Spring Farm Surgery

Quality Report

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

Ratings

Overall rating for this service	Inadequate
Are services safe?	Inadequate
Are services effective?	Requires improvement
Are services caring?	Inadequate
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 Spring Farm Surgery 22 May 2017.

The inspection was a comprehensive follow up of an inspection on 17 February 2016 where the practice was rated inadequate for safe, requires improvement for effective, caring and well led and good for responsive. Overall the practice was rated requires improvement. At this inspection we found breaches of legal requirements and we issued an urgent suspension of the provider's registration for a period of six months to enable the provider to take action to improve while removing patients from the risk of harm. A caretaker practice has since been identified by NHS England to provide care and treatment to patients at the practice during this period. Overall, at this inspection the practice is rated as inadequate.

The report from our last comprehensive inspection can be found by selecting the 'all reports' Spring Farm Surgery on our website at www.cqc.org.uk.

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

- There was no evidence of learning and communication with staff about incidents, near misses and concerns.
- Patients were at risk of harm because systems and processes were not in place to keep them safe. For example, the practice had failed to adequately review its ability to respond effectively in the event of an emergency or mitigate any risks associated with the absence of oxygen, adequate supplies of emergency medicine and a defibrillator.
- The practice failed to mitigate the risks associated with fire. There was no testing of fire alarms or fire drills. There was no evidence that all staff had undergone fire safety training. There were no designated fire marshals within the practice.
- Electrical safety checks had not been carried out on portable equipment and no health and safety audits were carried out.
- Staff undertaking chaperone duties had not been trained to conduct this role and had limited understanding of what the role entailed.
- There was no programme of in-house training. The practice could not demonstrate how they ensured role-specific training and updating for relevant staff.

Summary of findings

For example, the practice could not demonstrate that all staff had received mandatory training such as fire safety, basic life support, infection control and information governance.

- Appropriate recruitment checks had not always been undertaken prior to employment.
- Patient outcomes were hard to identify as there was limited reference to audits or quality improvement. The audits carried out by the practice were single cycle audits meaning they had not been repeated to ensure improvements had been achieved. There was no evidence that the practice was comparing its performance to others; either locally or nationally.
- Rates of childhood immunisations were below average.
- The practice did not have a patient participation group (PPG). It did have a patient reference group (PRG) however this group was not used effectively as a source of obtaining patient views and keeping patients informed about what was going on at the practice.
- Patients were positive about their interactions with most staff and said they were treated with compassion and dignity. However patient feedback in relation to consultations with GPs was less positive.
- Patients we spoke with told us they were able to get appointments when they needed them however some patients stated on the comment cards that they had to wait too long to get an appointment.
- The practice could not demonstrate that learning from complaints was shared with all staff and that complaints were reviewed regularly to identify any trends.
- The practice had a leadership structure however we found insufficient leadership capacity and limited formal governance arrangements.
- The practice did not have a complete set of practice specific policies which were implemented and were available to all staff. For example staff were unable to show us policies about staff training, health and safety, infection control, complaints and chaperoning.

The areas where the provider must make improvements are:

- Review the system for reporting, recording and sharing learning from significant events to ensure it is effective and that it supports the recording of notifiable incidents under the duty of candour.
- Ensure sufficient quantities of equipment or medicines to ensure the safety of patients and to meet their needs. In particular, the availability of oxygen, a range of emergency medicines and a defibrillator.
- Ensure persons employed for the purposes of carrying on a regulated activity are of good character including by carrying out appropriate pre-employment checks for all staff.
- Update the business continuity plan and ensure it contains contact details for all staff and service providers.
- Ensure a continuous programme of quality improvement, including re-audits is introduced.
- Ensure learning from complaints is discussed, analysed and shared for the purposes of evaluating and improving their practice.
- Ensure effective systems and processes are in place at the practice, in particular regarding vision and strategy, governance, staffing, practice policies, performance awareness, quality improvement, risk management and leadership.
- Provide staff with appropriate support and training to carry out their duties.
- Improve processes to support the seeking and acting on of feedback from relevant persons, including a patient participation group (PPG), on the services provided for the purposes of continual evaluation and improvement.

The areas where the provider should make improvement are:

- Review how patients with caring responsibilities are identified and recorded on the clinical system to ensure information, advice and support is made available to them.

Summary of findings

- Consider how to assist patients with a hearing impairment accessing the service.

On 23 May 2017 we took urgent enforcement action to suspend the providers of Spring Farm Surgery from providing primary medical services under Section 31 of the Health and Social Care Act 2008 ("the Act") for a period of six months to protect patients. We will inspect the practice again prior to the end of the six month suspension. A caretaker practice has been put in place by NHS England to provide primary medical services to patients of the practice during this period.

I am also 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.

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 aware 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 and so safety was not improved.
- Patients were at risk of harm because systems and processes were not in place to keep them safe. For example the practice was not adequately equipped to respond effectively in the event of a medical emergency with the absence of oxygen, no defibrillator and insufficient supplies of medicines to deal with a range of emergencies. Risks to patients, for example those associated with fire and electrical safety were not adequately assessed and mitigated.
- Staff undertaking chaperone duties had not been trained to conduct this role and had limited understanding of what the role entailed.
- Appropriate recruitment checks had not always been undertaken prior to employment.

Are services effective?

Requires improvement

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

- Clinical audits were not repeated to identify any improvements and there for any resulting patient outcomes were hard to identify. There was limited reference to quality improvement overall.
- There was no evidence that the practice was comparing its performance to others; either locally or nationally.
- Multi-disciplinary working was taking place but was generally informal and record keeping was limited or absent.
- The practice could not demonstrate role-specific training for non-clinical staff. There was no programme of training in place for staff. Not all mandatory training had been completed.
- There was limited recognition of the benefit of an appraisal process for staff and little support for any extra training that may be required.
- Data showed patient outcomes were at or above average compared to the national average.

Summary of findings

- End of life care was effectively coordinated.

Are services caring?

Inadequate

The practice is rated as inadequate for providing caring services, as there are areas where improvements should be made.

- Data from the national GP patient survey showed patients rated the practice lower than others for some aspects of care. This was in relation to consultations with GPs in particular.
- The majority of patients said they were treated with compassion, dignity and respect. However, not all felt cared for, supported and listened to.
- The practice did not have a patient participation group (PPG). It did have a patient reference group (PRG) however this group was not used effectively as a source of obtaining patient views and keeping patients informed.
- The practice had only identified 0.9% of its list as carers. There was no carer's pack or other written information available to direct carers to the various avenues of support available to them.
- Information for patients about the services available was easy to understand and accessible.
- We saw staff treated patients with kindness and respect and maintained patient information confidentiality.

Are services responsive to people's needs?

Requires improvement

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

- The practice understood its population profile and had used this understanding to meet the needs of its population.
- Patients we spoke with told us they were able to get appointments when they needed them however some patients stated on the comment cards that they had to wait too long to get an appointment.
- Urgent appointments were usually available the same day.
- The practice did not have an effective system for handling complaints and concerns. The practice's complaints process was not openly advertised. There was no evidence that learning from complaints had been shared with staff.
- The practice did not have a hearing loop in place to support patients with a hearing impairment.

Summary of findings

Are services well-led?

Inadequate

The practice is rated as inadequate for being well-led and improvements must be made.

- The practice did not have a clear vision and strategy. Staff were not clear about their responsibilities in relation to the vision or strategy.
- There was a clear leadership structure; however there was limited evidence of staff empowerment and delegation of responsibilities.
- Safety was not prioritised and this was demonstrated by the lack of appropriate measures to respond effectively to medical emergencies and a general lack of oversight over safety.
- There was no overarching governance framework to support the delivery of the strategy and good quality care. There was limited evidence of arrangements to monitor and improve quality and identify risk.
- The practice was unable to provide evidence of any practice meetings and issues were discussed on an ad hoc basis.
- The practice had not proactively sought feedback from staff or patients and did not have a patient participation group (PPG).
- The specific training needs of staff were not identified and addressed.
- The practice had some awareness of the requirements of the duty of candour, however the systems and processes in place did not always support this. The system in place for managing notifiable safety incidents was not effective in ensuring information was shared with all staff.
- There was little focus on continuous learning and improvement at the practice.

Summary of findings

The six population groups and what we found

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

Older people

Inadequate

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

- Staff were able to recognise the signs of abuse in older patients and knew how to escalate any concerns.
- The practice offered proactive, personalised care to meet the needs of the older patients in its population.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs.
- Health checks for the over 75s were offered as were flu vaccinations.

People with long term conditions

Inadequate

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

- Nursing staff had lead roles in long-term disease management.
- At 98% performance for diabetes related indicators was higher than the CCG average of 80% and the national average of 90%.
- 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.

Summary of findings

Families, children and young people

Inadequate

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

- 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.
- Immunisation rates were below national targets for all 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.

Working age people (including those recently retired and students)

Inadequate

The provider was rated as inadequate for safety and for well-led and requires improvement for effective, caring and responsive. The issues identified as requiring improvement overall affected all patients including this population group. There were, however, examples of 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 and Saturday appointments.
- The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group.

People whose circumstances may make them vulnerable

Inadequate

The provider was rated as inadequate for safety and for well-led and requires improvement for effective, caring and responsive. The issues identified as 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.

Summary of findings

- 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.
- The practice regularly worked with other health care professionals in the case management of vulnerable patients.
- The practice had information available for vulnerable patients about how to access various support groups and voluntary organisations.
- 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)

Inadequate 

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

- The practice carried out advance care planning for patients living with dementia.
- 100% of patients diagnosed with dementia had their care reviewed in a face to face meeting in the last 12 months, which is above the CCG average of 82% and the national average of 84%.
- The practice had a system for monitoring
- repeat prescribing for patients receiving medicines for mental health needs.
- At 100% performance for mental health related indicators was higher than the CCG average of 92% and the national average of 93%.
- The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those living with dementia.
- Patients at risk of dementia were identified and offered an assessment.
- The practice had information available for patients experiencing poor mental health about how they could access various support groups and voluntary organisations.

Summary of findings

- 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.

Spring Farm Surgery

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 and a practice manager specialist adviser.

Background to Spring Farm Surgery

Spring Farm Surgery is a GP practice based in Rainham, a town in the London Borough of Havering. The practice is situated in a residential area on a main road which is well served by local bus routes. There are a few car parking spaces on the practice forecourt and free parking is available outside the practice on surrounding streets. The premises are a converted semi-detached property. They consist of three consulting rooms, a reception area and waiting area all on the ground floor. Additional rooms used as offices are available on the first floor as well as a bathroom. The patient list size at the time of this inspection was around 5400.

The practice is staffed by two GP partners (one male, one female) and a long term locum GP (male) working a total of eight sessions per week. There is also a female practice nurse working 26 hours per week. There is a part time practice manager and six part time reception/ administrative staff. The practice has a General Medical Service contract with NHS England.

The practice is open from 8.30am to 6.30pm on Monday and Friday, 8.30am to 8pm Tuesday and Wednesday and 8.30am to 12.30pm on Thursday. Surgery times are 8.30am to 12.30pm Monday to Friday and then 3pm to 6pm on Monday, 4pm to 8pm on Tuesday and Wednesday (extended hours 6.30pm to 8pm) and 2pm to 6.30pm on Friday. The practice is closed on Thursday afternoon. Outside of these hours patients can contact the local GP hub on a designated number and book appointments in advance. Appointments are available at the hub from 6.30pm daily.

The practice's age distribution data shows a higher than average number of patients aged 75 to 84 years and above. At 79 years for men and 83 years for females the average life expectancy is the same as the national average. The practice locality is in the sixth less deprived decile out of 10 on the deprivation scale.

The practice is registered to carry out the following regulated activities: Surgical procedures; Diagnostic and screening procedures; Treatment of disease, disorder or injury; Family planning from 382 Upminster Road North, Rainham, Havering RM13 9RZ.

The practice was previously inspected on 17 February 2016. At that inspection the practice was rated requires improvement overall with an inadequate rating for safety, requires improvement ratings for effective, caring and well-led and a good rating for responsive. Requirement notices were issued in respect of the breaches of the regulations identified during that inspection.

Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The inspection was planned to check whether the provider is meeting the legal

requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 22 May 2017. During our visit we:

- Spoke with a range of staff including GPs, nursing, management and reception/administrative staff. We 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 a sample of the personal care or treatment records of patients.
- Reviewed comment cards where patients and members of the public shared their views and experiences of the service.
- Visited all practice locations.
- 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 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.

Inadequate

Are services safe?

Our findings

At our previous inspection on 17 February 2016, we rated the practice as inadequate for providing safe services as the arrangements in respect of risk management, medicines management, arrangements for emergencies and major incidents and cleanliness and infection control were not adequate.

These arrangements had not adequately improved when we undertook a follow up inspection on 22 May 2017. The practice is still rated as inadequate for providing safe services.

Safe track record and learning

There was a system for reporting and recording significant events.

- 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).
- There had been eight significant events in the previous 12 months. From the sample of four documented examples we reviewed we found 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.
- At our inspection of 17 February 2016 we found incident reports and alerts were not always discussed at meetings and shared with all staff. The practice had been unable to demonstrate how learning from incidents was shared. At this inspection we found this had not improved. We were told significant events were not discussed with the whole practice at meetings and there was no evidence to demonstrate learning from such incidents was identified and shared. The practice did not carry out a thorough analysis of the significant events in order to identify any trends to prevent reoccurence.
- We reviewed patient safety alerts and saw appropriate action was taken. For example following the receipt of medicines alerts from Medicines and Healthcare products Regulatory Agency (MHRA) we saw that the affected patients were identified and invited to attend for reviews. Medicines were changed where necessary.

Overview of safety systems and processes

Systems and processes in place to minimise risks to patient safety were not always clearly defined and embedded.

- 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. GPs attended safeguarding meetings when possible or provided reports where necessary for other agencies.
- Staff interviewed demonstrated they understood their responsibilities regarding safeguarding and had received training on safeguarding children and vulnerable adults relevant to their role. GPs and nurses were trained to child protection or child safeguarding level three. Non-clinical staff were trained to level one.
- A notice in the waiting room advised patients that chaperones were available if required. At the inspection on 17 February 2016 we found staff acting as chaperones had not been trained for this role. At this inspection we were told that reception/administrative staff acted as chaperones, but they still had not received any training. We found staff were not clear about the responsibilities of this role and how to carry it out effectively, including where to stand during an examination. All staff had received a Disclosure and Barring Service (DBS) check. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).

The practice maintained appropriate standards of cleanliness and hygiene.

- At our inspection on 17 February 2016 we had noted areas of the practice which were visibly dirty and inadequate measures were in place to protect against the risks associated with infections. At this inspection 22

May 2017 we observed the premises to be visibly clean and tidy. There were cleaning schedules and monitoring systems in place. However we found the cleaner's cupboard containing various potentially harmful cleaning products was not lockable.

- It was unclear who the infection prevention and control (IPC) clinical lead for the practice was. The GP partners said it was themselves and the practice nurse. The practice nurse was unaware who the IPC lead was. We were told there was an IPC protocol however this could not be accessed by staff during the inspection. Staff training records were disorganised and incomplete however we saw evidence that one member of staff had received infection control training within the previous year. We also saw that two other members of staff had evidence of some infection control training undertaken in 2015.
- An infection control audit had been carried out by the local infection control team in January 2016. The actions identified had been completed.

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).

- 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. The practice had carried out an audit of patients who had been prescribed methotrexate (a medicine mainly used to treat cancer and autoimmune diseases) to ensure prescribing was in line with best practice guidelines for safe prescribing. Blank prescription forms and pads 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. (PGDs are written instructions for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment).
- At the 17 February 2016 inspection we found the fridge was frozen over which affected the integrity of some of the vaccines being stored inside. At this inspection we found this had been resolved.

At the inspection on 17 February 2016 references could not be found for the majority of staff members but these were longstanding staff members who were employed before the practice registered with the Care Quality Commission. At the inspection of 22 May 2017 we reviewed eight personnel files and found appropriate recruitment checks had not always been undertaken prior to employment. For example, for a member of staff recruited in January 2016 we found no references had been obtained although there was proof of identification and the appropriate checks through the DBS. This was the only member of staff recruited since the practice registered with the Care Quality Commission.

Monitoring risks to patients

At the previous inspection of 17 February 2016 we found risks to patients were not well managed. This included systems relating to management of patients prescribed high risk medicines and monitoring risks to patients. At this inspection of 22 May 2017 we found the procedures for assessing, monitoring and managing risks to patient and staff safety did not adequately support patient safety.

- There was no health and safety policy available and no health and safety risk assessments had been carried out.
- At the inspection of 17 February 2016 we found the practice did not have a fire risk assessment, fire drills were not carried out, and there were no fire or smoke detectors in the premises. At the inspection of 22 May 2017 we found the practice had an up to date fire risk assessment and smoke detectors had been installed. However fire drills were not being carried out. There were no designated fire marshals within the practice. There was a fire evacuation plan within the business continuity plan.
- Clinical equipment was checked and calibrated to ensure it was safe to use and was in good working order however testing of portable electrical appliances (PAT testing) had not been carried out.
- We were told the practice manager carried out Legionella testing. (Legionella is a term for a particular

bacterium which can contaminate water systems in buildings). However we were not assured the practice manager had sufficient understanding of the relevant risks and procedures to carry out this function effectively. Records of temperature checking for hot water were not maintained. The practice had not carried out an assessment of control of substances hazardous to health (COSHH) although substances such as cleaning products which are subject to this legislation were stored and used on the premises.

- 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

At the inspection on 17 February 2016 we found the practice did not have adequate arrangements in place to respond to emergencies and major incidents. As this inspection we found this had not improved.

- There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency.
- Staff training records were disorganised and incomplete. We saw evidence of basic life support training for only three members of staff within the previous year.
- The stock of emergency medicines available at the practice was insufficient. We found the practice had an antiemetic medicine (a drug that is effective against vomiting and nausea) and adrenalin solution to treat severe allergic reaction. However they did not have medicines to treat patients in the event of suspected bacterial meningitis, hypoglycaemia or severe acute asthma. No risk assessment had been carried out by the practice to demonstrate the decision making process followed to decide which emergency medicines they should hold. There was no process in place to ensure the medicines were checked regularly to ensure they were available and safe to use which was something we had raised with the practice at our previous inspection and they had failed to act on.
- At the inspection of 22 May 2017 we found some emergency medicines were out of date. For example, Chlorophenamine for anaphylaxis which expired in April 2017, Glyceryl Trinitrate spray (to treat high blood pressure and heart failure) which expired in January 2017 and Metoclopramide (used to treat and prevent nausea and vomiting) which was labelled with a patient's name and had expired in February 2017. We had also found out of date medicines amongst the emergency medicines at our previous inspection on 17 February 2016.
- At the inspection on 17 February 2016 we found the practice did not have a defibrillator available on the premises and no risk assessment had been undertaken to demonstrate they had considered how they would be able to sufficiently respond to a medical emergency . A requirement notice was issued as a result. At this inspection on 22 May 2017 we found the practice had still not obtained a defibrillator and the risk assessment they had carried out did not adequately assess the risk this posed to patients. We raised this with one of the partners who told us in the event of a person suffering a cardiac arrest they would call the emergency services or borrow a defibrillator from a nearby practice. They were unable to demonstrate that the any risks associated with these procedures had been assessed and fully appreciated. A first aid kit and accident book were available.
- There was no oxygen source available on the premises. We were told the practice previously had an oxygen tank but this was removed several years previous as it was old and had not been used for some time. This had not been replaced with no consideration given to the risk this posed for patients.

The practice had a business continuity plan for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff but it did not include details and contact information for the practice's utility and service providers. Copies of the plan were not kept off site in the event that the practice premises became inaccessible.

Requires improvement

Are services effective?

(for example, treatment is effective)

Our findings

At our previous inspection on 17 February 2016 we rated the practice as requires improvement for providing effective services as there was no evidence of a programme of quality improvement including completed clinical audits where the improvements made were implemented and monitored.

These arrangements had not improved when we undertook a follow up inspection on 22 May 2017. 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. For example the practice used standard templates for care plans and regularly reviewed unplanned admissions to ensure appropriate action was taken.
- The practice monitored that these guidelines were followed through 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 100% of the total number of points available compared with the clinical commissioning group (CCG) average of 93% and national average of 95%. The exception reporting rate was 6% which was the same as the CCG and national average. (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).

This practice was not an outlier for any QOF (or other national) clinical targets. Data from April 2015 to March 2016 showed:

- At 98% performance for diabetes related indicators was higher than the CCG average of 80% and the national average of 90%. (Exception reporting rate 19% - CCG rate 13%, national rate (12%).
- At 100% performance for mental health related indicators was higher than the CCG average of 92% and the national average of 93%. (Exception reporting rate 9% - CCG and national rate 11%).

  At the inspection on 17 February 2016 we found limited evidence of quality improvement including clinical audit. At this inspection we found this had not improved.
- There had been three clinical audits commenced in the last two years, none of these were completed audits where the improvements made were implemented and monitored.
- Findings were used by the practice to improve services. For example, in November 2016 the practice had carried out an audit of patients with chronic obstructive pulmonary disease (COPD) and receiving a repeat prescription for a high dose combination inhaler. The audit objectives were to review the prescribed inhaler for these patients for suitability and assess whether a suitable alternative could be prescribed and to improve patients' inhaler technique. As a result of this audit six out of the 13 relevant patients identified had their inhaler changed. We were told this audit would be repeated in 2017.
- There was no evidence of participation in local audits, national benchmarking, accreditation, peer review and research.

Information about patients' outcomes was used to make improvements. For example being aware of the increased risk of blood abnormalities and liver cirrhosis with low-dose methotrexate patients the practice reviewed patients prescribed methotrexate to ensure they were having regular blood test. (Methotrexate is a medicine mainly used to treat cancer and autoimmune diseases). They had identified the 13 patients prescribed methotrexate and out of those three patients had blood

tests outstanding. The practice had flagged these patients to ensure when their repeat was due they would be contacted to ensure their blood tests were done prior to any further prescription being issued.

Effective staffing

At the inspection of 17 February 2017 we found staff had the skills, knowledge and experience to deliver effective care and treatment. At the inspection of 22 May 2017 we found evidence of staff training to demonstrate staff had the skills and knowledge to deliver effective care and treatment was limited.

- The practice had an induction programme for all newly appointed staff. This included training in topics such as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality. There was no evidence to show this induction programme was followed in practice.
- The practice could not demonstrate how they ensured role-specific training and updating for relevant staff. For example, the practice could not demonstrate that all staff had received mandatory training such as fire safety, basic life support, infection control and information governance. There was no programme of in-house training. Staff training records were disorganised and incomplete.
- The practice employed a cleaner but had failed to ensure the cleaner had undergone training in infection control and control of substances hazardous to health (COSHH).
- 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.
- Appraisals were carried out by the GPs however this did not include a full assessment of staff learning needs. There was no evidence that non-clinical staff had an appropriate training programme in place to meet their learning needs and to cover the scope of their work. This included ongoing support, one-to-one meetings, coaching and mentoring.

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 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 every six weeks 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.

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:

Requires improvement

Are services effective?

(for example, treatment is effective)

- 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.
- All clinicians were able to advice about diet. The practice nurse offered a weighing service and patients could be referred to a local exercise scheme.

The practice's uptake for the cervical screening programme was 82%, which was the same as the CCG average of 82% and the national average of 81%. There was a policy to offer telephone or written reminders for patients who did not attend for their cervical screening test. A female sample taker was available. 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 also encouraged its patients to attend national screening programmes for bowel and breast cancer.

Childhood immunisations were carried out in line with the national childhood vaccination programme. At the inspection on 17 February 2016 we found childhood immunisation rates were below local and national averages. Childhood immunisation rates for the vaccinations given were lower when compared to the national averages. There are four areas where childhood immunisations are measured; each has a target of 90%. The practice was below the target in all four areas. These measures can be aggregated and scored out of 10, with the practice scoring 8.4 (compared to the national average of 9.1). The practice was aware that this was an area of challenge and would contact parents to remind them about the need for vaccination and to offer education where parents had questions or concerns about having their children vaccinated.

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.

Inadequate

Are services caring?

Our findings

At our previous inspection on 17 February 2016, we rated the practice as requires improvement for providing caring services due to below average survey results and failure to take steps to address these.

At this inspection on 22 May 2017 we found patient's views about some aspects of care remained below average. The provider was unaware of the results of the GP patient survey. In addition the practice did not have an effective patient participation or representation group in place, only 0.9% of patients had been identified as carers and there were no measures in place to ensure they received the necessary support. The practice is now rated as inadequate 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.

Most of the 46 patient Care Quality Commission comment cards we received were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect. Ten responses reported dissatisfaction with the waiting time for a routine appointment which they said was about a week. Two responses reported dissatisfaction with consultations with GPs stating they felt the GP didn't listen and was dismissive.

The practice did not have a patient participation group (PPG). We were told they had a patient reference group (PRG) which is a virtual group of patients practices contact, mainly by email to request their views on various aspects of the practice. We spoke with three patients the practice told us were part of this PRG. 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 did not always feel they were treated with compassion, dignity and respect. The practice was below average for its satisfaction scores on consultations with GPs and above average for its satisfaction scores on consultations with nurses. For example:

- 70% of patients said the GP was good at listening to them compared with the clinical commissioning group (CCG) average of 83% and the national average of 89%.
- 78% of patients said the GP gave them enough time compared to the CCG average of 81% and the national average of 87%.
- 81% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 93% and the national average of 95%.
- 64% of patients said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 78% and the national average of 85%.
- 97% of patients said the nurse was good at listening to them compared with the clinical commissioning group (CCG) average of 90% and the national average of 91%.
- 97% of patients said the nurse gave them enough time compared with the CCG average of 91% and the national average of 92%.
- 100% of patients 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%.
- 99% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 90% and the national average of 91%.
- 91% of patients said they found the receptionists at the practice helpful compared with the CCG average of 86% and the national average of 87%.

Inadequate

Are services caring?

The practice was not aware of the results of the GP patient survey. Prior to the inspection the practice provided the results of the Friends and Families Test from 1 April 2016 to 31 March 2017 which showed out of 172 respondents, 84 (49%) said they were extremely likely to recommend this practice. The practice had ascertained that the main area of dissatisfaction was around getting appointments. They told us they had applied for funds to extend the practice premises in order to employ provide additional clinical staff/hours however this had been turned down by the local CCG. The practice said they would refer patients to local walk in services if they were unable to get a suitable appointment at the practice. No other plans were in place to address the low patient satisfaction scores identified.

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 mostly 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 in relation to the nurse. Responses in relation to the GPs were less positive. For example:

- 71% of patients said the last GP they saw was good at explaining tests and treatments compared with the CCG average of 79% and the national average of 86%.
- 67% of patients said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 73% and the national average of 82%.
- 98% of patients said the last nurse they saw was good at explaining tests and treatments compared with the CCG average of 89% and the national average of 90%.
- 96% of patients said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average of 84% and the national average of 85%.

The practice was not aware of these results at the time of our inspection. At the inspection on 17 February 2016 it had been pointed out to the provider that patient satisfaction was low in some areas following the previous GP patient survey. At that time the practice had not put any systems in place to address those concerns.

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. Staff were aware of this service however it was not advertised in the reception areas to inform patients.
- 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 52 patients as carers (0.9% of the practice list). There was no carer's pack or other written information available to direct carers to the various avenues of support available to them.

The practice did not have a carers' champion to help ensure that the various services supporting carers were coordinated and effective.

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

At our previous inspection on 17 February 2016, we rated the practice as good for providing responsive services.

At this inspection on 22 May 2017 we found the practice did not have an effective system for handling complaints and concerns. This had not been a concern at the time of the inspection of 17 February 2016. 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 Tuesday and Wednesday evening until 8.30pm for working patients who could not attend during normal opening hours.
- Appointments could be booked online and text reminders were available for appointments booked online.
- There were longer appointments available for patients with a learning disability. The practice was aware of patients with a learning disability who lived in a local service and ensured their health needs were met.
- Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice.
- The practice offered dementia screening for patients aged over 65 years.
- 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 such as for Yellow Fever.
- There were was no hearing loop. An interpretation service was available.
- The practice offered minor surgery procedures including cryosurgery.

Access to the service

The practice was open from 8.30am to 6.30pm on Monday and Friday, 8.30am to 8pm Tuesday and Wednesday and 8.30am to 12.30pm on Thursday. Surgery times were 8.30am to 12.30pm Monday to Friday and then 3pm to 6pm on Monday, 4pm to 8pm on Tuesday and Wednesday (extended hours 6.30pm to 8pm) and 2pm to 6.30pm on Friday. The practice was closed on Thursday afternoon. Outside of these hours patients could contact the local GP hub on a designated number. Patients could call ahead and book in advance. Appointments were available at the hub from 6.30pm daily. 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 70% and the national average of 76%.
- 90% of patients said they could get through easily to the practice by phone compared to the CCG average of 70% and the national average of 73%.
- 79% 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 82% and the national average of 85%.
- 98% of patients said their last appointment was convenient compared with the CCG average of 90% and the national average of 92%.
- 84% of patients described their experience of making an appointment as good compared with the CCG average of 69% and the national average of 73%.
- 74% of patients said they don't normally have to wait too long to be seen compared with the CCG average of 60% and the national average of 65%.

Patients told us on the day of the inspection that they were able to get appointments when they needed them however ten responses of the 46 comment card respondents reported dissatisfaction with the waiting time for a routine appointment which they said was about a week.

The practice had a system to assess:

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

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

Patients were asked to contact the practice before 10am. They would then be contacted by a GP in advance to gather information to allow for an informed decision to be made on prioritisation according to clinical need. 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 did not have an effective system for handling complaints and concerns.

- The practice did not have a designated complaints form or policy and verbal complaints were not recorded.
- We were told patients who wished to make a complaint were referred to the practice manager.
- We did not see any information on display advising patients about what to do should they wish to make a complaint or to help them understand the practice's complaints system. A poster in reception provided information about the NHS complaints advocacy service.
- The practice's leaflet directed patients to contact the practice manager if they wished to make a complaint.

We looked at four complaints received in the last 12 months and found add findings for example, whether these were satisfactorily handled, dealt with in a timely way, openness and transparency with dealing with the complaint. We were told lessons were learned from individual concerns and complaints and also from analysis of trends and action was taken to as a result to improve the quality of care. However the practice was unable to provide any evidence of complaints being discussed, for example at practice meetings, and learning being shared.

Are services well-led?

Inadequate

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

Our findings

At our previous inspection on 17 February 2016, we rated the practice as requires improvement for providing well-led services as the practice's governance framework did not always support the delivery of good quality patient care. Also, there was no evidence of the practice seeking or acting upon feedback from staff or patients.

When we undertook a follow up inspection of the service on 22 May 2016 we found these issues remained unaddressed. In addition we found there was no vision or strategy for the practice and no clear leadership arrangements. The partners in the practice could not demonstrate they had the experience, capacity and capability to run the practice and ensure high quality care. The practice is now rated as inadequate for being well-led.

Vision and strategy

The practice did not have a clear vision to deliver high quality care and promote good outcomes for patients.

- The practice did not have an articulated mission statement. Its vision and values were not formalised or known and shared by all staff.
- The practice did not have a clear strategy and supporting business plans which reflected its vision and values. We were told the practice list size had been growing rapidly due to the merger of two practices which created the practice in its present form and the closure of two other local practices. We were told the practice had had plans to extend the building in order to be able to offer additional clinical staff/hours, however this had been turned down by the local Clinical Commissioning Group (CCG). There was no evidence of any future plans or strategy to address the identified ongoing pressures on its services.

Governance arrangements

At the inspection on 17 February 2016 we found the practice's governance framework did not always support the delivery of good quality patient care. At this inspection we found this was still the case.

- There was a clear staffing structure and staff were aware of their own roles and responsibilities. However we found limited examples of joint working or meetings between GPs and the nurse and between the practice team as a whole.
- The practice did not have a complete set of practice specific policies which were implemented and were available to all staff. For example staff were unable to show us policies about staff training, health and safety, infection control, complaints and chaperoning.
- The practice had limited understanding of the performance of the practice.
- We were given conflicting information about the holding of practice meetings. We were told meetings took place where significant events were discussed, however the practice was unable to demonstrate this with practice minutes for example. We were also told clinical and whole practice meetings took place where complaints were discussed but again, no evidence of this was provided. The practice nurse told us clinical meetings did not take place.
- There was no coordinated programme of continuous clinical and internal audit to monitor quality and to make improvements. We saw evidence of three clinical audits but none of these were completed audits where the improvements made were implemented and monitored.
- The arrangements for identifying, recording and managing risks were inadequate. The practice did not have a defibrillator or a source of oxygen and emergency medicines reasonably expected to be held by a GP practice were not available. There was no health and safety policy available and there was no evidence of health and safety risk assessments. Fire drills were not carried out. There were no designated fire marshals within the practice. The practice was unable to provide evidence of electrical safety testing for portable appliances (PAT testing) at the practice. Arrangements to manage the risk of Legionella in the practice's water system were insufficient. The practice did not have its own programme of regular infection control auditing.
- The practice was unable to provide any minutes of any practice meetings.

Leadership and culture

Are services well-led?

Inadequate

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

On the day of inspection the partners in the practice could not demonstrate they had the experience, capacity and capability to run the practice and ensure high quality care. They told us they prioritised safe, high quality and compassionate care, however this was not evident given the lack of action in response to the issues highlighted during the previous inspection. Staff told us the partners were approachable and always took the time to listen to all members of staff.

Arrangements to ensure compliance with the requirements of the duty of candour were not sufficient. (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).There was no evidence of support training for all staff on communicating with patients about notifiable safety incidents. We were told the partners encouraged a culture of openness and honesty. However they were unable to demonstrate this, for example by meeting minutes or any other evidence of discussion about such incidents. There was limited evidence to demonstrate 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 keep written records of verbal interactions as well as written correspondence.

There was a leadership structure in place, however we found that whilst there was a practice manager in place they were not empowered to carry out many of the regular functions associated with practice management such as carrying out appraisals for non-clinical staff and planning staff training programmes. Staff were not allocated any lead roles.

- The practice held and minuted integrated care meetings and meetings with palliative care teams to monitor vulnerable patients. GPs, where required, met with health visitors to monitor vulnerable families and safeguarding concerns.
- Staff told us the practice held team meetings but these were not regular. However they were unable to produce any meeting minutes to demonstrate this.
- Staff told us they could raise any issues as when they arose or by writing it in the team diary. We noted team away days were held every once a year and at Christmas time.
- We found there were limited opportunities for staff to get involved in discussions about how to run and develop the practice. There was no evidence that 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

At the inspection on 17 February 2016 we found limited evidence of the practice encouraging feedback from patients and staff. At this inspection we found this was still the case.

- There was limited evidence of regular communication with patients through the patient reference group (PRG). The practice did not have a Patient Participation Group (PPG). Representatives of the PRG told us they were not contacted regularly or involved in any patient surveys. One member told us they had contacted the practice recently to ask if the group was still functioning as they had not been contacted for some time. Another member said they had been contacted to be informed of the inspection. On being questioned it was apparent the representatives had limited understanding of the role of a PRG. They told us they had previously submitted suggestions for improvements on request but did not get feedback from the practice. They were unable to identify any changes or improvements that had taken place as a result of their feedback.
- The practice was unable to demonstrate improvements as a result of complaints and compliments received. The practice had reviewed the results if the NHS Friends and Family test from April 2016 to March 2017. We were provided with an action plan however this did not detail any measures put in place to address the areas of concerns identified.
- Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management.

Continuous improvement

Are services well-led?

Inadequate

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

There was limited evidence of continuous learning and improvement within the practice. The practice team was part of a local incentivised pilot scheme relating to pre-diabetic checks for patients aged 16 years and above.

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 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 registered person did not do all that was reasonably practicable to assess, monitor, manage and mitigate risks to the health and safety of service users by failing to: • Ensure its ability to respond effectively in the event of an emergency or mitigate any risks associated with the absence of oxygen, adequate supplies of emergency medicine and a defibrillator. • Ensure all staff had received basic life support training. • Assess the risks to the health and safety of service users of receiving the care or treatment and take steps to mitigate such risks, for example regarding health and safety, infection control, fire safety and the safety of electrical equipment. • Ensure a business continuity plan was in place to be followed in the event of a major incident. • Ensure appropriate employment history checks were carried out prior to employing staff in accordance with the practice's policy. • Ensure staff undertaking chaperone duties had received suitable training and were aware of the requirements of the role. • Ensure learning from significant events was shared with all staff. This was in breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation

This section is primarily information for the provider

Enforcement actions

Regulated activity	Regulation
Diagnostic and screening procedures Family planning 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 registered person did not do all that was reasonably practicable to ensure effective systems and processes were in place, specifically by failing to: • Ensure there was a process of quality improvement for example completed clinical audits. • Consolidate the complaints process and ensure learning from complaints was discussed and shared and any trends were analysed and acted upon. • Take steps to improve systems or processes at the practice, in particular regarding vision and strategy, governance, staffing, practice policies, performance awareness, continuous improvement including audits, risk management and leadership. • Ensure systems and processes were in place to support appropriate recruitment checks. • Ensuring all mandatory training was completed by all staff including chaperoning, fire, infection control and information governance. • Ensure the practice had a patient participation group in place. This was in breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
Diagnostic and screening procedures Family planning services Surgical procedures Termination of pregnancies	Regulation 18 HSCA (RA) Regulations 2014 Staffing **How the regulation was not being met:** The registered person had failed to ensure persons employed in the provision of the regulated activities had received such appropriate training as was necessary to enable them to carry out the duties they were employed to perform.

This section is primarily information for the provider

Enforcement actions

- There was no evidence of an induction programme followed for the most recent recruit.
- Evidence of mandatory training in respect of all staff was limited including in fire safety, infection control, basic life support and information governance.

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