The Mandeville Practice

Quality Report

Hannon Rd,
Aylesbury,
Buckinghamshire
HP21 8TR
Tel: 01296 337546
Website: www.mandevillesurgery.co.uk

Date of inspection visit: 5 April 2017
Date of publication: 29/06/2017

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?	Requires improvement
Are services effective?	Inadequate
Are services caring?	Requires improvement
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 The Mandeville Practice on 5 April 2017. Overall the practice is rated as inadequate.

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

- Over the previous two years the practice had gone through significant changes including a new provider and changes of key members of staff, such as some of the GPs and the practice manager.
- The Mandeville practice had a new leadership structure. Staff told us the management and leadership team were approachable and always took the time to listen to all members of staff. However, the findings during the inspection were that the communication between the provider and the practice leadership could be improved.
- The delivery of high quality care was not assured by the leadership, governance or culture in the practice. Systems to monitor and make quality improvements were limited.
- Patients were at risk as they were not always given appropriate support, care and treatment to manage their long term conditions.
- There was an open and transparent approach to safety and a system in place for reporting and recording significant events. However, there was no evidence of identifying learning and communicating this with staff.
- Risks to patients were assessed and managed, with the exception of those relating to the access of emergency medicines and the storage and security of prescription stationery.
- Staff were aware of current evidence based guidance. Staff training records were held centrally by the provider human resources team.
- The practice had a number of policies and procedures to govern activity. This was supported centrally by human resources checking processes and records.
- Information about services and how to complain was available.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- The practice was aware of the requirements of the duty of candour. Examples we reviewed showed the practice complied with these requirements.

Summary of findings

- Data showed some patient outcomes were significantly low compared to the national average. Although some audits had been carried out, we saw no evidence that audits were driving improvements to patient outcomes.

The areas where the provider must make improvements are:

- Ensure they assess, monitor and improve the quality and safety of the services provided and mitigate the risks relating to the health, safety and welfare of patients and others who may be at risk.
- Ensure records for the care and treatment provided to patients are kept securely.
- Seek and act on feedback for the purpose of continually evaluating and improving the services.

The areas where the provider should make improvements are

- Continue to encourage patients to engage with national cancer screening programmes.

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 practice from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

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

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

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

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

- Staff understood their responsibilities to raise concerns, and to report incidents and near misses. However, when things went wrong lessons learned were not always communicated to support improvement.
- Risks to patients were assessed and managed, with the exception of those relating to the storage of emergency medicines and the storage and security of prescription stationery.
- The practice had the necessary equipment and procedures for dealing with emergencies. However, the emergency medicines were stored in a way which could casue a delay in the event of an emergency.
- Recruitment checks were not always carried out in accordance with the practice policy. For example, we saw nurses at the practice had not had relevant checks with the nurse governing body to ensure nurses were eligible to practice within the UK.
- Arrangements for safeguarding reflected relevant legislation and local requirements.
- Staff were appropriately trained to act as chaperones.
- The practice had a comprehensive business continuity plan for major incidents.

Are services effective?

Inadequate

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

- There were limited systems in place to monitor outcomes of care and treatment and measure quality improvement. This included limited clinical audits.
- Not all staff had received appraisals in the last 12 months due to the new provider's staff transfer arrangements. The provider had made the decision to delay the appraisals until May 2017 and following the inspection they have confirmed annual appraisals are in the process of being completed for all staff.
- Some patient outcomes were significantly worse than expected when compared with other local and national services. Necessary action was not taken to improve patient outcomes.
- Unvalidated data from the Quality and Outcomes Framework (QOF) showed outcomes was significantly lower than the local

Summary of findings

and national averages. For example,patients with a foot risk assessment in the last 12 months the practice had achieved 70% compared to the practice target of 90%. For patients with asthma having a review in the last 12 months they had achieved 45% compared to a practice target of 70%.

- Unvalidated data provided following the inspection showed the practice had achieved 100% in other areas of clinical case, for example atrial fibrillation. There was no data provided to show the exception reporting for these clinical areas.
- The practice worked with other services to promote better health outcomes. The practice told us the GP access centre pilot has been adopted by other local practices. The practice told us they engaged with Buckinghamshire County Council Stop Smoking Service and promotional pods are situated within the practice to promote stop smoking.
- The practice took account of the needs and preferences of patients with life-limiting conditions, including patients with a condition other than cancer. However, of patients living with dementia only 37% had a documented care plan in the last 12 months compared to the practice target of 70%.
- Staff worked with other health care professionals to understand and meet the range and complexity of patients' needs.
- Although training needs were centrally managed by human resources the practice management team were not aware of the processes in place on the day of inspection. Following the inspection, the provider has submitted a training monitoring document to demonstrate the training completed by staff.

Are services caring?

Requires improvement

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

- Data from the national GP patient survey (which was completed under the old provider but included satisfaction about some current team members and relates to the same patients) showed patients rated the practice lower than others for many aspects of care. The provider had not taken any action to measure and improve patient feedback in many of the areas which showed lower satisfaction with care provided in the July 2016 patient survey.
- 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 83% and the national average of 82%.
- 74% of patients said the last GP they spoke with was good at treating them with care and concern compared to the CCG average of 87% and the national average of 85%.

Summary of findings

- NHS Friends and Family test results showed that patient satisfaction had increased from 67% (April 2016) to 79% (February 2017) of patients that would be likely or extremely likely to recommend the practice to their family and friends.
- Information for patients about the services available was accessible.
- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.
- Patients told us they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.

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.

- Data from the national GP patient survey (which was completed under the old provider but included satisfaction about some current team members and relates to the same patients) showed patients rated the practice lower than others for many aspects of care. The provider had not taken any action to measure and improve patient feedback in many of the areas which showed lower satisfaction with care provided in the July 2016 patient survey.
- Patient survey reported that access to a named GP and continuity of care was not always available quickly, although urgent appointments were usually available the same day.
- Patients could get information about how to complain in a format they could understand. However, there was no evidence that learning from complaints had been shared with staff.
- The practice had implemented a GP access centre pilot with the aim to improve patient access overall. However, the practice did not offer extended hours for working age patients.
- The practice had a higher than average A&E attendance and this had been identified through an audit undertaken. The practice was involved in a GP access centre pilot with the aim of improving these figures.
- Patients we spoke with said they found it easy to make an appointment with a named GP and there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.

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 had a vision and mission statement but this was not supported by an effective leadership and governance structure locally in the practice.
- The level of care and quality outcomes for some patients was poor.
- The practice had not implemented changes to address previous poor patient outcomes and most of the patient dissatisfaction with the practice.
- A comprehensive understanding of the performance of the practice was not maintained.
- The practice had a governance framework but this was not always effective and did not support the delivery of safe, effective, caring and responsive care.
- An understanding of the performance (clinical performance and patient satisfaction) of the practice was not always used to ensure systems were improved.
- There was no programme of continuous clinical or internal audit to monitor quality of care provided and to make improvements.
- There was no evidence that all staff had received inductions and regular performance reviews or attended staff meetings and events.
- The practice did not hold regular governance meetings and issues were discussed at ad hoc meetings.
- The practice had sought feedback regarding the new GP Access Centre however, they had not proactively engaged with other ways of seeking feedback and ideas for improvement.
- There was no focus on continuous learning and improvement within the practice.
- The practice had recently identified the requirements of the duty of candour. We saw evidence the practice complied with these requirements.
- The provider encouraged a culture of openness and honesty. The practice had systems for being aware of notifiable safety incidents and sharing the information with staff and ensuring appropriate action was taken.
- Staff told us the management and leadership team were approachable and always took the time to listen to all members of staff. Practice staff reported feeling motivated with the recent management support and felt that positive changes had occurred. They told us that they were optimistic that improvements would be made.

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 practice was rated as inadequate. The concerns which led to these ratings apply to everyone using the practice, including this population group.

- Staff were able to recognise the signs of abuse in older patients and knew how to escalate any concerns.
- The practice did not offer personalised care to meet the needs of all the older patients in its population. For example, in relation to the care of patients with dementia. However, the practice did involve older patients in planning and making decisions about their end of life care.
- Nationally reported data showed that outcomes for patients for conditions commonly found in older people were low. For example, 62% of patients with chronic obstructive pulmonary disease had a review of their care compared to a practice target of 90%.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs.
- The practice identified at an early stage older patients who may need palliative care as they were approaching the end of life.
- The practice no longer worked with patients to reduce unplanned admissions to hospital for patients at high risk of admission due to the fact that they were no longer funded for this.
- The practice followed up on older patients discharged from hospital and ensured that their care plans were updated to reflect any extra needs.
- Where older patients had complex needs, the practice shared summary care records with local care services, such as the out of hours service.
- The clinical leadership of the practice had little understanding of the needs of older patients and were not attempting to improve the service for them**.** Services for older patients were therefore reactive, and there was a limited attempt to engage this patient group to improve the service.

People with long term conditions

Inadequate

The practice was rated as inadequate. The concerns which led to these ratings apply to everyone using the practice, including this population group.

Summary of findings

- Nursing staff had lead roles in some areas of long-term disease management but patients at risk of hospital admission were not identified as a priority.
- The practice were in the process of recruiting staff to further enhance the practice knowledge of long-term condition management.
- Performance for diabetes related indicators showed: For patients with a foot risk assessment in the last 12 months they had achieved 70% compared to the practice target of 90%. For patients with asthma having a review in the last 12 months they had achieved 45% compared to a practice target of 70%.
- Performance for asthma related indicators showed: For patients having a review completed in the last 12 months the practice had achieved 45% compared to a practice target of 70%.
- There were emergency processes for patients with long-term conditions who experienced a sudden deterioration in health.
- Home visits were available when needed. However, not all of these patients had a personalised care plan or structured annual review to check that their health and care needs were being met.

Families, children and young people

Inadequate

The practice was rated as inadequate. The concerns which led to these ratings apply to everyone using the practice, including this population group.

- From the sample of documented examples we reviewed we found there were systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances.
- Immunisation rates were relatively high for all standard childhood immunisations.
- Patients told us, on the day of inspection, that children and young people were treated in an age-appropriate way and were recognised as individuals.
- The practice provided support for premature babies and their families following discharge from hospital.
- Appointments were available outside of school hours and the premises were suitable for children and babies.
- The practice worked with midwives, health visitors and school nurses to support this population group. For example, in the provision of ante-natal, post-natal and child health surveillance clinics.
- The practice had emergency processes for acutely ill children and young people and for acute pregnancy complications.

Summary of findings

Working age people (including those recently retired and students)

Inadequate

The practice was rated as inadequate. The concerns which led to these ratings apply to everyone using the practice, including this population group.

- 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.
- The age profile of patients at the practice was mainly those of working age, students and the recently retired but the services available did not fully reflect the needs of this group. The practice did not offer appointments outside of usual working hours. There were no early or extended opening hours for patients who worked or students
- Face to face routine and urgent appointments could not be directly booked by telephone, all patients requiring an appointment had to book a telephone appointment and did not know until they had that telephone consultation whether they would be offered a face to face appointment (if it was considered necessary by the GP).
- Routine appointments could also be booked online as well as ordering of repeat prescriptions.

People whose circumstances may make them vulnerable

Inadequate

The practice was rated as inadequate. The concerns which led to these ratings apply to everyone using the practice, including this population group.

- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice offered longer appointments for patients with a learning disability.
- 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 we spoke with knew how to recognise signs of abuse in children, young people and adults whose circumstances may

Summary of findings

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 practice was rated as inadequate. The concerns which led to these ratings apply to everyone using the practice, including this population group.

- 37% of patients diagnosed with dementia who had their care reviewed in a face to face meeting in the last 12 months, compared to the previous years national average of 84%.
- The practice had a system for monitoring repeat prescribing for patients receiving medicines for mental health needs.
- Only 60% of patients experiencing poor mental health had received an annual physical health check compared to a practice target of 80%.
- The practice had information available for patients experiencing poor mental health about how they could access various support groups and voluntary organisations.
- The practice had a system to follow up patients who had attended accident and emergency where they may have been experiencing poor mental health.
- Staff interviewed had a good understanding of how to support patients with mental health needs and dementia.
- The practice did not carry out advance care planning for patients living with dementia.

Summary of findings

What people who use the service say

The national GP patient survey results were published on June 2016. The survey was completed under the previous provider but relates to the same patients and most of the staff under the current provider. The results showed the practice was performing below local and national averages. 309 survey forms were distributed and 118 were returned. This represented a 38% response rate and 0.7% of the practice's patient list.

- 61% of patients described the overall experience of this GP practice as good compared with the CCG average of 85% and the national average of 85%.
- 55% of patients described their experience of making an appointment as good compared with the CCG average of 72% and the national average of 73%.
- 53% of patients said they would recommend this GP practice to someone who has just moved to the local area compared the national average of 78%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 13 comment cards which were all positive about the standard of care received.

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

NHS Friends and Family test results showed that patient satisfaction had increased from 67% (April 2016) to 79% (February 2017) of patients that would be likely or extremely likely to recommend the practice to their family and friends.

The Mandeville Practice

Detailed findings

Our inspection team

Our inspection team was led by:

a CQC Lead Inspector**.** The team included two GP specialist advisers (a lead GP Spa and a newly recruited GP Spa in an observational role).

Background to The Mandeville Practice

The Mandeville Practice is managed by Practice U Surgeries Limited who are an organisation commissioned to deliver a range of services nationally. They deliver community outpatient appointments across a range of services and hold the contract for 48 GP practices, including four walk-in centres across England.

The Practice U Surgeries Limited took over The Mandeville Practice contract in April 2016 when the previous partnership dissolved. The practice has a patient list size of around 16,000 patients. The practice is part of the Aylesbury Vale clinical commissioning group (CCG). There has been a practice manager in post since the contract was taken over with a new practice manager in post since January 2017.

There are six salaried GPs at the practice and one self-employed (with a mix of three male and four female). The practice has seven nurses (including a lead nurse and two advanced nurse practitioners), three health care assistants, two clinical pharmacists. There are three members of the practice specific management team and a team of reception and administration staff.

The Mandeville Practice is a purpose built premises with car parking for patients and staff. There is easy access for patients/carers with a ramp and a lift. All patient services are on both the ground and first floor. The practice comprises of 13 consulting rooms, two treatment rooms, two patient waiting areas together with administrative and management office and meeting spaces.

The average male and female life expectancy for the practice is 78 and 83 years respectively, which is similar to the national averages of 79 and 83 years. Information from Public Health England 2015 shows the practice population age distribution is not comparable to national averages; the practice has a higher working age population and a lower elderly population. The population has a relatively low ethnicity mix with 3.7% mixed, 13.9% Asian and 4% black. The general Index of Multiple Deprivation (IMD) population profile for the geographic area of the practice is in the fifth less deprived. (An area itself is not deprived: it is the circumstances and lifestyles of the people living there that affect its deprivation score. Not everyone living in a deprived area is deprived and that not all deprived people live in deprived areas).

The Mandeville Practice is registered to provide services from the following location:

The Mandeville Practice

Hannon Road

Aylesbury

Buckinghamshire

HP21 8TR

Prior to the inspection we were informed the practice did not have a registered manager in post. However, we saw evidence that the practice manager had applied to become the new registered manager and this application started before the inspection was announced.

Detailed findings

A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

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, such as the clinical commissioning group, Healthwatch and NHS England, to share what they knew. We carried out an announced visit on 5 April 2017. During our visit we:

- Spoke with a range of staff (including 3 GP, two nurses, the practice manager and various administrator staff) and spoke with patients who used the service.
- Observed how patients were being cared for in the reception area and talked with carers and family members
- Reviewed a sample of the personal care or treatment records of patients.
- Reviewed comment cards where patients and members of the public shared their views and experiences of the service.
- Looked at information the practice used to deliver care and treatment plans.

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

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

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

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

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

Requires improvement

Are services safe?

Our findings

Safe track record and learning

There was a system for reporting and recording significant events.

- Since the new practice manager started in January 2017 a significant event recording process had been implemented and staff knew how to action this. There had been no reported significant events in this time period to review.
- From October 2016 until January 2017 there were no documented incidents.
- Prior to the inspection the clinical commissioning group provided us with a log of significant events from April 2016 until October 2016, that the practice had submitted to them. The practice did not have a copy of this at the time of inspection.
- 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 11 documented examples we reviewed for significant events from April 2016 until October 2016, 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. However, there were no documented incidents or events since October 2016.
- Staff on the day of our inspection told us they thought that there had been significant events reported since October 2016, including when the practice had to call in external services to clear away evidence of drug use from the clinical waste storage area. The practice was unable to provide documented evidence of the event or the discussions, actions and learning following the incident. However, the practice had taken some action and had secured funding to install a metal fence that would discourage antisocial behaviours on the practice premises.
- There was limited evidence that the practice monitored trends in significant events and evaluated any action taken.
- We reviewed safety records, incident reports, patient safety alerts and minutes of meetings where significant events were discussed up until October 2016. However, the clinical meetings and discussions of safety events had not taken place since November 2016.
- We saw some evidence that action was taken to improve safety in the practice. For example, appropriate action was taken following a failure in multiple vaccine fridges, which resulted in the loss of vaccine stock.
- We saw evidence that national safety alerts including from the Medicines and Healthcare products Regulatory Agency were appropriately responded to and relevant action taken.

Overview of safety systems and processes

The practice had clearly defined systems, processes and practices in place to minimise risks to patient safety. However, these were not always followed.

- 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. From the sample of five documented examples we reviewed we found that the GPs attended safeguarding meetings when possible or provided reports where necessary for other agencies.
- Staff we spoke with demonstrated they understood their responsibilities regarding safeguarding and told us they had received training on safeguarding children and vulnerable adults relevant to their role. However, there was no documented evidence of this training available on the day of inspection as staff training records were held centrally by the provider human resources team and the practice management was unaware of the training matrix.
- A notice in the waiting rooms and all consulting rooms 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

Requires improvement

Are services safe?

person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).

The practice maintained appropriate standards of cleanliness and hygiene.

- We observed the premises to be clean and tidy. There were cleaning schedules and monitoring systems in place.
- The practice 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 and there was an IPC protocol. Annual IPC audits were undertaken and we saw evidence that action was taken to address any improvements identified as a result.

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

- There were processes for handling repeat prescriptions 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 carried out some 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 and pads were securely stored when the practice was closed; however, the monitoring system was not sufficient to ensure they were effectively managed during practice opening hours. For example, we found blank prescriptions were stored in printers in unlocked consulting rooms, where there was the risk of them being stolen. They had been left for several hours while staff were out of the practice undertaking home visits. The tracking of prescriptions did not allow for the identification of serial numbers if any were to be missing.
- 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 six personnel files and found most of the appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, evidence of satisfactory conduct in previous employments in the form of references, qualifications, registration with the appropriate professional body and the appropriate checks through the DBS. Although we found all nurses were registered with the governing body there was no documented evidence of checks that nurses were appropriate registered with the Nursing and Midwifery Council upon employment or annually as required.

Monitoring risks to patients

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

- There was a health and safety policy available.
- 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.
- 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).
- 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 did not have adequate arrangements to respond to emergencies and major incidents.

Requires improvement

Are services safe?

- Emergency medicines were not easily accessible to staff. They were kept in a locked store room inside a locked wall cupboard. The medicines were stored individually and not easily transported in the event of an emergency. Equipment to ensure effective use of emergency medicines, such as needles and syringes, were stored in the same store room as the medicines but were also not easily transported in the event of an emergency. The oxygen and defibrillator were stored in a separate location. This could impact the efficiency of responding to an emergency.
- All the medicines we checked were in date and stored securely.
- There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency.
- Although training needs were centrally managed by human resources the practice management team were not aware of the processes in place or records kept on the day of inspection. Following the inspection, the provider has submitted a training monitoring document to demonstrate the basic life support training completed by staff.
- There were emergency medicines, to treat anaphylaxis, available in the treatment room.
- A first aid kit and accident book were available.
- 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.

Inadequate

Are services effective?

(for example, treatment is effective)

Our findings

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 did not monitor 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 (from October 2016) were for the previous provider.

Following the inspection, the practice provided their most recent unvalidated data for 2016/17 and this is detailed with the previous clinical commissioning group (CCG) and national averages to show a comparison. Overall performance provided showed an achievement of 76% compared to the CCG average of 96% and England average of 95% of the previous year.

Data for 2016/2017 showed the practice was significantly below QOF (or other national) clinical targets for some areas of clinical care :

- Overall performance for diabetes related indicators showed an achievement of 72% compared to the CCG average of 92% and England average of 90% of the previous year.
- Overall performance for dementia related indicators showed an achievement of 21% compared to the CCG average of 95% and England average of 97% of the previous year.
- Overall performance for mental health related indicators showed an achievement of 82% compared to the CCG average of 98% and England average of 93% of the previous year.
- Overall performance for chronic obstructive pulmonary disease indicators showed an achievement of 73% compared to the CCG average of 98% and England average of 96% of the previous year.
- Overall performance for asthma related indicators showed an achievement of 57% compared to the CCG average of 92% and England average of 97% of the previous year.

Data from 2016/2017 for the practice showed:

- The practice levels of exception reporting for diabetes related indicators was 16% (Data for 2015/2016 showed the national average as 12%).
- The practice levels of exception reporting for mental health related indicators was 1% (Data for 2015/2016 showed he national average as 11%).

The GP specialist advisor reviewed a sample of records and identified that the exception reporting was not always clinically appropriate. We noted patients with dementia who had not been offered reviews annually but had been exception reported. We also saw patients with diabetes who were inappropriately exception reported as the patient was not 'compliant' with some areas of their treatment. Clinical staff told us that they were not aware of the appropriate clinical reasons for exception reporting.

However, unvalidated data provided following the inspection showed improvement in a number of clinical areas. Performance for the following indicators was 100%:

- Atrial fibrillation
- Secondary prevention of coronary heart disease
- Heart failure
- Hypertension
- Peripheral arterial disease
- Stroke and transient ischaemic attack
- Cancer
- Rheumatoid arthritis

There was no evidence of continuous improvement such as completed clinical audits. However, there were four clinical audits undertaken.

Inadequate

Are services effective?

(for example, treatment is effective)

- Although the practice had completed a number of searches on the clinical system there had been no implemented actions resulting from these.
- The practice were working with the clinical commissioning group pharmacist and had recently started an audit to improve the anticoagulation (blood clotting) in patients with atrial fibrillation (a form of abnormal heart rhythm which can lead to a stroke). This was not a completed audit.
- None of the audits were completed where any improvements identified were implemented and monitored.

The audits were titled:

- Childhood obesity at Mandeville.
- A&E attendances in the under 2's.
- AF in Excellence Anticoagulation Project.
- Impact of GP Access Centre on DNA rates

Effective staffing

Staff demonstrated that in some areas they had the skills and knowledge to deliver effective care and treatment.

- Staff had access to appropriate training to meet their learning needs and to cover the scope of their work. However, this had not been monitored within the practice and the practice were unaware of any training that had been undertaken. This included: safeguarding, fire safety awareness, basic life support and information governance. However, following the inspection, the provider has submitted a training monitoring document to demonstrate the training completed by all staff.
- Staff we spoke with on the day of the inspection told us they had received training and they had an appropriate knowledge and understanding of training in adult safeguarding, infection control and fire safety.
- Staff administering vaccines and taking samples for the cervical screening programme had received specific training which had included an assessment of competence. This was organised and supported by the practice nurse lead. 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 nursing staff were identified through a system of appraisals, meetings and reviews of practice development needs with the lead nurse. GPs completed regular appraisals to renew their General Medical Council (GMC - the public body that maintains the official register of medical practitioners within the United Kingdom) membership.
- Not all staff administration and reception staff had received appraisals in the last 12 months due to the new provider's staff transfer arrangements. The provider had made the decision to delay the appraisals until May 2017 and following the inspection they have confirmed annual appraisals are in the process of being completed for all staff.

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.
- From the sample of five documented examples we reviewed we found that the practice shared relevant information with other services in a timely way, for example when referring patients to other services.

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.

Inadequate

Are services effective?

(for example, treatment is effective)

- 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 not 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 those 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 and smoking and alcohol cessation.

The practice's uptake for the cervical screening programme was 83%, which was comparable with 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. The practice demonstrated how they encouraged uptake of the screening programme by using information in different languages and for those with a learning disability and they ensured a female sample taker was available.

There were failsafe systems 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.

Childhood immunisation rates for the vaccinations given were comparable to the national averages for 2015/2016. There are four areas where childhood immunisations are measured; each has a target of 90%. The practice had achieved the target in all four areas.

The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer. From 2015/16 data the practice results showed.

- For females, 50-70, screened for breast cancer in the last 36 months the practice achieved 69% compared to a CCG average of 77% and national average of 73%.
- For patients, 60-69, screened for bowel cancer within six months of invitation the practice achieved 45% compared to a CCG average of 58% and national average of 56%.

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

Requires improvement

Are services caring?

Our findings

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.

All of the 13 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.

We spoke with six patients. 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.

NHS Friends and Family test results showed that patient satisfaction had increased from 67% (April 2016) to 79% (February 2017) of patients that would be likely or extremely likely to recommend the practice to their family and friends.

We reviewed data from the national GP patient survey, which was published in July 2016. The Practice U Surgeries had taken over the practice in April 2016 and therefore, the published data was not a whole representation of the current provider's performance. The practice was aware of the lower than average feedback from patients regarding their care. Whilst this referred to services received from a provider that no longer managed the practice there was no evidence that the practice had sought more up to date feedback on this aspect of the services they delivered. The staff undertaking the care were mostly the same. However, the practice were currently recruiting for a number of clinical roles as they felt that this would better meet the patients' needs and resulting in increased satisfaction.

The results from the national GP patient survey showed patients felt they were not always treated with compassion, dignity and respect. The practice was below average for its satisfaction scores on consultations with GPs and nurses. For example:

- 78% of patients said the GP was good at listening to them compared with the clinical commissioning group (CCG) average of 88% and the national average of 90%.
- 75% of patients said the GP gave them enough time compared to the CCG average of 88% and the national average of 87%.
- 92% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 97% and the national average of 95%
- 74% of patients said the last GP they spoke with was good at treating them with care and concern compared to the CCG average of 87% and the national average of 85%.
- 84% 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%.
- 87% of patients said the nurse gave them enough time compared with the CCG average of 92% and the national average of 92%.
- 95% of patients said they had confidence and trust in the last nurse they saw compared with the CCG average of 97% and the national average of 97%.
- 83% of patients said the last nurse they spoke with was good at treating them with care and concern compared to the CCG average of 91% and the national average of 91%.
- 78% of patients 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 negatively to questions about their involvement in planning and making decisions about their care and treatment. Results were below local and national averages. For example:

- 70% of patients said the last GP they saw was good at explaining tests and treatments compared with the CCG average of 87% and the national average of 86%.
- 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 83% and the national average of 82%.
- 78% of patients said the last nurse they saw was good at explaining tests and treatments compared with the CCG average of 88% and the national average of 90%.
- 72% 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 provided facilities to help patients be involved in decisions about their care:

- Staff told us that interpretation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patients this service was available.
- Information leaflets were available in easy read format.
- The NHS e-Referral Service was used with patients as appropriate. (The NHS e-Referral Service 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 267 patients as carers (1.7% of the practice list). Written information was available to direct carers to the various avenues of support available to them. Older carers were offered timely and appropriate support.

Staff told us that if families had experienced bereavement, their usual GP contacted them or sent them a sympathy card. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service.

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

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 did not offer extended hours. They had plans to conduct a survey to see when patients would prefer the extended hours to be.
- 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.
- The practice had a higher than average A&E attendance and this had been identified through an audit undertaken. The practice was involved in a GP access centre pilot with the aim of improving these figures.
- 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 and were referred to other clinics for vaccines available privately.
- There were accessible facilities, which included a hearing loop, and interpretation services available.
- The practice had lift to improve access to the first floor consulting rooms.
- Other reasonable adjustments were made and action was taken to remove barriers when patients find it hard to use or access services.
- The practice has considered and implemented the NHS England Accessible Information Standard to ensure that disabled patients receive information in formats that they can understand and receive appropriate support to help them to communicate.

Access to the service

The practice was open between 8am and 6.30pm Monday to Friday. Appointments were from 8.10am to 6.20pm daily. 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.

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

We reviewed data from the national GP patient survey, which was published in July 2016. The Practice U Surgeries had taken over the practice in April 2016 and therefore, the published data was not a whole representation of the current provider's performance. The practice was aware of the lower than average feedback from patients regarding their care. Whilst this referred to services received from a provider that no longer managed the practice there was no evidence that the practice had sought more up to date feedback on this aspect of the services they delivered, other than to review the system for booking appointments. The staff undertaking the care were mostly the same.

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

- 63% of patients were satisfied with the practice's opening hours compared with the clinical commissioning group (CCG) average of 72% and the national average of 76%.
- 49% of patients said they could get through easily to the practice by phone compared to the CCG average of 72% and the national average of 73%.
- 69% of patients said that the last time they wanted to speak to a GP or nurse they were able to get an appointment compared with the CCG average of 84% and the national average of 85%.
- 85% of patients said their last appointment was convenient compared with the CCG average of 92% and the national average of 92%.
- 55% of patients described their experience of making an appointment as good compared with the CCG average of 72% and the national average of 73%.
- 44% of patients said they did notnormally have to wait too long to be seen compared with the CCG average of 55% and the national average of 58%.

The practice were aware of the low satisfaction with accessing appointments and had introduced a new system

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

for booking appointments. All appointments were booked through the GP Access Centre. This meant that all patients that call for an appointment or request an appointment online were offered a telephone call back in place of a 10 minute face to face appointment. Following this call back if the GP or nurse felt that an appointment was necessary then they would book an appointment (usually on the same day).

The practice had undertaken a survey to show patient satisfaction with this service. Between December 2016 and February 2017 the practice surveyed 100 patients that had used this service. The data showed that 79% of patients were either satisfied or very satisfied with this new service, 10% were neither satisfied nor dissatisfied and 10% were either dissatisfied or very dissatisfied with the service.

The practice had a system to assess:

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

This was done by offering a telephone triage appointment with the GP 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 had a system for handling complaints and concerns.

- Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England.
- There was a designated responsible person who handled all complaints in the practice.
- We saw that information was available to help patients understand the complaints system. For example on patient information leaflets and in the patient waiting area.

We looked at eight complaints received in the last 12 months and found these were satisfactorily handled, dealt with in a timely way and with openness and transparency with dealing with the complaint. Lessons were learned from individual concerns and complaints. For example, the practice reviewed the call back procedure following a complaint from a patient who had missed a phone call from the GP and was then unable to speak to the GP when they called the surgery back. However, since November 2016 there has been no documented sharing of learning within the practice team and no meetings to discuss and analyse for trends.

Are services well-led?

Inadequate

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

Our findings

Vision and strategy

The practice had a clear vision to work in partnership with patients and staff to provide the best Primary Care services possible working within local and national governance, guidance and regulations. The practice had a mission statement to improve the health, well-being and lives of patients. However, at the time of our inspection neither the vision or mission statement was supported by an effective leadership and governance structure, there was a lack of strategy and supporting business plans to reflect the vision and values and these were not regularly monitored and updated.

The evidence collected at inspection confirmed that the level of care and quality outcomes for some patients was poor. The quality outcomes were taken over the twelve months since the provider had taken over the practice and provided a snapshot of their performance. The practice had not implemented changes to address previous poor patient outcomes and most of the patient dissatisfaction with the practice.

The practice had recent changes in the leadership team which had resulted in improvements to some areas of governance, particularly in relation to safety within the practice. However, there had not been sufficient time to ensure that all improvements were made and to ensure that procedures were embedded.

Governance arrangements

The practice had a governance framework but this was not always effective and did not support the delivery of safe, effective and responsive care.

- The staffing structure within the leadership team did not ensure that all staff were aware of their own roles. The leadership was provided from two areas – the internal practice management team and the providers' external management team. Until recently there was a lack of communication and integration of processes to ensure that both were working coherently.
- For example, the head office held the staff files which included details of staff employment and ongoing checks. The practice manager did not have direct access to these to ensure that the ongoing checks were being completed.
- There was a lack of governance and systems to ensure that risks associated with the assessment of emergency medicines and nurses governing body checks were identified and mitigated within the practice.
- The practice was in the process of transferring all training to an online package where training could be accessed and compliance recorded. However, staff had not complied with this and on the day of inspection we were not provided with records of staff training undertaken for the 12 months prior and since the provider had taken over the practice. However, training needs were centrally managed by human resources team and following the inspection, the provider has submitted a training monitoring document to demonstrate the training completed by staff.
- Appraisals for non-clinical staff were last undertaken in 2015.
- At the time of inspection some staff were not always aware of all aspects of their role. For example, in relation to managing health reviews for long-term conditions and exception reporting patients appropriately. This led to inappropriate exception reporting and patients not receiving the optimum care to help manage their long term conditions.
- A comprehensive understanding of the performance of the practice was not maintained. Practice meetings had not been held for five months and opportunities for staff to learn about the performance of the practice and to share any learning from significant events and complaints were not utilised.
- There was no programme of continuous clinical and internal audit to monitor quality and to make quality improvements.
- On the day of inspection we found that the practice had not stored records securely at all times. We found documenting relating to a patient's health and well-being left on a printer in an unlocked and empty consulting room.
- Practice specific policies were implemented and were available to all staff. These were updated and reviewed regularly.

Leadership and culture

On the day of inspection the practice told us they prioritised safe, high quality and compassionate care. However, this was not reflected in the evidence on the day of inspection. The Practice Group had policies and procedures in place to enable the practice to enable

Are services well-led?

Inadequate

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

improvements but a lack of cohesion with the practice specific policies and ensuring staff compliance with procedures had not facilitated this. Despite a clinical lead being in place within The Practice U Surgeries and each GP at The Mandeville Practice providing clinical leadership for different areas, this had not ensured clarity and decisions about mitigating risks or to make quality improvements. There had been failures in communication between the provider, the leadership team and staff. For example, significant events learning was not shared with staff and all in-house practice meetings had been cancelled since November 2016.

Staff told us the practice was approachable and always took the time to listen to all members of staff. Practice staff reported feeling motivated with the recent management support and felt that positive changes had occurred. They told us that they were optimistic that improvements would be made.

The practice was aware of and had recently implemented systems to ensure compliance with the requirements of the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).This included support training for all staff on communicating with patients about notifiable safety incidents. The practice encouraged a culture of openness and honesty. From the sample of ten documented examples we reviewed we found 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 kept written records of verbal interactions as well as written correspondence.

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

The practice had sought feedback regarding the new GP Access Centre (this was a new service provided externally that meant patients would ring a call centre to book a telephone appointment with a GP who would then assess whether a face to face appointment was required). The feedback showed that between December 2016 and February 2017, 79% of patients were either satisfied or very satisfied with the new access service. However, they had not proactively engaged with other ways of seeking feedback and ideas for improvement for The Mandeville Practice.

- Due to a lack of team meetings staff were not able to be involved in discussions about how to run and develop the practice or to identify opportunities to improve the service delivered by the practice.
- Staff told us they had the opportunity to raise any issues and felt confident and supported in doing so and that action would be taken.
- The practice did not currently have a patient participation group to enable them to work with the practice to identify and implement improvements
- The NHS Friends and Family test had shown a decrease in patient satisfaction over the last few months. The practice had not found a way to identify why this might be.
- Complaints and compliments received were documented and responded however a wider learning of actions from these were not identified and shared.

Continuous improvement

There was no focus on continuous learning and improvement within the practice. The practice team, however, was forward thinking and part of local pilot schemes to improve outcomes for patients in the area. The practice was one of three local practices to take part in the GP Access Centre project. They worked closely with the clinical commissioning group pharmacist to ensure they had support with medicines management within the practice. The practice told us that they had had approached a local healthy living centre charity to develop a working relationship with them to improve public health outcomes within the local area.

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 17 HSCA (RA) Regulations 2014 Good governance Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: **How the regulation was not being met:** • There was an overall lack of governance structure to drive improvement. There was no system in place to assess, monitor and improve the quality of the services provided, including the quality of the experience of patients in receiving those services. • The practice did not have systems such as regular audits to monitor and improve the quality of the service. • The practice did not have effective communication systems to ensure that views were sought of people who used the service. • Records relating to the management of regulated activity was not kept secure at all times. • The practice did not ensure that accurate and complete records were maintained in relation to the training of staff employed to carry on the regulated activity. • The practice did not mitigate the risks relating to responding to patients promptly in an emergency. • Learning from significant events and complaints was not communicated with all staff within the practice. • There was not an effective system for logging distribution of blank prescription stationery in line with national guidance. This was in breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.