Conway PMS

Quality Report

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

Ratings

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

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Conway PMS on 2 February 2016. We inspected the main site in Plumstead and the branch surgery in Welling. Overall the practice is rated as inadequate.

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

- There was a system in place for reporting, recording, investigating and learning from significant events. We saw one instance where an incident had not been reported.
- Although risks to patients who used services were assessed, the systems and processes to address these risks were not implemented well enough to ensure patients were kept safe. This was in relation to fire safety, infection control, medicines management, training, recruitment, and the administration of vaccines by nurses. Some of these issues were addressed after the inspection.
- Data showed patient outcomes were low in several areas in comparison to national averages. Consent was not always recorded appropriately.
- The majority of patients told us they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment; however we observed several instances where patients' confidentiality was not maintained. The national GP patient survey results showed the practice was rated as being average for consultations with GPs and nurses.
- Patient information and information about services was not always available.
- Patients said they were not always able to make an appointment with a named GP and that there was limited continuity of care. Patients did not always have access to a GP. Urgent appointments were available the same day but non-clinical staff told us they assessed whether patients were in genuine need of urgent care.
- The national GP patient survey results showed the practice was rated below local and national averages for some aspects of access to care.

Summary of findings

- There was a leadership structure and staff felt supported by management; however, governance and leadership arrangements did not support the delivery of good quality care.
- The practice sought feedback from staff and patients; however, actions taken were not sufficient to make improvements to patient satisfaction.

The areas where the provider must make improvements are:

- Ensure annual fire safety training and fire drills are completed, medicines are managed in line with current guidelines and all staff complete training at appropriate intervals.
- Ensure nurses are working to up-to-date Patient Group Directions for the administration of vaccines, policies are reviewed and updated, and all staff are kept aware of and have access to practice policies.
- Ensure patient confidentiality is maintained at all times and patients' records are stored securely.
- Ensure all issues identified in relation to infection control processes are addressed and improved.

In addition the provider should:

- Ensure consent is always appropriately recorded and staff undertake mental capacity training.
- Ensure recruitment procedures include two references for all newly recruited staff, in accordance with the practice's recruitment policy.
- Improve arrangements to address identified risks.
- Ensure homeless patients are able to register and access continuity of care at the practice.
- Ensure all staff are clear on the chaperone procedure.
- Improve the process to ensure patients' need for urgent care is assessed by clinical staff.
- Ensure it continually monitors patient feedback and any areas identified for improvement are acted on.

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

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Inadequate

The practice is rated as inadequate for providing safe services.

- Most staff understood their responsibilities to raise concerns, and to report incidents and near misses. When there were unintended or unexpected safety incidents, reviews and investigations were thorough and lessons learned were communicated to support improvement.
- Risks to patients who used services were not always well assessed and the systems and processes to address risks were not implemented well enough to ensure patients were kept safe. This was in relation to infection control, medicines management and administration, prescription pad monitoring, recruitment procedures, fire safety, infection control and safeguarding training for a nurse. The practice addressed some of these risks after the inspection.
- Staff who acted as chaperones were not trained for the role and not all were aware of the chaperoning procedure. They received this training after the inspection.
- The practice did not conduct regular fire drills. They carried out additional fire drills after the inspection.
- Two Patient Group Directions used by nurses to administer flu vaccines under the proper authorisation had expired in August 2015 and had not been renewed; they were renewed after the inspection.
- There was limited access to a GP across both sites on several days a week, and no access to a GP at either site on one afternoon a week. We saw no evidence of arrangements for GP cover during this time. Patients were able to see a nurse or nurse practitioner at both sites on every day of the week.

Are services effective?

Requires improvement

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

- Data from the Quality and Outcomes Framework showed patient outcomes were average for most health indicators, but it was below average for some diabetes indicators compared to the national average.
- We saw an instance where consent had not been appropriately recorded.
- There was evidence of a programme of quality improvement activity, including a programme of clinical audits.

Summary of findings

- There was evidence of appraisals and personal development plans for all staff.
- Staff worked with multidisciplinary teams to understand and meet the range and complexity of patients' needs.

Are services caring?

Requires improvement

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

- Data from the National GP patient survey published in January 2016 showed patients rated the practice as being average in comparison to others for several aspects of care compared with the local Clinical Commissioning Group (CCG) and national averages.
- Information for patients about the services was not always available. For example, there was no health information, leaflets on finding support or a chaperone poster at the branch site. These were implemented after the inspection.
- We saw that staff treated patients with kindness and respect, but we saw several instances where they did not maintain patient and information confidentiality.
- Most patients we spoke with told us they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. The practice took steps to address this with staff after the inspection.

Are services responsive to people's needs?

Inadequate

The practice is rated as inadequate for providing responsive services.

- Nationally reported data showed the practice was rated below average for some aspects relating to access to care. For example, 50% of respondents were able to get an appointment the last time they tried compared to the Clinical Commissioning Group (CCG) average of 70% and the national average of 76%.
- Some patients reported to us that access to a named GP and continuity of care was not always available quickly, although urgent appointments were usually available the same day. This was consistent with results from the national GP patient survey which showed 7% of patients were always or almost always see or speak to the GP they prefer which was significantly below the CCG average of 34%, and the national average of 36%.
- There were no baby changing facilities.
- There was a hearing loop at the main site to assist patients who had hearing difficulties, but there was no hearing loop at the branch site.

Summary of findings

- A GP partner told us that homeless patients were not able to register as patients to receive on-going care. The practice told us after the inspection that they would allow homeless patients to register.
- The practice signed up to a pilot scheme with a health technology company to trial 20 patients on personal health monitoring equipment
- The practice had a health trainer available who provided advice on diet and exercise to improve health outcomes for patients.
- Information about how to complain was available and easy to understand. Learning from complaints was shared with staff and other stakeholders.

Are services well-led?

Inadequate

The practice is rated as inadequate for being well-led.

- The practice had a vision and a strategy but not all staff were aware of this and their responsibilities in relation to it.
- The governance framework did not support the delivery of the strategy and good quality care. For instance, there were a number of policies and procedures to govern activity, but some of these required updating with practice-specific information and not all staff were aware of processes, procedures and their roles.
- Arrangements for identifying, recording and managing risks, issues and implementing mitigating actions were not robust.
- The practice sought feedback from patients and staff. It had an active patient participation group (PPG).
- Appropriate actions had not been taken to address or improve areas where performance and patient outcomes were below average.

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 is rated as inadequate for the care of older people. The practice is rated as inadequate overall and the issues identified affects all patients including this population group.

- The practice was responsive to the needs of older people, and offered home visits and urgent appointments for those with enhanced needs; however, staff we spoke with told us there was no register of patients aged over 75 years. The practice provided evidence after the inspection of a list of patients aged over 75 years.
- Care and treatment of older people reflected current evidence-based practice, and older people had care plans where necessary.

People with long term conditions

Inadequate

The practice is rated as inadequate for the care of people with long-term illnesses. The practice is rated as inadequate overall and the issues identified affects all patients including this population group.

- Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. The practice contacted patients who presented in hospital to ensure that any on-going needs were quickly addressed.
- Performance for diabetes related indicators was variable. For example, 58% of patients with diabetes had well-controlled blood pressure which was below the national average of 78%. 92% had received the annual flu vaccine over the previous nine months which was in line with the national average of 94%.
- Longer appointments and home visits were available when needed, and there was a dedicated diabetic and respiratory clinic with the practice's specialist nurse.
- All of these patients had a named GP, and most had a personalised care plan in their records. 72% of patients with asthma had a review of their condition in the previous 12 months, which was comparable to the national average of 75%. 91% of patients with chronic obstructive pulmonary disease had a review in the previous 12 months, which was in line with the national average of 90%.

Summary of findings

- For those patients with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multi-disciplinary package of care.
- The practice participated in a local Clinical Commissioning Group scheme with an aim to improve the diagnosis and management of patients with diabetes, hypertension, chronic obstructive pulmonary disease and heart failure.

Families, children and young people

Inadequate

The practice is rated as inadequate for the care of families, children and young people. The practice is rated as inadequate overall and the issues identified affects all patients including this population group.

- There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances.
- Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals. Daily priority appointment slots were reserved for young children who needed to be seen urgently.
- 85% of women aged between 25 and 64 years had a cervical screening test in the previous five years, which was similar to the national average of 82%.
- Appointments were available outside of school hours and the premises were suitable for children; however there were no baby changing facilities.
- We saw examples of joint working with health visitors.

Working age people (including those recently retired and students)

Inadequate

The practice is rated as inadequate for the care of working-age people. The practice is rated as requires inadequate and the issues identified affects all patients including this population group.

- Some patients told us there was limited continuity of care.
- The practice did not have a website available at the time of our inspection but patients were able to book/cancel appointments and order repeat prescriptions via the NHS Choices website.
- The practice offered a range of health promotion and screening that reflects the needs for this age group.

Summary of findings

- There was a 'commuter clinic' from 7.00am to 8.00am on Mondays and there were appointments from 6.30pm to 7.00pm four days a week for working patients who were unable to attend the practice during normal opening hours.
- Telephone appointments were available.

People whose circumstances may make them vulnerable

Inadequate

The practice is rated as inadequate for the care of people whose circumstances may make them vulnerable. The practice is rated as inadequate overall and the issues identified affects all patients including this population group.

- A GP partner told us there were no arrangements to allow people without a fixed address to register or be seen at the practice. They told us the practice would provide immediate care to homeless patients but would not register them as patients at the practice because they were challenging, and that their needs would be better met via local walk-in clinics. The practice told us after the inspection that they would allow homeless patients to register.
- The practice held a register of patients living in vulnerable circumstances including those with a learning disability. It had carried out annual health checks for people with a learning disability and out of 20 of these patients, nine had received a review of their care in the previous nine months. The practice manager told us the remaining 11 patients had not previously been able to attend and they were due to be reviewed by March 2016.
- The practice offered longer appointments for patients with a learning disability and regularly worked with multi-disciplinary teams in the case management of vulnerable people.
- Staff knew how to recognise signs of abuse in vulnerable adults and children and 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. We requested, but were not provided with, evidence of safeguarding training to the appropriate level for all members of staff.

People experiencing poor mental health (including people with dementia)

Inadequate

The practice is rated as inadequate for the care of people experiencing poor mental health (including people with dementia). The practice is rated as inadequate overall and the issues identified affects all patients including this population group.

Summary of findings

- 76% of patients diagnosed with dementia had had their care reviewed in a face-to-face meeting in the previous 12 months, which was comparable to the national average of 84%.
- 93% of patients with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive, agreed care plan in the previous 12 months, which was comparable to the national average of 88%.
- The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. They had carried out advance care planning for patients with dementia.
- The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations.
- The practice had a system in place to follow up patients who had attended accident and emergency where they may have been experiencing poor mental health.
- Staff had a good understanding of how to support patients with mental health needs and dementia. Some staff told us they had received training on how to care for people with enhanced mental health needs, but none had received dementia awareness training.

Summary of findings

What people who use the service say

The national GP patient survey results published on 7 January 2016 showed the practice was performing below local and national averages. Four hundred and nine survey forms were distributed and 109 were returned. This represented approximately 2% of the practice's patient list.

- 60% found it easy to get through to this surgery by phone compared to the clinical commissioning group (CCG) and national average of 73%.
- 50% were able to get an appointment to see or speak to someone the last time they tried (CCG average 70%, national average 76%).
- 58% described the overall experience of their GP surgery as fairly good or very good (CCG average 81%, national average 85%).
- 54% said they would definitely or probably recommend their GP surgery to someone who has just moved to the local area (CCG average 75%, national average 79%).

As part of our inspection we also asked for Care Quality Commission comment cards to be completed by patients prior to our inspection. We received four comment cards which were all positive about the standard of care received. There were comments regarding pleasant and helpful staff.

We spoke with eight patients during the inspection, including a member of the practice's patient participation group. The majority of these patients said they were happy with the care they received and thought staff were approachable, committed and caring. There were two comments regarding difficulties getting appointments or seeing a preferred GP.

The practice carried out a monthly friends and family test. In January 2016, 338 survey forms were distributed and 51 were returned, which represented around 1% of their patient list. Results showed that 75% of patients at the practice were either likely or very likely to recommend the practice to a friend or family member, and 14% were unlikely or very unlikely to do so. There were positive comments on the service being efficient with approachable doctors**,** and negative comments about difficulty reaching the practice by telephone and a lack of continuity of care with GPs.

Conway PMS

Detailed findings

Our inspection team

Our inspection team was led by:

a CQC lead inspector**.** The team included a GP specialist advisor, a second CQC inspector and a practice manager specialist advisor.

Background to Conway PMS

The practice operates from two sites; the main site (Conway PMS) is situated in Plumstead and the branch site (Welling Medical Centre) is located in Welling. Conway PMS is one of 42 GP practices in the Greenwich Clinical Commissioning Group (CCG) area. There are approximately 4,600 patients registered at the practice. The practice is registered with the Care Quality Commission (CQC) to provide the regulated activities of diagnostic and screening procedures, family planning, maternity and midwifery services, surgical procedures, and treatment of disease, disorder or injury.

The practice has a personal medical services (PMS) contract with the NHS and is signed up to a number of enhanced services (enhanced services require an enhanced level of service provision above what is normally required under the core GP contract). These enhanced services include influenza and pneumococcal immunisations, remote care monitoring and rotavirus and shingles immunisation.

The practice has a higher than average population of patients aged 15 to 59 years. It has an above national average income deprivation level affecting children and adults.

The clinical team includes two male partners, one of whom is a pharmacist who does not work at the practice, and the other is a GP. There are two male locum GPs and a female locum GP. There are two practice nurses and a nurse practitioner. The GPs provide a total of 10 fixed sessions per week, with one of the locum GPs providing additional sessions as and when required. The female locum GP provides a varying number of sessions, with one session per week planned in February 2016. The clinical team is supported by a practice manager, an assistant practice manager and six reception/administrative staff.

The main site is open from 8.00am to 6.30pm Monday, Tuesday, Wednesday and Friday, and 8.00am to 2.00pm Thursday. The branch site is open from 9.00am to 7.00pm Monday to Friday, and 9.00am to 2.00pm Wednesday. It offers extended hours at both sites from 7.00am to 8.00am on alternate Mondays and from 6.30pm to 7.00pm Monday, Tuesday, Wednesday and Friday. Appointments are available from 7.00am to 6.00pm Monday, 8.00am to 1.00pm and 2.30pm to 7.00pm Tuesday and Wednesday, 9.30am to 1.00pm and 3.30 to 7.00pm Thursday, and from 8.00am to 12.00pm and 3.30 to 7.00pm Friday. Appointments with the GP are not available on Wednesday afternoon. Both sites are closed on bank holidays and at weekends.

There are two consulting rooms and a treatment room on the ground floor and one consulting room on the first floor at the main site, and two consulting/treatment rooms at the branch site, both of which are on the ground floor. There is wheelchair access at both sites but there are no baby changing facilities.

The practice has opted out of providing out-of-hours (OOH) services and directs patients needing urgent care out of normal hours to contact the NHS emergency and urgent care service.

Detailed findings

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme. This provider had not previously been inspected by the Care Quality Commission.

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 2 February 2016.

During our visit we:

- Spoke with a range of staff including the practice manager, GPs, nurses, non-clinical staff, and spoke with patients who used the service.
- Observed how patients were being cared for and talked with carers and/or family members.
- 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.

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

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

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

- Older people
- People with long-term conditions
- Families, children and young people
- Working age people (including those recently retired and students)
- People whose circumstances may make them vulnerable
- People experiencing poor mental health (including people with dementia)

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

Inadequate

Are services safe?

Our findings

Safe track record and learning

There was a system in place for reporting and recording significant events.

- Staff told us they would inform the practice manager of any incidents and there was a recording form available on the practice's computer system. We saw one instance where a nurse had identified an error in the week prior to the inspection. This was investigated by the nurse with the GP in charge of the patients' care, and the patient received a verbal apology and full verbal explanation but the incident had not been recorded as a significant event or discussed practice-wide.
- The practice carried out an analysis of significant events.
- We reviewed safety records, incident reports national patient safety alerts and minutes of meetings where these incidents were discussed.

When there were unintended or unexpected safety incidents, patients received reasonable support, truthful information, a verbal and written apology and were told about any actions to improve processes to prevent the same thing happening again.

Overview of safety systems and processes

The practice had insufficient systems, processes and practices in place to keep patients safe, which included:

- An infection control audit was undertaken in 2014 but the practice had not taken action to address all improvements identified as a result. For example, hand-washing sinks had not been changed to meet current recommendations; the practice told us they were waiting for funding to replace them. The practice installed a new sink that was compliant with current requirements after the inspection. They carried out a further audit after the inspection to check their cleaning and infection control processes; the audit identified areas that required improvement, with agreed timescales.
- There was a hand washing sink in the main site's reception office but there was no tissue dispenser available and hand tissues had been stored directly in front of and above paper records and other documents, which presented a risk of cross-contamination. Staff at the main site told us they used gloves to handle specimen bags but there were none available in the reception office during our inspection. They also said they were not aware of spill kits being available for the management of spilled bodily fluids. After the inspection, the practice ensured that gloves were available and they updated staff on the availability and location of the spill kits.
- At the branch site a small vaccines fridge was dirty. After the inspection, the practice submitted a daily cleaning rota template that included the fridge, to ensure that fridges would be cleaned.
- The lead GP was the infection control lead but staff we spoke with, including the lead GP and the nurse, were not clear about this, and the infection control policy did not contain this information. Most staff had received up to date infection control training but there was no evidence of training for a locum GP. The GP received this training after the inspection and the practice created a separate document detailing who the practice's infection control leads were.
- The practice did not maintain appropriate standards of cleanliness and hygiene in all areas of the practice. We observed the majority of the premises to be clean and tidy but the light cord in the patient toilet at the main site was visibly dirty; the practice provided evidence that the cord was replaced after the inspection. In a nurse's room, dust behind an examination light had not been cleaned and there were stains on the walls, flooring had come away from a wall, which would reduce the effectiveness of cleaning and pose a risk of the spread of infection.
- Arrangements were in place to safeguard children and vulnerable adults from abuse that reflected relevant legislation and local requirements and 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. The GPs attended safeguarding meetings when possible and always provided reports where necessary for other agencies. Staff demonstrated they understood their responsibilities. The practice manager told us GPs and nurses were trained to Safeguarding level 3 and non-clinical staff were trained to level 1. We requested, but were not provided with, evidence of safeguarding training for a nurse. Following

the inspection, the practice provided evidence of training which had been received by the nurse after the inspection, but it did not specify whether the training was for safeguarding adults or children, and it did not state what level of training had been received.

- A notice in the waiting room at the main site advised patients that chaperones were available if required but there were no such posters at the branch site. The practice manager told us non-clinical staff acted as chaperones. None were trained for the role and not all were clear on the chaperoning procedure, but all had received a Disclosure and Barring Service check (DBS check). (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable). Following the inspection, the practice installed chaperone posters at the branch site and ensured chaperones received training for their role.
- There was a fuse box at floor level which could easily have been reached by young children; the practice manager told us they were not certain whether the fuse box was still in use and that they would carry out investigations to confirm this.
- The arrangements for managing medicines, including emergency medicines and vaccines, in the practice were not robust enough to keep patients safe (including obtaining, prescribing, recording, handling, storing and security). In a nurse's room, a box containing medicines used to treat anaphylaxis was not stored securely when not in use. The practice manager told us this was to facilitate access in case of a medical emergency but this had not been risk assessed to ensure patient safety. A small vaccines fridge at the branch site was stocked to full capacity, which did not allow for sufficient air circulation. Temperature records showed that this fridge frequently reached and exceeded maximum recommended temperatures for the safe storage of vaccines but there was no record of what actions the practice had taken to investigate or rectify this. After the inspection, the practice submitted evidence of an investigation of fridge reading errors; although the investigation document identified that the fridge temperature exceeded 11 Celsius (maximum recommended upper limit for safe storage is 8 Celsius) there was no record of disposal of the vaccines, or any attempt to contact the vaccines manufacturer or any public health bodies to seek further advice on whether the vaccines were safe to use. They also sent us evidence showing that the contents of the fridge had been arranged to ensure adequate air circulation.
- Two vaccines fridges were not locked during the inspection and three of them did not have a second thermometer which was independent of the mains power. There was no system in place to ensure that the power to the vaccine fridge at the main site was uninterrupted. There was no system to record medicines which were due to expire shortly. For example, an injectable analgesic medicine had an expiry date of February 2016 (the month of the inspection) but the practice nurse and manager were not aware of this. The practice implemented systems after the inspection to minimise the risk of power to the fridge being interrupted.
- The practice carried out regular medicines audits, with the support of the local CCG pharmacy teams, to ensure prescribing was in line with best practice guidelines for safe prescribing. Prescription pads were securely stored but a GP partner informed us that there was no system in place to monitor the use of prescription pads taken on home visits. After the inspection, the practice provided evidence of a prescription log they had created to track the use of prescription pads.
- Patient Group Directions had been adopted by the practice to allow nurses to administer medicines in line with legislation; however, two of these for flu vaccines had expired in August 2015 (PGDs are written instructions for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment). These PGDs were updated after the inspection.
- We reviewed 15 staff files and found there was evidence of qualifications and registration with the appropriate professional body but other appropriate recruitment checks had not always been undertaken prior to employment. For example, the practice's recruitment policy stated that two references should be obtained prior to new staff commencing work at the practice; we

requested but were not provided with any references for a recently recruited receptionist. After the inspection, the practice sent us evidence of two references, one of which they had received after the inspection.

- There were systems in place 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.

Monitoring risks to patients

Risks to patients were not always well assessed or well managed.

- There was a health and safety policy available but there were no health and safety posters in the reception offices at either site. The practice had an up to date fire risk assessment. The practice manager told us they carried fire evacuation drills involving all staff every six months but we were only provided with evidence of one drill conducted in May 2015 involving the practice manager and assistant practice manager. We requested but were not provided with evidence that any other staff member had been involved in annual fire drills and none of the staff members we spoke with could recall participating in any fire drill, for as long as three years. In addition, we were only provided with evidence of fire safety training for three receptionists. Following the inspection the practice sent us evidence of two fire drills they had conducted after the inspection that involved staff on duty and fire marshal training for the practice manager and assistant practice manager.
- All electrical equipment was checked in January 2012 to ensure the equipment was safe to use and this had been updated in 2015. Clinical equipment was last checked in 2015 to ensure it was working properly. The practice had a variety of other risk assessments in place to monitor safety of the premises such as asbestos, 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).
- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs; however, we noted that there was no GP available at the branch site on Tuesday and Friday afternoons, Wednesday mornings and all day on Mondays, none at the main site on Tuesday and Friday mornings and on all day on Thursdays. There was no GP at either site on Wednesday afternoons. The practice manager told us that patients were still able to receive care from the practice nurse or nurse practitioner, or from a local urgent care centre; however, these members of staff were not able to provide certain treatments for very young babies and women who were over 12 weeks pregnant. There was a rota and peer cover system in place for all the different staffing groups.

Arrangements to deal with emergencies and major incidents

Arrangements in place to respond to emergencies and major incidents were not robust.

- There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency, and there was a panic button in the reception office and two clinical rooms at the main site. The emergency pull cord used to alert staff to an emergency by wheelchair users in the toilet at the main site was broken.
- All staff received annual basic life support training.
- Non-clinical staff told us they assessed whether patients were in genuine need of urgent care. The practice manager informed us they had trialled a pilot to take away the responsibility for decision making in emergency situations from receptionists but the practice had decided not to continue with the pilot and that there was no formal protocol in place. Following the inspection, the practice held a meeting with all staff members to clarify that decisions about patients needing urgent care should be decided by clinicians only.
- The practice had oxygen and a defibrillator available at the main site. There was no audit log to monitor the condition of the oxygen. There was oxygen at the branch site and staff told us they were able to access a defibrillator from a private practice which was in very close proximity in the same building. However, there was no formal agreement in place with this practice and a risk assessment had not been carried out to determine the risks of not having a defibrillator available at the branch site. Following the inspection, the practice sent us an audit log for the oxygen and a formal agreement for shared use of the defibrillator that they had drawn up after the inspection.

Inadequate

Are services safe?

- A first aid kit and accident book were available.
- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the emergency medicines we checked were in date and fit for use. The practice had not carried out a risk assessment to determine which emergency medicines they should have available; they sent us a risk assessment after the inspection which stated that the practice should stock hydrocortisone (a medicine used in the treatment of anaphylaxis) but this medicine was not available at the branch and main sites during the inspection.
- The practice had a comprehensive business continuity plan in place for major incidents such as power failure or building damage but three staff members were not aware of this. After the inspection, the practice held a meeting where they briefed all staff on the continuity plan. The plan included emergency contact numbers for staff.

Requires improvement

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

- There were systems in place to keep clinical staff up to date. The practice manager informed us they disseminated emails informing staff of guideline updates and safety alerts to staff. A nurse told us they could not recall receiving any of these emails, and that they checked various websites sporadically for updates.
- The practice monitored that guidelines were followed through risk assessments and audits for consent, and they carried out random sample checks of patient records.

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent published results were 89.5% of the total number of points available, with 4.7% exception reporting. (Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects). Data from 2015 showed;

- Performance for diabetes related indicators varied;

  92% of patients with diabetes received the annual flu vaccine in the previous seven months, which was comparable to the national average of 94%.

  58% of patients with diabetes had well-controlled blood pressure in the previous 12 months, which was significantly below the national average of 78%.

  71% of patients with diabetes had well-controlled blood sugar levels in the previous 12 months, which was comparable to the national average of 78%.
- Performance for hypertension related indicators was average. 76% of patients with hypertension had well-controlled blood pressure (national average 84%).
- Performance for mental health related indicators was average. 93% of patients with schizophrenia, bipolar disorder and other psychoses had a comprehensive, agreed care plan in the previous 12 months (national average 88%).
- Performance for dementia related indicators was average. 76% of patients with dementia had a face-to-face review of their care in the previous 12 months (national average 84%).

  The practice manager told us the practice had struggled to gain patients' compliance with medicines and attendance to reviews, and they aimed to improve their performance for diabetes and hypertension over the coming year through their participation in the Greenwich CCG's Year of Care scheme. They also informed us that some patients with dementia had not been able to attend for reviews and those outstanding were due to be completed by March 2016.

There was evidence of quality improvement activity, including a programme of clinical audits.

- Prior to the inspection, we requested evidence of audits completed in the previous two years. The practice provided us with three clinical audits, all of which they informed us were completed audits although they contained no re-audit dates. Following the inspection, the practice sent us evidence of two further audits, one of which had been re-audited after the inspection.
- Findings from a respiratory audit conducted on patients with respiratory disease identified an adult patient who needed to step down from receiving triple inhaled therapy, and two children who needed to step down from corticosteroid treatment. All of these patients received the necessary interventions.
- The practice participated in local audits and national benchmarking, and they told us they participated in peer reviews.

Effective staffing

- The availability of GPs was limited across both sites. There was no GP available on several mornings or afternoons of the week, and none throughout the day on one day of the week. During periods when a GP was

Requires improvement

Are services effective?

(for example, treatment is effective)

not available, patients who attended to see a GP during this time were directed to a local urgent care centre, or a nurse or nurse practitioner but there were limitations on the care they were able to provide to certain patients.

- The practice had an induction programme for all newly appointed staff. It covered such topics as the computer system, health and safety and confidentiality.
- During the inspection the practice could not demonstrate how they ensured role-specific training and updating for relevant staff. Following the inspection, the practice provided us with training templates for non-clinical staff that indicated their training needs.
- Staff administering vaccines and taking samples for the cervical screening programme had received specific training that included an assessment of competence. Nurses who administered vaccines could demonstrate how they stayed up to date with changes to the immunisation programmes, for example by access to online resources and discussion at external meetings; however, two Patient Group Directions giving the nurse legal authorisation to administer flu vaccines had expired in August 2015 and had not been renewed. These documents were updated after the inspection.
- The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. All staff had received an appraisal within the last 12 months. Clinical staff had access to support during sessions, one-to-one meetings, appraisals, clinical supervision and facilitation and support for revalidating GPs.
- Staff received training that included safeguarding, basic life support and information governance awareness; however, during the inspection the practice was unable to demonstrate that all members of staff had received appropriate training to meet their learning needs and to cover the scope of their work; some outstanding training was completed after the inspection.

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. Health information leaflets were available at the main site but not at the branch site.
- 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 services to understand and meet the range and complexity of patients' needs and to assess and plan on-going care and treatment. This included when patients moved between services, including when they were referred, or after they were discharged from hospital. We saw evidence that multi-disciplinary team meetings took place on a monthly basis and that care plans were routinely reviewed and updated.

Consent to care and treatment

Staff sought patients' consent to care and treatment in line with legislation and guidance but consent had not always been appropriately recorded.

- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005. When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance.
- Where a patient's mental capacity to consent to care or treatment was unclear the GP or practice nurse assessed the patient's capacity and recorded the outcome of the assessment.
- The process for seeking consent was monitored through regular records audits. We saw an example where a nurse who had administered a vaccine to a young child had not recorded details of who the child had attended with, or who consent for the procedure had been sought from. They told us they did not always record this information. Following the inspection, the practice carried out two consent audits for nursing staff to ensure that recording of consent complied with legislative requirements and guidance. Learning from these audits were discussed with the relevant staff.

Supporting patients to live healthier lives

Requires improvement

Are services effective?

(for example, treatment is effective)

The practice identified patients who may be in need of extra support.

- These included patients in the last 12 months of their lives, those at risk of developing a long-term condition and those requiring advice on their diet and smoking cessation.
- The practice nurse provided smoking cessation and weight management advice. Patients requiring advice on alcohol cessation were signposted to the relevant service.
- The practice had a health trainer available who provided advice on diet and exercise.

The practice's uptake for the cervical screening programme was 85%, which was similar to the national average of 82%.

There was a policy to offer telephone reminders for patients who did not attend for their cervical screening test. The practice ensured a female sample taker was available. The practice encouraged its patients to attend national screening programmes for bowel and breast cancer screening.

Childhood immunisation rates for the vaccinations given to under children aged under two years ranged from 55% to 100% and for five year olds from 40% to 65%.

Patients had access to appropriate health assessments and checks. These included health checks for new patients and NHS health checks for people 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

We observed members of staff were helpful to patients but care was not always taken to maintain patients' confidentiality.

- At the main site, we observed a receptionist informing a patient of their screening result in the waiting area within earshot of other patients, and observed a nurse discussing medicine recommendations with a different patient in the waiting area, also within earshot of other patients. In addition. Paper records were stored on open shelving in the reception office and some patients' surnames were visible from the reception desk. The door to the reception office was kept open throughout our inspection, which gave greater visibility of the records and other confidential information on computer screens to patients we observed standing in the doorway of the reception office to speak with a receptionist. Following the inspection, the practice held a meeting with staff to reinforce the importance of maintaining patient confidentiality. Paper records were rearranged to prevent patients' names from being seen.
- Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments, with the exception of a nurse's room at the Plumstead main site but this room could be locked
- We noted that consultation and treatment room doors were closed during consultations and conversations taking place in these rooms could not be overheard.
- Discussions held at the reception desks at the main and branch sites could easily be heard from the waiting areas due to the close proximity to the reception desk. The practice manager told us they were limited to the layout of the building. Staff told us they were able to take patients to a room if they needed to discuss something in private. This facility was not advertised and needed to be requested by patients; following the inspection, the practice implemented a notice informing patients that a private room was available if needed.

All of the four patient Care Quality Commission comment cards we received were positive about the service experienced. Patients said they felt the practice offered a good service and staff were helpful and caring. We spoke with a member of the patient participation group who also told us they were satisfied with care they had received, and that they were treated with kindness and respect.

Results from the national GP patient survey published on 7 January 2016 showed the majority of patients felt they were treated with compassion, dignity and respect. For example:

- 77% said the GP was good at listening to them compared to the CCG average of 85% and national average of 89%.
- 71% said the GP gave them enough time (CCG average 81%, national average 87%).
- 84% said they had confidence and trust in the last GP they saw (CCG average 93%, national average 95%).
- 72% said the last GP they spoke to was good at treating them with care and concern (CCG average 80%, national average 85%).
- 87% said the last nurse they spoke to was good at treating them with care and concern (CCG average 85%, national average 91%).
- 79% said they found the receptionists at the practice helpful (CCG average 88%, national average 87%).

Care planning and involvement in decisions about care and treatment

Most of the eight patients we spoke with 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 on the comment cards we received was also positive and aligned with these views.

Results from the national GP patient survey showed patients rated the practice comparable to local and national averages for involving them in planning and making decisions about their care and treatment. For example:

- 71% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 81% and national average of 86%.

Requires improvement

Are services caring?

- 66% said the last GP they saw was good at involving them in decisions about their care (CCG average 76%, national average 82%).
- 74% said the last nurse they saw was good at involving them in decisions about their care (CCG average 80%, national average 85%)

The practice did not demonstrate good care towards homeless people. A GP partner told us homeless patients not able to register as patients; therefore they were unable to access continuity of care at the practice. Staff told us translation services were available for patients who did not speak or understand English. We saw notices in the waiting areas informing patients this service was available. After the inspection, the practice told us they would allow homeless patients to register.

The practice manager told us they were aware of feedback from patients and they carried out monthly audits of their Friends and Family test, and quarterly practice patient survey. They informed us there were plans for a locum GP to become a partner working two additional days per week, and they hoped this would offer better continuity of care for patients and improve patient satisfaction. We saw that customer service training had been booked to be completed by reception/administrative staff in March 2016.

Patient and carer support to cope emotionally with care and treatment

Notices and leaflets in the waiting area at the main site told patients how to access a number of support groups and organisations, but this information was very limited at the branch site.

The practice's computer system alerted GPs and nurses if a patient was a carer. The practice had identified 1% of the practice list as carers. We raised this with the practice manager who informed us that carers were identified on new patient registration forms and by read codes if a patient was flagged as a carer by a clinician. There was written information available to direct carers to the various avenues of support available to them.

Staff told us the practice did not offer any bereavement services to patients who had suffered bereavement. Patients who had suffered bereavement and requested to see a GP were given quick access to a clinician who could give them advice on how to find a local support service. Leaflets advertising these services was available in the waiting area at the main site but not at the branch site.

Inadequate

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. For example, the practice signed up to Greenwich CCG's Year of Care scheme in August 2015 with an aim to improve the diagnosis and management of chronic obstructive pulmonary disease, diabetes, hypertension and heart disease.

- The practice offered a 'Commuter's Clinic' on Monday mornings from 7.00am to 8.00am, and evening appointments Tuesday to Friday for working patients who could not attend during normal opening hours.
- There were longer appointments available for patients with a learning disability.
- Home visits were available for older patients and patients who would benefit from these.
- Same day appointments were available for children and those with serious medical conditions.
- Patients were able to receive travel vaccinations available on the NHS. They were directed to other clinics for vaccines which were only available privately.
- A GP partner told us the practice would provide immediate care for homeless patients, but they would not register them as patients because they were challenging, and that the needs of these people could be better met in via local walk-in clinics. After the inspection, the practice told us they would allow homeless patients to register.
- There was no GP available on several mornings or afternoons of the week, and none throughout the day on one day of the week. A nurse or nurse practitioner was always available but there were limitations on the care they were able to provide.
- There were translation and disabled facilities available but the emergency pull cord in the toilet was broken.
- There was a hearing loop available at the main site for patients who had hearing difficulties, but there was no hearing loop at the branch site.
- There were no baby changing facilities.
- Non-clinical staff were due to receive customer service training in March 2016 to improve patients' experience of the service.
- The practice signed up to a pilot scheme with a health technology company to trial 20 patients on personal health monitoring equipment to monitor blood pressure, daily activity and weight. This data would be directly accessible by their GP via an online profile, and would enable a more holistic and effective approach to the patients' care. At the time of inspection, the practice had not assessed the impact of this pilot on patient outcomes.

Access to the service

The main site was open from 8.00am and 7.00pm Monday, Tuesday, Wednesday and Friday, and 8.00am to 2.00pm Thursday. The branch site was open from 9.00am to 7.00pm Monday to Friday, and 9.00am to 2.00pm Wednesday. It offered extended hours at both sites from 7.00am to 8.00am on alternate Mondays. Appointments were available from 7.00am to 6.00pm Monday, 8.00am to 1.00pm and 2.30pm to 7.00pm Tuesday and Wednesday, 9.30am to 1.00pm and 3.30 to 7.00pm Thursday, and from 8.00am to 12.00pm and 3.30 to 7.00pm Friday. Appointments with a GP were not available on Wednesday afternoon. Appointments that could be booked up to six weeks in advance, and daily urgent appointments were available for people that needed them.

Results from the national GP patient survey published in January 2016 showed that patient's satisfaction with how they could access care and treatment was below local and national averages for access to a preferred GP and access to appointments.

- 69% of patients were satisfied with the practice's opening hours compared to the CCG average of 76% and national average of 78%.
- 60% patients said they could get through easily to the surgery by phone (CCG and national average 73%).
- 7% patients said they always or almost always see or speak to the GP they prefer (CCG average 34%, national average 36%).
- 50% said they were able to get an appointment the last time they tried (CCG average 70%, national average 76%).

The practice manager told us they were aware of on-going issues with their telephone system, and that a new digital

Inadequate

Are services responsive to people's needs?

(for example, to feedback?)

call handling telephone system with a queue facility would be implemented following the end of their existing contract in May 2016. They informed us that telephone appointments had been introduced in 2015 to free up physical appointments for patients, and they were in the process of developing an action plan to increase the number of available appointments.

Most patients told us on the day of the inspection that they were able to get appointments when they needed them, but two out of eight had to wait for up to three weeks to get a bookable appointment and found it difficult to see either a GP or the same GP.

Listening and learning from concerns and complaints

The practice had an effective system in place 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 there were posters displayed in the waiting areas to help patients understand the complaints system.

We looked at three complaints received in the last 12 months and found they were dealt with in a timely way, with openness and transparency. Apologies given were appropriate and patients were advised on how to escalate their complaint to external organisations if they were not satisfied with how it had been handled by the practice. Lessons were learnt from concerns and complaints and action was taken to as a result to improve the quality of care. For example, following a complaint from a patient regarding the poor attitude of a nurse and member of reception staff, the practice manager discussed the complaint with the relevant staff members and the patient received a full apology.

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 mission statement which was not displayed in the waiting areas, and staff we spoke with did not know or understand the values.
- The practice had a strategy in place but it was not robust enough to ensure appropriate actions were taken to address and make improvements to several areas of the service.

Governance arrangements

The governance framework did not support the delivery of the strategy or good quality care,

- Not all staff were aware of their own roles and responsibilities. Non-clinical staff told us they carried out informal assessments to determine whether patients required urgent appointments, and they were not clear on the chaperone procedure. A nurse and the lead GP were not aware of their infection control roles. Following the inspection, the practice provided evidence that they had addressed these issues after the inspection.
- Policies were available to all staff on the computer system's shared drive, but a nurse told us they were not aware that a whistleblowing policy was available and other staff were not aware of the business continuity plan for use in non-medical emergencies. Several policies were generic templates. For example, the infection control policy did not name the infection control lead. The policy for needle stick injuries referred to the 'Responsible Person' and local Accident & Emergency department but did not contain details for either. Also the chaperone policy did not state the procedure to be followed. Following the inspection, the practice held a meeting where staff were made aware of the availability and location of policies and the business continuity plan. They had created a separate document detailing the names of the practice's infection control leads, and chaperones received chaperone training.
- Some understanding of the performance of the practice was maintained by the practice leaders but actions implemented to make improvements had not been effective.
- There was evidence of clinical audits which had been carried out in response to issues and incidents.
- There was no effective system for identifying, capturing and managing risks, issues and implementing mitigating actions. Annual fire drills had not been conducted and we were not provided with evidence of fire training for several members of staff. There were inadequate infection control processes in place, medicines had not been managed appropriately and risk assessments had not been conducted in relation to the lack of a defibrillator at the branch site. After the inspection, the practice carried out additional fire drills involving staff on duty, they carried out an additional infection control audit to check their cleaning and infection control processes, and made improvements to the management of vaccines. They also sent us a formal agreement that they had drawn up after the inspection for shared use of the defibrillator with the private practice.
- Two patient group directions in place to give the nurse legal authorisation to administer flu vaccines had expired. These were updated after the inspection.
- Governance systems did not make sure documents such as policies, training certificates and staff files were maintained, and did not ensure staff were up to date with all training appropriate to their roles. The practice ensured outstanding training for infection control and chaperoning was received after the inspection. We were unable to determine whether safeguarding training for a staff member was at the appropriate level.

Leadership and culture

The practice did not have effective leadership arrangements in place. The partners were not always visible in the practice. The practice management team told us that the practice was committed to offering the best care possible for their patients but this was not demonstrated during our inspection.

The provider was aware of and complied with the requirements of the Duty of Candour. The partners encouraged a culture of openness and honesty. The practice had systems in place for knowing about notifiable safety incidents but they were not always shared widely enough.

Are services well-led?

Inadequate

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

When there were unexpected or unintended safety incidents:

- The practice gave affected people reasonable support, truthful information and a verbal and written apology.
- They kept written records of verbal interactions as well as written correspondence.

Staff told us the practice held regular clinical meetings and separate meetings for reception/administrative staff.

- Staff told us there was an open culture within the practice and they had the opportunity to raise any issues at team meetings; they felt confident in doing so and felt supported if they did.
- All staff said they felt respected, valued and supported by the management and partners in the practice.

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

The practice sought patients' feedback but responses to the national GP patient survey published on 7 January 2016 showed the practice was rated below average for aspects of care in relation to access to appointments and preferred GPs. The practice had not implemented a robust plan of action to address this and make the necessary improvements.

- The practice had gathered feedback from patients through the patient participation group (PPG) and through surveys and complaints received. There was an active PPG of seven members which met regularly, carried out patient surveys and submitted proposals for improvements to the practice management team. The practice introduced telephone consultations in response to feedback from PPG members; however, patients' satisfaction with being able to contact the practice by telephone was below average.
- The practice had gathered feedback from staff through informal discussions and yearly appraisals. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and the manager. In response to a suggestion from a receptionist, a formalised prescription form and a more comprehensive new patient registration form were implemented and made available to staff. The practice manager told us they had received positive feedback from staff following this change. Staff told us they felt involved and engaged to improve how the practice was run.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect **How the regulation was not being met:** The registered person failed to ensure the privacy of service users. • Discussions about patients' medicine recommendations and test results were held where they could be overheard by other patients in the waiting area. This was in breach of regulation 10 (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **How the regulation was not being met:** The registered person did not do all that was reasonably practicable to assess, monitor, manage and mitigate risks to the health and safety of service users. They had failed to: • Conduct annual fire evacuation drills and ensure all staff received annual fire training. • Ensure Patient Group Directions used by nurses to administer vaccines under the appropriate authority were up to date.

This section is primarily information for the provider

Requirement notices

- Ensure vaccines were properly and safely managed in line with current guidance.
- Ensure robust infection control processes were in place.
- Ensure all staff were up to date with infection control and safeguarding training.

This was in breach of regulation 12 (1) (2) (b) (c) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **How the regulation was not being met:** The provider failed to implement effective systems to enable them to identify and assess risks to the health and safety and/or welfare of service users. • The registered person failed to securely maintain records in respect of service users. • The provider failed to provide staff with appropriate policies and guidance to carry out their roles in a safe and effective manner which are reflective of the requirements of the practice. This was in breach of regulation 17 (1) (2) (b) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Good governance