Circuit Lane Surgery

Quality Report

Circuit Lane Surgery
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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

Are services safe?	
Are services effective?	
Are services responsive to people's needs?	
Are services well-led?	

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We undertook an unannounced responsive inspection of Circuit Lane Surgery on 1 December 2016. This was in response to concerns reported to CQC from patients that they were unable to book appointments and there were a series of concerns regarding access to care and treatment and patient safety. As a result of our findings on the inspection we have taken urgent action. We have issued conditions on the provider's registration and told them they must make improvements to the levels of staffing, the safety and quality of services and their governance processes.

Services from Circuit Lane Surgery are provided by One Medicare Ltd.

At this inspection we found:

- There were not sufficient numbers of skilled and experienced staff deployed to ensure patients received the care they needed.
- There was a backlog of patient record summarisation (the incorporation of new patients' medical records to the practice's record system), which dated back to October 2015.
- Patients reported significant delays in obtaining repeat prescriptions. This left patients at risk as they were unable to access their medicines in a timely way. On the day of inspection, there were 435 prescriptions waiting to be processed with the oldest being from 25 October 2016.
- Patient correspondence from external providers, such as hospital and paramedics, was not consistently being dealt with in a timely way. The system for acting on this correspondence posed a risk to patients' health and welfare. For example, letters from external clinicians which required actions from GPs were not always acted on in a timely way.
- A search on the patient medical record system showed 21% of patients on less than four medicines had up to date reviews and for those on four or more 51% were up to date. This indicated that patients were frequently accessing medicines without receiving reviews to ensure their repeat prescriptions were appropriate.
- Governance systems did not ensure that quality improvements were made in a timely way. For example, when risks to patients were identified they were not always acted on or mitigating actions undertaken to address the seriousness and reduce the level of risk to patients.

Summary of findings

- Staff working at the practice were dedicated to the needs of the patient population. We found they were working additional hours or through their protected administration time to provide care to patients.

The areas the provider must make improvements are:

- Improve the level of qualified, skilled and trained staff deployed to protect patients from the associated risks related to their health and welfare and ensure that patients can access appointments in a timely way.
- Ensure governance systems to assess, monitor and improve the quality and safety of the services are reviewed. This includes the implementation of a system which effectively assesses and mitigates risk. The provider must urgently address the continued risks relating to overdue repeat prescription requests, referrals, medication reviews, patient correspondence and paper medical records.

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?

The practice was not providing safe services. There were significant risks to patients' health and welfare:

- Concerns reported by staff and patients to the provider were not acted on to identify, assess and mitigate the risks.
- Staffing levels were not sufficient to ensure the service was safe. The levels of staffing posed a risk to the health and welfare of patients.
- There was not sufficient staffing to enable access to meet patients' needs, undertake tasks related to care and treatment or to prioritise patients on the basis of need.

Are services effective?

The practice was not providing effective services. There were significant risks to patients' health and welfare:

- Patients reported that they were being directed to a local walk-in service by staff because there was a significant shortfall of appointments to meet the demand of the local population. Some of the staff on inspection confirmed that patients were being redirected without an assessment of risk to the patients. There was no assessment process to determine whether a patient was well enough to be redirected.
- There was a backlog of patient records summarisation (the incorporation of new patients' medical records to the practice's record system) from October 2015. This posed a risk due to the potential for a lack of appropriate assessment of each patient registered since October 2015.
- Patients reported long delays in issuing repeat prescriptions, leaving patients at risk if they were unable to access their medicines. On the day of inspection there were 435 waiting to be processed with the oldest being from 25 October 2016.
- Patient correspondence from external providers, such as hospital and paramedics, was often not being dealt with in a timely way. The system for acting on this correspondence posed a risk to patients' health and welfare. For example, letters from external clinicians which required actions from GPs were not always acted on in a timely way.

Summary of findings

- A search on the record system showed 21% of patients on less than four medicines had up to date reviews and for those on four or more 51% were up to date. This indicated that patients were frequently accessing medicines without receiving reviews to ensure their repeat prescriptions were appropriate.
- We saw that there were 116 referrals waiting to be sent. There was a risk that patients would not access external services in a timely way due to the backlog of referrals.

Are services responsive to people's needs?

The practice was not responsive in meeting the needs of all patients. For example:

- Appointments with female and male GPs could be booked; however, the availability of appointments was poor.
- The availability of appointments was significantly low and patients reported not being able to see GPs or nurses without significant waits and having to try and access same day appointments which were booked up quickly morning. Clinical staff worked through their designated administration hours to try and meet the needs of some patients who required appointments and other care.
- Patients told us they found it difficult to book advanced appointments and had to try and book on the day appointments until they found an available appointment slot.
- On the day of inspection, the staff informed us the practice had no pre-bookable appointments until the 23 December.

Are services well-led?

The practice was not well-led. The practice had a governance framework but this did not support the delivery of its model. For example:

- Whilst the provider had identified that there were backlogs of repeat prescriptions, summarising of records and patient correspondence, they did not implement plans to effectively manage the significant risks or implement improvement plans to mitigate these in a timely manner.
- Concerns reported to the provider by staff and patients were not acted on to identify, assess and mitigate risks or the quality of the service.
- When requested, the provider did not provide us with the consistent information we requested regarding appointment scheduling or significant event investigations.

Summary of findings

- Significant events and concerns from staff were discussed, but there was no clear action planning regarding risks identified from significant events.

Summary of findings

What people who use the service say

On the day of inspection, we spoke with six patients who told us that they found it very difficult to book appointments and that there were significant delays in receiving repeat prescriptions. We received three comment cards and two reported significant difficulty in booking appointments.

We looked at patient feedback on NHS Choices and saw that since the provider had taken on the contract there were 10 ratings of the service all of which rated the practice one out of a possible five marks. Patients reported significant difficulties in booking appointments and obtaining prescriptions. In some cases this suggested risks to patients' health and welfare.

Patients who contacted CQC with concerns during November and early December 2016 reported that they were unable to book appointments and those who required repeat prescriptions were often unable to obtain them. There were risks regarding patient safety.

Circuit Lane Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

This unannounced inspection was undertaken by a CQC lead inspector and supported by a GP specialist adviser.

Background to Circuit Lane Surgery

Circuit Lane Surgery is located in the Southcote area of Reading. The premises were purpose built as a medical centre and cover two storeys. All consulting and treatment rooms are on the ground floor. There are approximately 9,800 patients registered with the practice. The age profile of the registered population is similar to the national average with slightly more patients aged between 55 and 69 than average. There are a number of patients experiencing medium to high income deprivation when compared to local and national averages.

All services are provided from: Circuit Lane Surgery, 53 Circuit Lane, Southcote, Reading, Berkshire, RG30 3AN.

The practice has been through a challenging three years with two changes in provider and a number of GPs and managers leaving, which has caused instability in the practice. One Medicare Ltd took the contract from the local clinical commissioning group (CCG) in September 2016. The previous provider was Berkshire Healthcare Foundation Trust who undertook the contract when the practice's partnership ended in 2014. The service is staffed by 2.75 whole time equivalent (WTE) GPs and 2.64 WTE nurses, supported by administration staff, receptionists and a management team. There were male and female GPs available.

The practice is open between 8am and 6.30pm Monday to Friday. Extended hours surgeries are offered on alternate Monday and Thursday evenings between 6.30pm and 8pm and on Saturday mornings between 8.30am and 11am.

When the practice is closed, out-of-hours (OOH) GP cover is provided by the Westcall OOH service.

Why we carried out this inspection

We carried out an unannounced responsive inspection on 1 December 2016 to determine whether the provider was meeting the requirements of the Health and Social Care Act 2008, including the Regulated Activity Regulations 2014.

How we carried out this inspection

Before visiting, we reviewed of information we hold about the practice and asked other organisations to share what they knew. We carried out an unannounced visit on 1 December 2016. During our visit we:

- Spoke with three GPs, three members of nursing staff and members of the reception, support and management staff.
- We spoke with six patients.
- Observed how patients were being cared for.
- Reviewed an anonymised 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.

Are services safe?

Our findings

Safe track record and learning

There was a system in place for reporting and recording significant events but this was not always effective. This included a reporting mechanism for staff. The process pathway for incidents included escalation to the clinical leadership team at One Medicare Ltd, and then dissemination of outcomes to staff at different locations via meetings and correspondence. However, during the inspection we noted concerns staff told us they had raised where no or limited changes had been implemented to make improvements to the service.

We asked staff and the registered manager to show us specific significant events reported in the last two months regarding clinical care at Circuit Lane Surgery. This included an event which had been identified as patient feedback via an NHS Choices website relating to a sick child. The provider noted on the NHS Choices website that an investigation of the concern would take place.

We asked the provider to provide the documentation that supported the investigation and learning from these events. An overview of events was provided with brief descriptions of what actions had been carried out and discussion points. However, we were not provided with the detailed investigation, analysis, learning and actions regarding these significant events.

We saw minutes where significant events were discussed. The discussions showed that GPs had raised concerns regarding staffing levels and the volume of unactioned patient correspondence, which required action. This was discussed on 8 November 2016 and action points noted included increasing emergency appointment slots and that the backlog of patient correspondence was to be reduced by clinicians via remote access (from other sites). However, during the 1 December inspection there were approximately 1,900 patient correspondence loaded onto the system and awaiting action and filing onto patient records, which showed that the action planned had not been implemented effectively to mitigate risks to patients.

Monitoring risks to patients

Risks to patients were not always assessed appropriately or well managed to ensure swift and effective action to improve the safety of the practice. There were procedures in place for monitoring and managing risks to patient and staff safety. However, the risks were not always assessed for their level of impact and the seriousness, with the appropriate action taken.

In November 2016 we received concerns from patients that they were unable to access appointments and their care and treatment needs were being affected as a result. During the inspection. The practice was not able to provide appointments to all the patients requesting access to GPs or nurses due to not having enough appointment slots for the demand.

- Patients we spoke with told us they had to book same day appointments because pre-bookable appointments were often not available. For example, one patient told us they had an acute and moderate health condition for a month and they were prescribed medicine over the phone, but this did not improve their health. They were eventually able to book an appointment after several weeks of ongoing illness. At the same time they tried to book another appointment for their child but were told they needed to choose between them and their child as there were no other appointments available. On the day of inspection, the staff informed us the practice had no pre-bookable appointments until the 23 December.
- We asked staff to provide us with an overview of pre-bookable and same day GP and nurse appointments for November and December 2016. The practice staff and registered manager provided different figures for appointments from data systems. The provider could not provide us with the complete number of appointments during December 2016. Only a week of appointment scheduling from screenshots of the record system was provided to us for December.
- The most complete set of data provided to us for November 2016 indicated there were only 1283 GP and 707 nurse appointments, including advanced nurse practitioner (ANP) appointments, during the whole month for approximately 9,800 patients. The capacity of appointments did not meet the demand for the list of patients.
- The appointments scheduled across the week from 5 December 2016 showed a significantly varied number of appointments per day. For example, on 7 December there were 84 GP appointments and 38 ANP appointments scheduled in contrast to 9 December 2016 where there were 17 GP appointments and 36 ANP appointments. On Wednesday 7 December 2016 the

appointment schedule showed there was no duty doctor on the staff rota. The planning of appointment scheduling was not consistent or aligned with the potential variation of patient demands.

- The provider informed us their care model incorporated support from Advanced Nurse Practitioners (ANPs) who were able to prescribe to patients for some minor illnesses and other conditions. We were informed that part of the additional support for GPs working at Circuit Lane Surgery was additional ANP appointments in December 2016. However, from the information we were provided it was not clear whether additional ANP appointments to support GPs were going to be available from December 2016. For example, an overview of the appointment schedule from 21 November to 25 November 2016 showed 202 ANP appointments were available. This was the same number from 5 December to 9 December 2016. This demonstrated there was no clear increase in ANP support in order to increase appointment capacity.
- The practice operated a duty GP system. However, out of a possible 46 duty doctor sessions in November there were only 25 where a duty GP was available. Without a duty GP available, urgent concerns regarding patient care may be delayed until a GP seeing patients becomes available. This also reduced the ability for GPs to call patients awaiting phone consultations or to see those who required urgent appointments. Non clinical staff told us the lack of duty GPs had put them in the position of having to make decisions as to whether patients needed appointments or not without appropriate clinical advice and support.
- All the staff who delivered services onsite that we received feedback from, including GPs, nurses and non-clinical staff, indicated that the service was unsafe due to staffing levels. .
- The provider informed us they were planning improvements to staffing levels in December 2016. They provided us with an appointment overview for the week beginning 5 December 2016. Data provided to us during the inspection indicated that there were 313 GP appointments provided in the week beginning 21 November. However, for the week beginning 5 December 2016, information provided by the provider indicated that there were 278 GP appointments, which was a decrease on the previous week. There was no indication that GP appointments had increased and the provider could not evidence they had increased the number of GP appointments for December.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice had not been able to offer appointments to all the patients requesting access to GPs or nurses in the three weeks preceding the inspection in December 2016. Therefore the needs of patients unable to access appointments could not be fully assessed.

Staff informed us that when appointment slots were full and patients requested access to a GP or nurse, they often had to refer them to a local GP walk-in service. This was without any assessment tool or training provided to assess whether it was appropriate to refer a patient to another service. The walk-in centre was located in the town centre and required significant travel for potentially unwell patients, including any which may require urgent care.

In August 2016, 57 patients were recorded as visiting the local walk-in centre. This was before the provider took over the contract to run this service in September 2016. However, in September and October this had steadily increased. In November 2016, three months into the provider's contract, 156 patients had been recorded as having attended the walk-in centre, which was significantly higher than any other practice in Reading and from the attendances at the walk-in centre in November 2015.

The practice had a backlog of new patient records requiring summarisation, which the provider inherited from the previous provider in September 2016. This placed patients at risk as their electronic medical record did not include a full assessment of their medical history and therefore potentially no full assessment of their medical needs. However, three months into the contract there were no robust plans to ensure the backlog was reduced. At the time of inspection no members of staff had been trained or employed to undertake summarisation and clear the backlog.

Staff showed us the backlog of records and confirmed the oldest records requiring summarisation was from October 2015. The provider informed us that training was due to be provided to a member of the administration team to undertake this, but no system of reviewing or dealing with the summarising had been put in place within three months of the contract starting. The provider had not appropriately assessed the risk of this backlog or taken appropriate urgent action to resolve and ensure electronic patient records were up to date and clinicians had full access to a patient's medical history.

Management, monitoring and improving outcomes for people

During the inspection, we reviewed the system for signing prescriptions. We found ineffective processes and systems for handling and issuing repeat prescriptions to patients in a timely way. Patients and staff reported significant delays and difficulties in issuing and obtaining repeat prescriptions. A member of support staff counted the repeat prescriptions awaiting processing. There were 435 waiting to be processed with the oldest dating back to 25 October 2016. We confirmed this backlog with a member of the management team and the inspection team reviewed a number of the prescriptions. Amongst the unprocessed prescriptions was a batch of 30 undated prescriptions. Our GP specialist advisor reviewed 10 of these prescriptions, which were for medicines which required a therapeutic level to be maintained to ensure the health of the patient. A delay in the medicines being prescribed placed patients at risk. For example, one prescription was for warfarin, a medicine used to moderate the coagulation of the blood.

From another batch of prescription requests the inspection team reviewed, not all prescriptions had been issued. Clinical and non-clinical staff told us that to reduce the back-log GPs had provided a service on a Saturday for patients to come and obtain their repeat prescriptions. However, this was an adhoc action from the employed GPs and not part of a robust or embedded process put in place by the provider. One member of support staff reported their concerns about the processing of repeat prescriptions for medicines for patients with serious health conditions, including those with heart conditions. They believed the serious and long delays meant patients were going without these important medicines and patients were at risk as a result.

We looked at a system used to receive and monitor correspondence from external providers such as hospitals. This information may include hospital discharge summaries, consultations with clinical consultants or a request for further assessment or tests. On inspection, we saw there were 1944 'active workflows' (tasks) on the system waiting to be filed electronically. The oldest was from 4 October 2016. There were an additional 416 paper

Are services effective?

(for example, treatment is effective)

correspondences and 131 electronic correspondences waiting to be added to the list of 1944. We looked a number of the oldest correspondences and saw a number had been acted on, but others had not. One request for the practice was to ensure a blood transfusion was arranged for a patient on end of life (EOL) care. We looked at the patients' records and identified that this had not been actioned. The request was dated 16 November 2016 and this had still not been actioned on the 1 December 2016. In another example, a patient who had been referred to a local secondary care service had been identified as needing follow up care in a letter received by the practice on 4 October 2016. The GP specialist advisor was unable to identify whether this had been actioned because actions which have been completed were not filed from the correspondence system in the patient's records.

We saw that there were 116 referrals waiting to be sent. There was a risk that patients would not access external services in a timely way due to the backlog of referrals.

A search on the record system showed 21% of patients on less than four medicines had up to date reviews and for those on four or more 51% were up to date. This posed a risk to patients who required long term medicines, because reviews required to ensure medicines remained effective and maintained the health of patients were either not taking place or not being recorded on the patients' records. Therefore the system to monitor medicine reviews was not operating effectively.

The provider informed us they had recognised the risks of the backlog of correspondence and prescriptions and additional clinical staff were going to be deployed. However, at the time of the inspection these changes had not been implemented. Before the inspection North and West Reading Clinical Commissioning Group confirmed that the additional funding had not been provided to the practice for the extra staffing hours required to resolve the backlog.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Access to the service

Circuit Lane Surgery was open between 8.00am and 6.30pm Monday to Friday. There were extended hours appointments on alternative Mondays and Thursdays until 8pm and alternative Saturdays from 8.30am to 11am.

Circuit Lane Surgery's registered population has an age profile similar to the national average with slightly more patients aged between 55 and 69 than average. There is a significant section of the population who experience social deprivation. This has an impact on the demands of the practice and can provide challenges in meeting patients' needs. The provider had not fully considered and planned accordingly to meet the needs of this population since taking on the contract in September 2016.

During our inspection, we spoke with six patients who told us that they found it very difficult to book appointments and that there were significant delays in receiving repeat prescriptions. Comments cards completed by a further three patients on the day of inspection reported significant difficulty in booking appointments.

We asked staff how patients could book specific appointments for cervical screening and home visits. We were informed patients would need to request an appointment slot for cervical screening. However, one patient informed us they had been asked to book a cervical screening appointment and were not able to get one.

We saw that between 14 and 16 home visit slots were allocated every day from 1 December 2016 to the 5 December 2016. We reviewed the number of appointments available with GPs of different genders and saw that there was the ability to see both male and female GPs.

The provider sent us information a formula they used as a baseline for staffing and they told us this was used at Circuit Lane Surgery. This formula indicated that the provider worked to a baseline of 72 prescribing appointments per 1000 patients per week. We asked the provider for a breakdown of appointments in December 2016. They informed us they could not provide a report of these appointments and would have to count them. As a result, we requested screenshots of appointments for a week in December 2016 in place of an overall breakdown across the whole month. This was provided and we counted all prescribing appointments for the week from 5 December to 9 December 2016 and this equated to 475 prescribing appointments. For a population of 9,800 patients the provider's formula would require 706 appointments per week. The 475 appointments for a normal working week during December 2016, did not meet the threshold for prescribing appointments based on the provider's formula per week on the basis of 9,800 patients.

There was a significant shortfall of appointments compared to the demand of the practice population. However, clinical staff told us they worked through their designated administration hours to try and meet the needs of some patients who required appointments and other care.

Patients who contacted CQC with concerns during November and early December 2016 reported that they were unable to book appointments and those who required repeat prescriptions were often unable to obtain them. In some cases patients reported risks to their health.

We looked at patient feedback on NHS Choices and saw that since the provider had taken on the contract there were 10 ratings of the service all of which rated the practice one out of a possible five marks. Patients reported significant difficulties in booking appointments and obtaining prescriptions. In some cases this suggested risks to patients' health and welfare.

The provider informed us they had recognised the risks of the backlog of correspondence and prescriptions and additional clinical staff were going to be deployed. The provider was due to implement additional clinical staffing from 19 December via 'open access' clinics. However, the provider could not provide us with accurate figures regarding the previous, ongoing and future appointments they were due to provide in December 2016.

Are services well-led?

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

Our findings

Vision and strategy

The provider had a clear vision to deliver high quality care and promote good outcomes for patients. However, at the time of inspection the level of care and quality outcomes for patients was poor.

The practice reported that they had worked closely with North and West Reading Clinical Commissioning Group on the development of a new model of care. This included a change from a traditional GP practice structure to one where there are less GPs supported by more advanced nurse practitioners. At the time of inspection, the provider confirmed that they were introducing incremental changes to the appointment system and their intention was to implement the new model of care from the middle of December 2016.

However, the provider told us that the national challenge of recruiting GPs and Advance Nurse practitioners had impacted on the levels of suitably qualified, experienced and skilled staff at Circuit Lane Surgery.

Governance arrangements

The practice had a governance framework but this did not support the delivery of safe, effective and responsive care. We found significant risks were not assessed appropriately to determine the high level of impact to patient safety. The actions to mitigate the risks were ineffective and had not made improvements to the levels and quality of service to patients. For example:

- The provider did not have a plan in place to mitigate the risks associated with the lack of consistent and appropriately trained GPs and Advance Nurse Practitioners. Staff told us that the provider had continued to reduce the number of GP appointments but the reduction had not corresponded with the shortfall in appropriately trained ANP's available to address the lack of GP appointments. The provider told us they were supporting the practice with remote clinical advice and senior leaders with clinical training had provided clinical sessions on some days over the previous three months. However, there was no contingency plan to allow for and ensure the levels of suitably trained, skilled and experienced clinical staff were maintained during the recruitment of new GPs and ANPs.
- The implementation of this model had not dealt with the inherent risks associated with the backlog of patient correspondence; medical record summarising and repeat prescriptions that the provider found were in place when they took on the contract. They did not implement additional plans to identify, assess and manage risks or implement improvement plans based on priorities of risk and patient need in a timely way.
- Staff who worked at the practice told us they repeatedly reported concerns about staffing levels and the backlog of patient correspondence and prescription requests to the provider. We saw there was evidence these concerns were raised or discussed at meetings. The provider did not respond appropriately to plan actions that would mitigate the risks. For example, the backlog of patient correspondence continued to increase from the time the provider took over the contract in September 2016, despite continued reports from staff that they could not deal with the backlog and incoming correspondence. The provider had not responded with action plans that would mitigate the risks and during the inspection we were unable to evidence any improvement.
- We saw meeting minutes which showed staff attended meetings. Significant events and concerns from staff were discussed, but the provider could not provide clear investigation outcomes to significant events. Staff reported that their concerns regarding staffing and risks to patients were not being responded to in order to improve the service.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 The provider was not assessing the risks to the health and safety of service users in regards to receiving the care or treatment and not doing all that is reasonably practicable to mitigate any such risks. The provider did not ensure that where responsibility for the care and treatment of service users was shared with, or transferred to, other persons, working with such other persons, service users and other appropriate persons to ensure that timely care planning took place to ensure the health, safety and welfare of the service users. Specifically risks associated with outstanding and future repeat prescription requests, referrals, medication reviews, patient correspondence and paper medical records. This was in breach of Regulation 12 Safe care and treatment (1)(2)(a)(b)(i)

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 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The system of clinical governance did not ensure that the provider assessed and monitored the quality and safety of the services provided in the carrying on of the regulated activity.

This section is primarily information for the provider

Enforcement actions

The provider did not implement quality improvement where this was required. They did not evaluate and improve their practice in respect of the processing of information regarding the performance of the service.

Specifically in regards to concerns reported by patients and staff and the inherent risks identified by a backlog of patient correspondence and other care related processes.

This was in breach of Regulation 17 Good governance (1)(2)

Regulated activity	Regulation
Diagnostic and screening procedures	Regulation 18 HSCA (RA) Regulations 2014 Staffing Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider did not deploy sufficient numbers of suitably qualified, competent, skilled and experienced persons in order to meet the requirements of this regulation. There was not sufficient staff to provide the care and appointments that the patient population required in a timely way. This posed a risk to the health and wellbeing of patients. This was in breach of Regulation 18(1) Staffing
Family planning services	
Maternity and midwifery services	
Surgical procedures	
Treatment of disease, disorder or injury	