Norvic Family Practice

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?	Good
Are services responsive to people's needs?	Requires improvement
Are services well-led?	Inadequate

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

This practice is rated as Inadequate overall. (The practice was previously inspected in November 2016 and rated as requires improvement)

The key questions are rated as:

Are services safe? – Inadequate

Are services effective? – Requires Improvement

Are services caring? – Good

Are services responsive? – Requires improvement

Are services well-led? - Inadequate

As part of our inspection process, we also look at the quality of care for specific population groups. The population groups are rated as:

Older People – Inadequate

People with long-term conditions – Inadequate

Families, children and young people – Inadequate

Working age people (including those retired and students – Inadequate

People whose circumstances may make them vulnerable – Inadequate

People experiencing poor mental health (including people with dementia) - Inadequate

We carried out an announced comprehensive inspection at Norvic Family Practice also known as Victoria Health Centre 16 November 2016. There is a branch surgery (Norman Road Family Surgery) which we also visited. The overall rating for the practice was requires improvement. The full comprehensive report on the November 2016 inspection can be found by selecting the 'all reports' link for Norvic Family Practice on our website at www.cqc.org.uk.

We carried out an announced comprehensive inspection at Norvic Family Practice on 16 January 2018 and this report covers our findings. We also visited the branch surgery (Norman Road Family Surgery). Overall the practice is rated as inadequate.

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. However, reviews and investigations were not thorough enough to review risks effectively.
- Patients were at risk of harm because systems and processes were not in place to keep them safe. For example, there were no risk assessments in the absence of Disclosure and Barring Service (DBS) check for reception staff carrying out the role of a chaperone.
- Infection control audits were not current and a concern identified from a previous audit had not been actioned.

Summary of findings

- Risk assessments such as fire, health and safety, COSHH and legionella had not been carried out at the branch site. Staff we spoke with told us that they were concerned about fire safety at the branch site. The practice did not have access to risk assessments carried out by the landlord (NHS Property Services) at the main site.
- The practice did not routinely review the effectiveness and appropriateness of the care it provided. Care and treatment was not always delivered according to evidence- based guidelines. The practice did not have an effective system to monitor patients on high risk medicines.
- The practice did not operate an effective recall system for medicine reviews and there was no systematic process for reviewing long term conditions.
- There was insufficient attention to safeguarding children. Staff did not recognise or respond appropriately to possible concerns.
- There was no evidence to demonstrate the use of patient feedback to improve the service.
- The practice had a number of policies and procedures to govern activity but not all were embedded.
- Patients we spoke with during our inspection were positive about their interactions with staff and said they were treated with compassion and dignity.
- The practice had no clear leadership structure, insufficient leadership capacity and limited formal governance arrangements. Staff did not feel empowered to feedback concerns or improvement areas. Staff were overdue appraisals.
- There was little innovation or service development and improvement was not a priority among staff and leaders.

The areas where the provider must make improvements are:

- Ensure care and treatment is provided in a safe way to patients.
- Ensure patients are protected from abuse and improper treatment.
- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.
- Ensure persons employed in the provision of the regulated activity receive the appropriate support, training, professional development and appraisal necessary to enable them to carry out the duties.

The areas where the provider should make improvement are:

- Ensure effective processes are in place so all patients are able to access care and treatment. This included assistance for patients using a wheelchair are and those who had difficulty with their hearing.
- Ensure carers are supported to take up offers for health checks.
- Ensure cleaning schedules are available for relevant staff at the main site.

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

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

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

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

Norvic Family Practice

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector**.**The team included a second CQC inspector, a practice nurse advisor, a GP specialist adviser and a second GP specialist advisor (shadowing).

Background to Norvic Family Practice

Norvic Family Practice is located in Smethwick, a town in Sandwell in the West Midlands. It is four miles west of Birmingham city centre and borders West Bromwich to the north and Oldbury to the west.

There is access to the practice by public transport from surrounding areas. There are parking facilities on site.

The practice holds a General Medical Services (GMS) contract with NHS England. The GMS contract to deliver primary care services to the local communities and currently has an approximate list size of 9150 patients. The practice provides GP services commissioned by NHS Sandwell and West Birmingham Clinical Commissioning Group (CCG). A CCG is an organisation that brings together local GPs and experienced health professionals to take on commissioning responsibilities for local health services.

The practice is situated in an area with high levels of deprivation at level one. Level one represents a most deprived area and level 10, the least deprived. The age distribution of the practice population broadly follows that of the national average.

The main site of the practice operates from purpose built premises. Patient services are all available on the ground level of the building. The premises are also shared with another GP practice and other healthcare professionals including district nurses, health visiting staff, physiotherapy and chiropody specialists. The practice has a branch site located at Norman Road Surgery, 110 Norman Road, Smethwick, West Midlands B67 5PU. We visited the branch practice during our inspection.

The practice is currently managed by three GP partners (one male, two female). The partners also employ a salaried GP. They are supported by one practice nurse, one healthcare assistant, a practice manager and a team of administrative and clerical staff.

The practice is a training practice for GP trainees. One of the GP partners is a GP educational supervisor for two trainees. At the time of our inspection, the practice did not have any trainees assigned to the practice.

The main practice site is open from 8am to 8pm Monday to Friday. Saturday opening is from 9am to 11.30am and Sunday opening is from 9am to 11am.

Inadequate

Are services safe?

Our findings

At our previous inspection on 16 November 2016, we rated the practice as requires improvement for providing safe services. The practice was able to demonstrate a system for reporting and recording significant events. However the system was not used to manage all identified incidents. Whilst meeting minutes supported that issues were addressed, the practice did not demonstrate that the system would identify themes and underlying system weaknesses. Information supported that the practice responded to Medicines and Healthcare products Regulatory Agency (MHRA) alerts, however the systems in place lacked a managed approach. The practice therefore, could not be assured that all alerts had been appropriately reviewed and actioned. We identified that some patients prescribed high risk medicine were not being monitored effectively to manage risks.

At this inspection the practice was unable to demonstrate improvement and we also identified concerns in other areas. As a result, the practice is rated as inadequate for providing safe services. All population groups have also been rated as inadequate. This was because:

- Staff understood their responsibilities to raise concerns and to report incidents and near misses. However, when things went wrong reviews and investigations were not thorough enough and lessons learned were not communicated widely enough to support improvement.
- Patients were at risk of harm because systems and processes were not in place or were not effective to keep them safe. For example, monitoring of patients on high risk medicines.
- The practice did not operate an effective recall system for medicine reviews.
- Prescription stationery that were kept in printers (branch site) were not secure.
- The practice did not operate an effective system to ensure a clear audit trail to enable immediate recognition of theft or fraud for prescription pads.
- Patient Group Directions (PGDs) were not signed by a designated manager.
- The practice was unable to provide evidence of Patient Specific Directions (PSDs) to authorise the health care assistant (HCA) to administer the flu vaccination.
- A variety of risk assessments were not available to the practice at the main site and had not been carried out for the branch site.
- Infection control audits were due and a concern following a previous audit had not been actioned at the main site.
- There were no risk assessments in the absence of DBS checks for reception staff carrying out the role of a chaperone.
- There was insufficient attention to safeguarding. Staff did not recognise or respond appropriately to possible abuse.

Safety systems and processes

The practice had some systems to keep patients safe and safeguarded from abuse. However, evidence we looked at did not demonstrate that processes were always embedded.

- There were some arrangements for safeguarding children and vulnerable adults that reflected relevant legislation and local requirements. Policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. There was a lead member of staff for safeguarding. Staff interviewed demonstrated they understood their responsibilities regarding safeguarding and had received training on safeguarding children and vulnerable adults relevant to their role. However, anonymised records we viewed showed that 28 children had not attended hospital appointments. There was no system or evidence in the patient's records that the practice had adequately considered the safeguarding risks to these children.
- We reviewed four personnel files which were incomplete and did not contain all relevant information in regards to recruitment. For example, we did not see proof of identification for some staff members that had been employed recently and current registration with appropriate professional body for relevant clinical staff was not included. We were unable to determine if appropriate recruitment checks had been carried out. The practice manager told us that they had been in the role for the past 12 months and were unaware of the gaps in staff files.
- There were notices in the practice advising patients that chaperones were available if required. We were told that

reception staff acted as chaperones and records we looked at confirmed that they were trained to carry out the role. However, most of the staff that acted as chaperones had not received a Disclosure and Barring Service (DBS) check. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable). In the absence of DBS checks there was no risk assessment carried out to support the decision making.

- The responsibility for maintenance and cleaning of the building at the main site was carried out by NHS Property services. We were told by the practice that cleaning schedules were not shared with the practice at the main site by NHS property services. The providers had the responsibility for maintenance of the branch site. We observed the premises to be clean and tidy and we saw that cleaning schedules were available at the branch site.
- There was infection prevention and control (IPC) protocol and staff had received up to date training. We saw evidence that an IPC audit at the branch site had been undertaken in December 2017 and no actions were identified. However, the most recent IPC at the main site was carried out in July 2016. We also saw an area for improvement identified in the audit; for example, locking the vaccines fridge had not been actioned. The practice manager was aware that this was overdue but had not yet been able to action this.

Risks to patients

The systems to assess, monitor and manage risks to patient safety were not always effective.

- We looked at recruitment files of staff that were employed recently and they did not demonstrate that an induction programme was in place.
- There were arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system to ensure enough staff were on duty to meet the needs of patients. The practice manager told us that they could use staff from the branch site if there was a shortage or vice versa. At the time of our inspection we were told that an advanced nurse practitioner had left and the practice had interviewed for the role and were waiting to hear from the successful candidate.
- Staff understood their responsibilities to manage emergencies on the premises and to recognise those in need of urgent medical attention. Clinicians we spoke with knew how to identify and manage patients with severe infections, for example, sepsis.

Information to deliver safe care and treatment

There was some evidence to demonstrate that staff had the appropriate information they needed to deliver safe care and treatment to patients.

- However, anonymised records we viewed did not always demonstrate that they had the appropriate information needed to deliver safe care and treatment. For example, the practice could not demonstrate an effective system for ensuring monitoring had been carried out for patients on high risk medicines
- The practice had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.
- Referral letters included all of the necessary information.

Safe and appropriate use of medicines

The practice did not have reliable systems for appropriate and safe handling of medicines.

- The systems for managing medicines, including vaccines, medical gases, and emergency medicines and equipment did not ensure quality and safety. During our previous inspection in November 2016 we asked the practice to improve its processes to ensure effective monitoring of patients on high risk medicines. However, the practice was unable to provide sufficient evidence that improvement had been achieved.
- The practice could not demonstrate that the appropriate monitoring of patients had taken place prior to issuing repeat prescriptions for high risk medicines. The practice had not downloaded the hospital blood results which was a contributing factor. Records we looked at showed that 11 out of 21 patients on Methotrexate (a medicine used to treat certain types of cancer as well as psoriasis and rheumatoid arthritis), did not have record of a blood test within the requirements for monitoring. We checked the hospital records of two patients and saw that they had a recent blood test (at the hospital) but this was not documented on the practices patient record system.

Therefore, we were unable to confirm if they had been reviewed before issuing a repeat prescription. According to the GP, these patients were on acute prescription and therefore reception staff were unable to issue any repeat medicines and the GP would have to check before being issued. However, we did not see evidence to support this explanation.

- There were five patients on Lithium (a medicine to treat bipolar disorder) and two patients had not had blood test for over four months (three months recommended). However, one patient had no record of having ever had a blood test since the medicine was first commenced in April 2017.
- Records we looked at showed that 51out of 1005 patients on anti-hypertensive medicines were more than three years overdue a kidney monitoring blood test (recommended annually).
- The practice did not operate an effective recall system. We saw evidence that 80% of patients receiving more than four medicines had not received a medication review within the last 12 months. The GP said that they were reviewing on an ad-hoc basis. We saw that there was no systematic process for reviewing long term conditions. The clinical records were not well documented to support the practice recall system and appropriate monitoring of patients medicines.
- We saw evidence that the local clinical commissioning group (CCG) pharmacy teams had carried out some audits/monitoring of the practices prescribing. Data provided to us showed that the practice was exceeding the target set by the CCG for antibiotic prescribing.
- We saw evidence that blank prescription forms and pads were securely stored in the main site. However, prescription stationery that were kept in printers at the branch site were not secure. The printers were located in the reception desk and we saw the door to secure the area did not close properly and therefore could not be locked to ensure security of prescription stationery. The practice did not operate an effective system to ensure a clear audit trail to enable immediate recognition of theft or fraud for prescription pads.
- Patient Group Directions (PGDs) allow professionals such as the practice nurse to supply and administer specified medicines to pre-defined groups of patients, without a prescription. We saw that the practice had available up to date PGDs but only one had been signed by the current practice nurse and none had been signed by a responsible person. The nurse could not legally administer vaccines if they had not signed the PGDs as they were not a prescriber.
- During the inspection staff were unable to show us that Patient Specific Directions (PSDs) had been in place for individual patients to authorise the health care assistant (HCA) to administer the flu vaccination.

Track record on safety

- There was a health and safety policy available. However, the practice did not have access to health and safety and fire risk assessments at the main site. We were told that this was carried out by NHS property services and had not been shared with the practice.
- The providers were responsible for the management of the branch site and the practice was unable to produce evidence of health and safety risk assessments or fire risk assessments. Staff at the branch site told us that they had some concerns in regards to fire safety. They told us that the building had two points of exit through the front and the rear. However, there was fencing to the rear of the building and in the event of a fire staff would not be able to move to safer location. We made a referral to the West Midlands Fire Service so that they could advise the practice to mitigate the risk.
- The practice could not demonstrate other risk assessments such as control of substances hazardous to health (COSHH) and legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings). We were told that Legionella and COSHH risk assessments were carried out by the landlord, managed by NHS Property services at the main site. We were unable to confirm this as the practice did not have access to these. However, the practice was responsible for maintenance of the building at the branch site and the practice could not provide any evidence that such risk assessments were in place.

Lessons learned and improvements made

- There was a system for reporting and recording significant events. However, this was not effective to ensure patients were kept safe. The practice had documented nine incidents in the last 12 months. We looked at one example which recorded a vaccine that

was left out for a period of time in June 2017. The practice recorded that this posed no harm and placed the vaccines in the fridge. The practice did not seek guidance from Public Health England (PHE) or the manufacturer. There was no evidence of share learning and the template for recording was limited to facilitate learning identified. There were little details of the timescale the vaccines were left out and the rationale for the decision. We also saw that not all relevant incidents were shared with stakeholders such as the Clinical Commissioning Group (CCG).

- There was a system for receiving safety alerts such as MHRA alerts. However, there was no evidence that they had been actioned. We carried out four searches and in one search identified 28 patients that should have been reviewed and medicines amended in-line with the alert.

Requires improvement

Are services effective?

(for example, treatment is effective)

Our findings

At our previous inspection on 16 November 2016, we rated the practice as requires improvement for providing effective services. The practice was unable to provide full cycle audits to demonstrate improved patient outcomes. Staff understood the processes involved for obtaining patient consent but consent had not been recorded when some minor procedures (joint injections) had been performed.

At this inspection the practice had carried out a two cycle audit on minor surgery consent which showed significant improvement. However, we also identified other concerns. As a result, the rating still remains as requires improvement for providing effective services. This was because:

- Quality and Outcomes Framework (QOF) data showed patient outcomes were above the national average. However, there was no evidence of a formal approach to the management of patients with long term conditions.
- GPs we spoke with were able to demonstrate knowledge of and reference to national guidelines. However, we did not see evidence that guidance related to medicine reviews was being followed.
- Staff did not feel empowered to raise concerns or issues to improve the service with management. Staff were not always supported to transition to their roles and we saw appraisals were overdue.
- There was some evidence that the practice was comparing its performance to others through the medicine management team from the CCG. However, there was no evidence that this was being done in any other areas.

Effective needs assessment, care and treatment

GPs we spoke with were able to demonstrate awareness of relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines.

- Clinical staff accessed NICE guidance via the internet and could provide some examples of recent guidance
- The practice had systems to keep all clinical staff up to date. Staff had access to guidelines from NICE and used this information to deliver care and treatment that met patients' needs. However, we saw that guidance was not always followed for example, in areas of medicine reviews and monitoring of patients on high risk medicines.

Older people:

This population group has been rated requires improvement for effective, however the overall rating for this population group is inadequate as safe and well led are rated inadequate and the concerns identified effect all population groups.

- Older patients who were frail or may be vulnerable received a full assessment of their physical, mental and social needs. However, the practice was unable to demonstrate that medicine reviews were being carried out.
- The practice followed up on older patients discharged from hospital. However, we saw evidence that 80% of patients receiving more than four medicines had not received a medicine review within the last 12 months.

People with long-term conditions:

This population group has been rated requires improvement for effective, however the overall rating for this population group is inadequate as safe and well led are rated inadequate and the concerns identified effect all population groups.

- The most recent published QOF data showed the practice had achieved 96% of the total number of points available compared with the clinical commissioning group (CCG) average of 94% and national average of 96%. Whilst this showed that QOF was being used to monitor outcomes for patients, we also saw that a formal recall system for medicine reviews were not in place. Other than those required for QOF there was no systematic process for reviewing long term conditions. One of the GP partners told us that they were reviewing on an ad-hoc basis.
- Performance for diabetes related indicators was higher than the CCG and national averages. The practice performance was 99% which was above the CCG average of 90% and the national average of 91%.
- There were emergency processes for patients with long-term conditions who experienced a sudden deterioration in health.

Families, children and young people:

Requires improvement

Are services effective?

(for example, treatment is effective)

This population group has been rated requires improvement for effective, however the overall rating for this population group is inadequate as safe and well led are rated inadequate and the concerns identified effect all population groups.

- Immunisation rates for under two year olds were slightly below the national target of 90%.
- There was evidence of multidisciplinary working with other health professionals such as midwives and health visitors.
- We saw evidence that the practice escalated concerns to midwives if children were not brought into the practice for their routine immunisations. However, anonymised records we viewed showed that 28 children had not attended hospital appointments and the practice had not adequately considered the safeguarding risks to these children.
- Appointments were available outside of school hours and the premises were suitable for children and babies.
- The practice had emergency processes for acutely ill children.

Working age people (including those recently retired and students):

This population group has been rated requires improvement for effective, however the overall rating for this population group is inadequate as safe and well led are rated inadequate and the concerns identified effect all population groups.

This population group was rated good because:

- The needs of these populations had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40-74. There was appropriate follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.

People whose circumstances make them vulnerable:

This population group has been rated requires improvement for effective, however the overall rating for this population group is inadequate as safe and well led are rated inadequate and the concerns identified effect all population groups.

This population group was rated requires improvement because:

- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice offered longer appointments for patients with a learning disability.
- There was evidence that the practice worked with other health care professionals in the case management of vulnerable patients.
- The practice had information available for vulnerable patients about how to access various support groups and voluntary organisations.
- The practice had carried annual health checks on their learning disability register. We saw 40% of patients had undergone a health check in the last 12 months.

People experiencing poor mental health (including people with dementia):

This population group has been rated requires improvement for effective, however the overall rating for this population group is inadequate as safe and well led are rated inadequate and the concerns identified effect all population groups.

- The practice carried out advance care planning for patients living with dementia. Data we looked at showed that 83% of patients diagnosed with dementia had their care reviewed in a face to face meeting in the last 12 months. This was slightly below the CCG average of 85% and the national average of 84%.
- The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who had a comprehensive, agreed care plan documented in the record, in the preceding 12 months was slightly below the CCG and national averages. The practice achievement was 88%, the CCG average was 91% and the national average was 90%.
- There was evidence that the practice worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those living with dementia.
- The practice did not have an effective system for monitoring repeat prescribing for patients receiving regular medicines including those for mental health needs.

Monitoring care and treatment

Requires improvement

Are services effective?

(for example, treatment is effective)

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 96% of the total number of points available compared with the clinical commissioning group (CCG) average of 94% and national average of 96%.

The overall exception rate at 14% was above the CCG and national average of 10%. (Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects).

This practice was not an outlier for any QOF (or other national) clinical targets. Data from 2016/17 showed:

- Performance for diabetes related indicators was higher than the CCG and national averages. The practice performance was 99% which was above the CCG average of 90% and the national average of 91%.
- Performance for mental health related indicators was slightly above the CCG and national averages. The practice achievement for mental health indicators was 95%, the CCG average was 92% and the national average was 94%.

Since our November 2016 inspection, the practice carried out a number of clinical audits. However, we saw that only one of these were repeated audit which demonstrated quality improvements.

Effective staffing

Evidence reviewed showed that improvements were required to ensure effective staffing.

- Staff files we looked at did not demonstrate that an induction programme for all newly appointed staff was in place.
- The practice could demonstrate how they ensured role-specific training and updating for most staff. However, when we looked at a staff file for a salaried GP the practice could not demonstrate that mandatory training such as CPR and safeguarding had been completed. The practice manager told us that the staff member had completed the training but they had not updated the staff files to reflect this. We were unable to confirm this on the day.
- There had been no appraisals in the last 12 months as a way to identify staff learning needs. Staff files we looked at showed that the last appraisals were carried out in July 2014. The practice were unable to demonstrate how they supported staff during their transition into new roles within the practice

Coordinating care and treatment

Staff worked together and with other health and social care professionals to deliver effective care and treatment in some areas.

- We saw records that showed that all appropriate staff, including those in different teams, services and organisations, were involved in assessing, planning and delivering care and treatment.
- We looked at examples of processing of hospital communication and there was evidence that they were being actioned appropriately. However, anonymised records we viewed also showed that 28 children had not attended hospital appointments and the practice had not adequately considered the safeguarding risks to these children.
- Processing of blood test results were shared by GPs and records we looked at showed that there was an effective system in place to manage these in a timely manner.were no results that were waiting to be actioned for more than one week. We saw that all blood tests had been viewed although some were waiting to be actioned.
- From the sample of documented examples such as palliative care register we reviewed we found that the practice shared relevant information with other services in a timely way, for example when referring patients to other services.

Helping patients to live healthier lives

Staff were consistent and proactive in helping patients to live healthier lives.

- The practice identified patients who may be in need of extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.
- The practice's uptake for the cervical screening programme was 75%; this was below the CCG average of 80% and the national average of 81%. There was a policy to offer telephone or written reminders for

Requires improvement

Are services effective?

(for example, treatment is effective)

patients who did not attend for their cervical screening test. There were failsafe systems to ensure results were received for all samples sent for the cervical screening programme and the practice followed up women who were referred as a result of abnormal results.
- Childhood immunisations were carried out in line with the national childhood vaccination programme. Uptake rates for the vaccines given were comparable to CCG/ national averages. For example, rates for the vaccines given to under two year olds ranged from 87% to 93%.

The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening. For example,

- 46% of patients were screened for bowel cancer in the last 30 months which was slightly above the CCG average of 42% but below the national average of 55%
- 72% of females aged 50-70 years were screened for breast cancer in the last 36 months (three year coverage) which was above the CCG average of 65% and similar to the national average of 72%.
- The practice supported national and local priorities and initiatives to improve the population's health, for example, stop smoking campaigns, tackling obesity.

Consent to care and treatment

The practice obtained consent to care and treatment in line with legislation and guidance.

- Clinicians understood the requirements of legislation and guidance when considering consent and decision making.
- Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.
- The practice monitored the process for seeking consent appropriately.

The practice had carried out a two cycle minor surgery audit which showed significant improvement.

Good

Are services caring?

Our findings

The practice is rated as good for providing caring services because:

- Data from the national GP patient survey showed the practice achievement was similar to the CCG averages for several aspects of care. Although its achievement was slightly below the national average.
- National patient survey data we reviewed showed that patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.
- Information for patients about the services available was accessible.
- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- Staff understood patients' personal, cultural, social and religious needs.
- The practice gave patients timely support and information.
- Reception staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.
- All of the seven patient Care Quality Commission comment cards we received were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect.
- We spoke with four patients on the day and they told us they were very satisfied with the care provided by the practice and said their dignity and privacy was respected. Patients were positive about the level of service received from the GPs. Comments highlighted that staff responded compassionately when they needed help and provided support when required.

Results from the July 2017 annual national GP patient survey showed patients felt they were treated with compassion, dignity and respect. Of the 335 survey forms that were distributed, 124 were returned. This represented 1% of the practice's patient list. The practice was generally in line with local CCG and national averages for its satisfaction scores on consultations with GPs and nurses when compared to the averages but below the national averages. For example:

- 79% of patients who responded said the GP was good at listening to them compared with the clinical commissioning group (CCG) average of 84% and the national average of 89%.
- 83% of patients who responded said the GP gave them enough time; CCG - 81%; national average - 86%.
- 94% of patients who responded said they had confidence and trust in the last GP they saw; CCG - 93%; national average - 95%.
- 78% of patients who responded said the last GP they spoke to was good at treating them with care and concern; CCG– 80%; national average - 86%.
- 86% of patients who responded said the nurse was good at listening to them; (CCG) - 87%; national average - 91%.
- 81% of patients who responded said the nurse gave them enough time; CCG - 87%; national average - 92%.
- 93% of patients who responded said they had confidence and trust in the last nurse they saw; CCG - 95%; national average - 97%.
- 88% of patients who responded said the last nurse they spoke to was good at treating them with care and concern; CCG - 85%; national average - 91%.
- 81% of patients who responded said they found the receptionists at the practice helpful; CCG - 82%; national average - 87%.

Involvement in decisions about care and treatment

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

- Interpretation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patients this service was available. Patients were also told about multi-lingual staff who might be able to support them.

Good

Are services caring?

- Staff communicated with patients in a way that they could understand, for example, the main site was located in a health centre and relevant signs were in braille. However, there was no hearing loop at the main site.
- Patient information leaflets and notices were available in the patient waiting area which told patients how to access a number of support groups and organisations. Information about support groups was also available on the practice website.
- Support for isolated or house-bound patients included signposting to relevant support and volunteer services.
- The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 95 patients as carers (1% of the practice list). Carers were offered timely and appropriate support. For example, carers were offered a flu vaccination and 69 had taken up the offer. Records indicated that 17 carers had also been invited for a health check.
- Staff told us that if families had experienced bereavement, their usual GP contacted them to offer further support and advice. The practice website advised and directed people on the actions to take and the support available to them.

Results from the national GP patient survey showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. Results were in line with local averages and below national averages. For example:

- 83% of patients who responded said the last GP they saw was good at explaining tests and treatments compared with the clinical commissioning group (CCG) average of 82% and the national average of 86%.
- 73% of patients who responded said the last GP they saw was good at involving them in decisions about their care; CCG - 76%; national average - 82%.
- 86% of patients who responded said the last nurse they saw was good at explaining tests and treatments; CCG - 86%; national average - 90%.
- 85% of patients who responded said the last nurse they saw was good at involving them in decisions about their care; CCG - 82%; national average - 85%.

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

Privacy and dignity

The practice respected and promoted patients' privacy and dignity.

- Staff recognised the importance of patients' dignity and respect.
- The practice complied with the Data Protection Act 1998. Staff had completed eLearning on data protection and confidentiality.

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

We rated the practice requires improvement for providing responsive services. This was because:

- The practice had some accessible facilities such as interpretation services. However there was no hearing loop available. The practice manager explained that they had a type –and –talk telephone system at the branch site. However, nothing had been considered for patients that were requiring additional support. The practice told us that there were no patients that were hard of hearing at the main site.
- The main site was located in a health centre and the premises were accessible to patients using a wheelchair. However, at the branch site patients needed assistance from staff to enter the building. We saw that a call bell at the front entrance was not working. Staff explained that they had a clear sight of the door and were able to see if a patient using a wheel chair required assistance.

Responding to and meeting people's needs

The practice organised and delivered services to meet patients' needs. It took account of patient needs and preferences.

- The practice understood its population profile and had used this understanding to meet the needs of its population. The practice was participating in the CCGs Primary Care Commissioning Framework (PCCF) to offer a range of services to enhance patient care.
- The practice offered extended hours service Monday to Friday from 6.30pm to 8pm. Weekend appointments were also available 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 had clinical needs which resulted in difficulty attending the practice.
- The practice took account of the needs and preferences of patients with life-limiting progressive conditions. There were early and ongoing conversations with these patients about their end of life care as part of their wider treatment and care planning.
- Same day appointments were available for children and those patients with medical problems that require same day consultation.
- The practice sent text message reminders of appointments.
- Patients were able to receive travel vaccines available on the NHS as well as those only available privately.

Older people:

This population group has been rated requires improvement for responsive, however the overall rating for this population group is inadequate as safe and well led are rated inadequate and the concerns identified effect all population groups.

- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs. The GP and practice nurse also accommodated home visits for those who had difficulties getting to the practice. The practice identified at an early stage older patients who may need palliative care as they were approaching the end of life.
- The practice offered home visits and urgent appointments for those with enhanced needs.

People with long-term conditions:

This population group has been rated requires improvement for responsive, however the overall rating for this population group is inadequate as safe and well led are rated inadequate and the concerns identified effect all population groups.

- The practice did not operate a formal recall system for medicine reviews and there was no systematic process for reviewing long term conditions.
- There was no process in place to monitor patients on high risk medicines. Records we looked at showed that patients were being re-issued high risk medicines without confirming results of recent blood tests.

Families, children and young people:

This population group has been rated requires improvement for responsive, however the overall rating for this population group is inadequate as safe and well led are rated inadequate and the concerns identified effect all population groups.

- There was evidence of multidisciplinary working with other health professionals such as midwives and health visitors.

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

- Immunisation rates for under two year olds were slightly below the national target of 90% but we saw evidence that the practice escalated concerns to midwives if children were not brought into the practice for their routine immunisations.
- Appointments were available outside of school hours and the premises were suitable for children and babies[HJ1].

Working age people (including those recently retired and students):

This population group has been rated requires improvement for responsive, however the overall rating for this population group is inadequate as safe and well led are rated inadequate and the concerns identified effect all population groups.

- The needs of these populations had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. The practice offered access to appointments from 8am to 8pm Monday to Friday. Saturday and Sunday morning appointments were also available.
- The practice offered online services as well as a full range of health promotion and screening that reflects the needs for this age group.
- Telephone consultations were also available.

People whose circumstances make them vulnerable:

This population group has been rated requires improvement for responsive, however the overall rating for this population group is inadequate as safe and well led are rated inadequate and the concerns identified effect all population groups.

- There was insufficient attention to safeguarding children. Staff did not respond appropriately to possible concerns.
- The practice had carried annual health checks on their learning disability register. We saw 40% of patients had undergone a health check in the last 12 months.
- There was an ad hoc process in place for monitoring patients on repeat prescriptions including these patients

People experiencing poor mental health (including people with dementia):

This population group has been rated requires improvement for responsive, however the overall rating for this population group is inadequate as safe and well led are rated inadequate and the concerns identified effect all population groups.

- Patients at risk of dementia were identified and offered an assessment.
- The practice carried out advance care planning for patients living with dementia. Data we looked at showed that 83% of patients diagnosed with dementia had their care reviewed in a face to face meeting in the last 12 months. This was slightly below the CCG average of 85% and the national average of 84%.
- The practice did not have an effective system for monitoring repeat prescribing for patients receiving regular medicines including those for mental health needs.
- The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who had a comprehensive, agreed care plan documented in the record, in the preceding 12 months was slightly below the CCG and national averages. The practice achievement was 88%, the CCG average was 91% and the national average was 90%.
- There was evidence that the practice worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those living with dementia.
- The practice had information available for patients experiencing poor mental health about how they could access various support groups and voluntary organisations.

Timely access to the service

Patients were able to access care and treatment from the practice within an acceptable timescale for their needs.

- Patients had timely access to initial assessment, test results, diagnosis and treatment.
- Waiting times, delays and cancellations were minimal and managed appropriately.
- Patients with the most urgent needs had their care and treatment prioritised.
- Patients told us that the appointment system was easy to use.

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

During our previous inspection in November 2016 results from the national GP patient survey showed that patient's satisfaction with how they could access care and treatment was above or in line with local and national averages. For example;

- 78% of patients were satisfied with the practice's opening hours compared to the CCG average of 71% and national average of 76%.
- 81% of patients were able to get an appointment to see or speak to someone the last time they tried compared to a CCG average of 75% and a national average of 85%.
- 56% of patients usually got to see or speak to their preferred GP compared to the CCG average of 45% and the national average of 59%.
- 67% of patients described their experience of making an appointment as good compared to a CCG average of 62% and the national average of 73%.
- 71% of patients said they could get through easily to the practice by phone compared to the CCG average of 60% and national average of 73%
- 56% of patients usually waited 15 minutes or less after their appointment time to be seen compared to a CCG average of 54% and a national average of 65%.

However, during this inspection results from the July 2017 annual national GP patient survey showed that patient's satisfaction with how they could access care and treatment was slightly below the local CCG averages and below the national averages. Importantly, the practice achievement in comparison to the July 2016 results showed a decline. However, we did not see any evidence of monitoring feedback to make improvements and to halt the decline. (The survey represented 1% of the practices list size, 335 survey forms were distributed and 124 were returned).

- 65% of patients were satisfied with the practice's opening hours compared with the CCG average of 75% and the national average of 76%.
- 74% of patients were able to get an appointment to see or speak to someone the last time they tried compared to a CCG average of 76% and the national average of 84%.
- 77% of patients who responded said their last appointment was convenient compared with the CCG average of 72% and the national average of 81%.
- 65% of patients who responded described their experience of making an appointment as good compared to the CCG average of 63% and the national average of 73%.
- 58% of patients who responded said they could get through easily to the practice by phone compared to the CCG average of 60% and the national average of 71%.
- 45% of patients who responded said they don't normally have to wait too long to be seen compared to the CCG average of 46% and the national average of 58%.

Listening and learning from concerns and complaints

The practice had a system for handling complaints and concerns.

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

We looked at seven complaints received in the last 12 months and found most were satisfactorily dealt with. However, we looked at one complaint which did not document any response. The practice manager told us that they had verbally responded to the complaint but had not recorded this. The practice did not have regular meetings and could not provide evidence where learning from complaints had been discussed and shared with staff.

The practice was unable to demonstrate that they had carried out a review of complaints following our previous inspection, to identify any possible trends.

Are services well-led?

Inadequate

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

Our findings

At our previous inspection on 16 November 2016, we rated the practice as requires improvement for providing well-led services. The practice was able to demonstrate that a governance framework was in place. However, some aspects required strengthening such as risk management and quality monitoring processes.

At this inspection the practice was unable to demonstrate improvement to the governance processes. We also identified other issues such as a lack of quality monitoring and improvement processes to ensure a well-led service. As a result, the practice is rated as inadequate for providing well-led services. This was because:

- The practice had a vision and a strategy but there was no effective system or processes to deliver that vision.
- There was a leadership structure but staff did not feel empowered to highlight and issues or concerns to members of the leadership team.
- The practice had a number of policies and procedures to govern activity but not all were embedded.
- The practice did not hold regular governance meetings, issues were discussed at ad hoc meetings which was not consistent and did not enable the practice to offer a quality service. There was no evidence that learning from incidents and complaints were shared.
- The practice had not proactively sought feedback from staff or patients and did not have a patient participation group (PPG).
- There was no evidence of induction of new staff and we saw performance reviews of other staff were overdue.
- The practice was unable to provide evidence of completion of core training such as safeguarding for one of the salaried GPs. There was a lack of support for staff to transition into their role.

Leadership capacity and capability

During our previous inspection in November 2016 we identified a number of concerns, most of which had not been actioned. One of the GP partners told us that they had experienced a number of difficulties at the practice with an advanced nurse practitioner leaving their role and a longstanding GP partner retiring amongst other changes. Therefore, whilst they were aware of some issues they were unable to address them. Some of the issues we had identified related to appropriate monitoring of patients on high risk medicines. This did not demonstrate that the GP partners had the capacity and capability to run the practice to ensure high quality care.

The practice could not demonstrate that GP partners and management staff had a satisfactory understanding of the systems and processes to ensure a quality service. For example, the patient record system we looked at showed that many patients were overdue medicine reviews which were not addressed. Furthermore, alerts on the system reminded clinicians that a medication review was overdue but these were either ignored or if a medicine review had taken place this was not reflected on the patient record system. The lack of an overview of the systems and processes contributed to this coupled with a lack of a consistent approach by clinical staff to complete or reflect any actions taken on the patient record system such a completing of medicine reviews.

The practice did not demonstrate that there was an effective process to develop leadership capacity and skills, including planning for the future leadership of the practice. For example, members of the management team were unable to demonstrate support or training to help leaders transition into the role. Staff we spoke with who had changed roles explained that they had not received appropriate handover from previous staff member.

Vision and strategy

The practice had a clear vision and a strategy to deliver high quality care and promote good outcomes for patients. This was displayed in the practice and staff members we spoke with were able to discuss that vision and values. However, we found evidence that showed that there was no effective leadership to ensure the vision was being delivered. The practice did not have a process to monitor progress against delivery of its vision and strategy.

Culture

- There was a leadership structure in the practice and staff felt supported by management. However, staff did not feel empowered to raise issues as they felt that management staff were not always able or ready to take on the responsibility to resolve any issues or concerns they had raised previously.

Are services well-led?

Inadequate

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

- We saw evidence that not all staff were provided with developmental needs and supported to transition in to their roles. We saw that appraisals had last been carried out in July 2014.
- There was evidence of multidisciplinary meetings taking place to discuss vulnerable patients. However, we saw practice meetings and clinical meetings were not held regularly. The practice manager told us that due to work pressures they found it difficult to hold meetings and therefore circulated bi-monthly memorandums to communicate learning with staff members. We looked at examples of these and saw that they did not always share learning. For example, we saw that the practice had documented an incident where learning had been identified. Our analysis of incidents and complaints did not confirm that learning had been shared in the corresponding memorandums.

Governance arrangements

The practice had some governance processes. For example, there was a lead for safeguarding. However, there was no framework to support the delivery good quality care.

- There was a clear staffing structure and staff were aware of their own roles and responsibilities. However, there was no evidence that staff were working as a team to share learning and improve service. For example, there was little evidence of learning from incidents and complaints.
- Practice specific policies were available to all staff but one staff member we spoke with was unable to access policies on the electronic system. Not all policies were embedded, for example, we spoke with a staff member who according to the policy was the responsible person for maintaining fire safety. However, they were unaware of this responsibility during our discussion with them.
- The practice could demonstrate some understanding of the performance of the service such as previous QOF achievements. However, there was a lack of a formal proactive approach to ensure monitoring of performance. We saw evidence that many patients were overdue medicine reviews according to the patient record system and this had not been prioritised and addressed.
- There was a lack of risk assessments such as health and safety, fire, COSHH and Legionella at the branch site. We were told that NHS Property services had carried out risk assessments at the main site but the practice was unable to access these documents.
- Most staff member we spoke with were clear on their roles and accountabilities including in respect of safeguarding and infection prevention and control. However, there was no overview and monitoring of these as we saw that improvements to infection prevention and control and safeguarding processes were required.

Managing risks, issues and performance

The processes for managing risks, issues and performance were not effective.

- There were no arrangements for identifying, recording and managing risks and implementing mitigating actions. For example, there was no fire risk assessment, health and safety risk assessment and legionella risk assessment at the branch site. Staff members we spoke with told us that they had some concerns in regards to fire safety. There were no spillage kits available at the branch site. At the main site spillage kits were available but staff did not have access to them as they were kept secure by NHS Property Services. We also identified some possible electrical risks at the branch sites which had not been identified and mitigated.
- The practice was unable to demonstrate processes to manage current and future performance. Performance of employed clinical staff could not be demonstrated through audit of their consultations, prescribing and referral decisions. Staff files we looked at showed that performance reviews had not been undertaken since July 2014. The practice was unable to demonstrate that MHRA alerts were being actioned. During our inspection, we found that alerts had been received but there was no evidence that they had been actioned. We carried out four searches and in one search identified 28 patients that should have been reviewed and medicines amended in-line with the alert. However, this had not been carried out.
- The process for recording and sharing learning from incidents and significant events required improvement.
- The practice had carried out one two cycle audit but there were no other processes to demonstrate quality assurance and improvement.

Are services well-led?

Inadequate

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

- The practice had plans in place and had trained staff for major incidents.

Appropriate and accurate information

The practice were not always acting on appropriate and accurate information.

- The practice did not have a system to regularly review and improve its performance. There was no evidence of patient feedback used to combine with performance information to improve service.
- The practice did not hold regular meetings and we saw evidence that learning from incidents and complaints were not always shared to improve the quality and safety of the service.
- The practice did not always share information such as incidents to external organisations such as the local CCG.
- There were robust arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems. We saw staff had completed eLearning in this area.

Engagement with patients, the public, staff and external partners

There was no evidence that the practice involved patients, the public, staff and external partners to support high-quality sustainable services.

- The practice did not have a patient participation group (PPG) through which surveys and complaints received could be received. The practice could not demonstrate any other mechanisms in place to receive patient feedback and where improvements had been made within the last 12 -18 months.
- The practice could not provide any evidence of recent patient surveys to improve service.
- We saw that the practice achievement in the national survey had declined in comparison to the data from our previous inspection in November 2016. However, there was no evidence that this was being monitored to halt the decline and to make improvements.
- Staff members we spoke with told us that they felt supported but did not feel that they could escalate any issues on a day to day basis. Although staff were aware of the roles of the senior management team and their responsibilities they did not feel management staff were always ready to or were available to take on responsibilities to resolve any issues raised by staff.

Continuous improvement and innovation

The practice was unable to demonstrate systems and processes for learning, continuous improvement and innovation.

- The practice is a training practice for GP trainees. One of the GP partners was a GP educational supervisor for trainees. We were told that the practice currently did not have any trainees assigned.
- The practice took part in regular Protected Learning Times (PLTs) to help continuous learning and improvement within the practice. However, this was organised by the CCG. There was no evidence of any other improvement activity.
- Staff were not supported to help them to understand about improvement methods and help them to develop skills to use them.
- The practice documented incidents but learning was limited and there was no evidence to demonstrate that identified learning had been shared with staff and other stakeholders to make improvements.

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 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **How the regulation was not being met** Systems and processes were not operated effectively to prevent abuse of service users. This was in breach of regulation 13 (2)

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **How the regulation was not being met** The registered person had failed to ensure that sufficient numbers of suitably qualified, competent, skilled and experienced persons were deployed in order to meet the requirements of fundamental standards in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. In particular: The service provider had failed to ensure that persons employed in the provision of a regulated activity received such appropriate support, training and professional development as was necessary to enable them to carry out the duties they were employed to perform. This was in breach of regulation 12 (2) (a)

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 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Care and treatment must be provided in a safe way for service users to ensure compliance with the requirements of the fundamental standards as set out in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014** • Assessments of the risks to the health and safety of service users of receiving care or treatment were not being carried out. The registered persons had not done all that was reasonably practicable to mitigate risks to the health and safety of service users receiving care and treatment. • There was no proper and safe management of medicines. In particular monitoring of patients on high risk medicines. There were no regular reviews of patients on long term medicines. • There was no assessment of the risk of, and preventing, detecting and controlling the spread of, infections, including those that are health care associated. • Patient Group Directions (PGDs) were not signed by a responsible person and Patient Specific Direction (PSD) was not in place. **This was in breach of regulation 12 (2) (a) (b) (g) (h)**

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

This section is primarily information for the provider

Enforcement actions

Systems or processes must be established and operated effectively to ensure compliance with the requirements of the fundamental standards as set out in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

There were no systems or processes that enabled the registered person to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk. In partircular:

- There was a lack of risk assessments such as health and safety, fire, COSHH and Legionella at the branch site. Staff were unable to access risk assessments carried out by NHS Property services at the main site. These omissions had not been identified and managed by an effective system or process established to ensure compliance with the regulations.
- There was a lack of risk assessment for staff members that acted as chaperones in the absence of a DBS check.
- Personnel files looked at were incomplete and did not contain all relevant information in regards to recruitment. There was no proof of identification for some staff members that had been employed recently. There was no current registration with appropriate professional body for a clinical staff member.

There were no systems or processes that enabled the registered person to assess, monitor and improve the quality and safety of the services being provided. In particular:

- There were no systems or processes that ensured the registered person maintained securely prescription pads as are necessary to be kept in relation to the management of the regulated activity or activities.
- The process to give assurance that all patient safety alerts have been appropriately considered and actioned was not effective.
- The processes to manage the risk of, and preventing, detecting and controlling the spread of, infections, including those that are health care associated were not effective.

This section is primarily information for the provider

Enforcement actions

- There were no systems or processes that enabled the registered person to seek and act on feedback from relevant persons and other persons on the services provided in the carrying on of the regulated activity, for the purposes of continually evaluating and improving such services.
- There were no systems or processes that enabled the registered person to evaluate and improve their practice in respect of the processing of the information obtained throughout the governance process.

This was in breach of regulation 17 (1) (2) (a) (b) (d) (e)