they wish to escalate their complaint. However, evidence was seen at this inspection that they were not following the complaints policy.

Staff felt supported by management and 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 said they felt

Are services well-led?

Inadequate

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

respected, valued and supported, particularly by the partners in the practice. All staff were involved in discussions about how to run and develop the practice, and the partners encouraged all members of staff to identify opportunities to improve the service delivered by the practice.

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

The practice encouraged and valued feedback from patients, the public and staff. It proactively sought patients' feedback and engaged patients in the delivery of the service.

• The practice had gathered some feedback from patients through the patient participation group (PPG) and through surveys and complaints received. The PPG met regularly; however, patients we spoke to on the day of inspection were not aware of the PPG or how to contact them. The practice told us that information was displayed on the television screen within the reception areas to inform patients of the group, however when viewing the screen as part of the inspection this information was not seen.

• The practice had also gathered feedback from staff through staff meetings and discussion. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged to improve how the practice was run.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints How the regulation was not being met: The practice could not demonstrate that they had complied with their complaints procedure. This was a breach of regulation 16 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing How the regulation was not being met: The practice could not demonstrate all staff received appropriate training. This was a breach of regulation 18 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: The provider had failed to ensure the medicine management systems were safe. This was a breach of regulation 12 (1) of the Health and Social Care Act 2008 Regulated Activities) Regulations 2014

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: The practice could not demonstrate that they had an adequate governance system in place to manage the assessing, monitoring and mitigation of risks relating to the health, safety and welfare of service users and others who may be at risk. This was in breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.