Sidley Medical 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	Requires improvement
Are services safe?	Requires improvement
Are services effective?	Requires improvement
Are services well-led?	Inadequate

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Sidley Medical Practice on 23 August 2016. The overall rating for the practice was requires improvement. The full comprehensive report on the August 2016 inspection can be found by selecting the 'all reports' link for Sidley Medical Practice on our website at www.cqc.org.uk.

This was an announced focused inspection carried out on 16 June 2017 to confirm that the practice had carried out their plan to meet the legal requirements in relation to the breaches in regulations that we identified in our previous inspection on 23 August 2016. This report covers our findings in relation to those requirements and also additional improvements made since our last inspection.

Our key findings were as follows:

- There was no formalised process for reviewing, assessing risk and taking action for patient and medicine safety alerts. There was no record of previous alerts that had been acted on and an alert from April 2017 was yet to have actions taken.
- Not all staff were aware of the process for reporting and recording significant events. Learning from events was shared with staff directly involved or disseminated through line managers.
- There were gaps in staff training. Some clinical and non-clinical staff had not received adult safeguarding training and one non-clinical member of staff had not received child safeguarding appropriate to their role. Some staff still had not received training in fire safety and information governance.
- Recruitment procedures had improved, although references for one member of clinical staff had not been requested prior to employment.
- Staff appraisals had been commenced but not all staff, who were eligible, had received an appraisal in the last 12 months.
- The practice had undertaken some clinical audits but there was little evidence of improvements to the quality of patient care.
- An infection control audit, carried out in March 2017, did not identify interventions required, which member of staff was responsible and a timescale for action. Completed actions were not documented.

Summary of findings

- Care plans were available for a variety of long term condition management but not all clinical staff accessed or used them.
- There was a lack of awareness of the practice vision and business plan amongst staff and not all staff felt involved in discussions about how to run and develop the practice.
- Patient group directions and patient specific directions were administered in line with legislation.
- Practice policies were practice specific and up to date.
- The practice had designated a GP as the overall clinical lead and other GP partners had been assigned lead roles.

There were areas of practice where the provider needs to make improvements.

Importantly, the provider must:

- 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, supervision and appraisal necessary to enable them to carry out the duties.

In addition the provider should:

- Ensure that alerts for children and adults at risk which are placed on the practice computer are also placed on family or other household members' records, as appropriate.

At our previous inspection on 23 August 2016, we rated the practice as requires improvement for providing safe, effective and well led services. The arrangements for reviewing and implementing action for patient and medicine safety alerts, staff awareness of significant event reporting and processes, infection control audit documentation, staff recruitment files, staff training records, appraisals and clinical audits were ineffective.

At this inspection we found that sufficient improvements had still not been fully introduced or implemented. Consequently, the practice is rated as requires improvement for providing safe and effective services and inadequate for well led services.

Where a service is rated as inadequate for one of the five key questions or one of the six population groups or overall, it will be re-inspected within six months after the report is published. If, after re-inspection, the service has failed to make sufficient improvement, and is still rated as inadequate for any key question or population group or overall, we will place the service into special measures. Being placed into special measures represents a decision by CQC that a service has to improve within six months to avoid CQC taking steps to 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?

Requires improvement

During our inspection in August 2016 the practice was rated as requires improvement for providing safe services. Insufficient improvements had been made when we undertook a follow up inspection on 16 June 2017. The practice is rated as requires improvement for providing safe services.

- There was no formalised process for reviewing, assessing risk and taking action for patient and medicine safety alerts. There was no record of previous alerts that had been acted on and an alert from April 2017 had yet to have actions taken.
- Not all staff were aware of the process for reporting and recording significant events. Learning from events was shared with staff directly involved or disseminated through line managers.
- Recruitment procedures had improved, although references for one member of clinical staff had not been requested prior to employment.
- An infection control audit, carried out in March 2017, did not identify interventions required, which member of staff was responsible and a timescale for action. Completed actions were not documented.

However, the practice had made some improvements:

- Patient group directions and patient specific directions were administered in line with legislation.
- Chaperone notices advised patients this service was available.
- A fire drill and complete evacuation had been carried out in March 2017.

Are services effective?

Requires improvement

During our inspection in August 2016 the practice was rated as requires improvement for providing effective services. Insufficient improvements had been made when we undertook a follow up inspection on 16 June 2017. The practice is rated as requires improvement for providing effective services.

- There were gaps in staff training. Some clinical and non-clinical staff had not received adult safeguarding training and one non-clinical member of staff had not received child safeguarding appropriate to their role. Some staff still had not received training in fire safety and information governance.
- Staff appraisals had been commenced but not all staff, who were eligible, had received an appraisal in the last 12 months.

Summary of findings

- The practice had undertaken clinical audits but there was little evidence of improvements to the quality of patient care.
- Care plans were available for a variety of long term conditions management but not all clinical staff accessed or used them. Patients were not routinely offered a copy of their care plan.

Are services well-led?

Inadequate

During our inspection in August 2016 the practice was rated as requires improvement for providing well led services. Insufficient improvements had been made when we undertook a follow up inspection on 16 June 2017. The practice is rated as inadequate for providing well led services.

- Governance arrangements had not identified the risks associated with a lack of formal process for reviewing and acting upon patient and medicine safety alerts, lack of training and appraisals for staff, poor documentation of infection control audit actions, background checks on staff not being undertaken prior to employment and not ensuring all staff were aware of the process for raising and acting on a significant event.
- There was a lack of awareness of the practice vision and business plan amongst staff and not all staff felt involved in discussions about how to run and develop the practice.

However, the practice had made some improvements:

- Practice policies were practice specific, up to date and contained relevant information.
- The practice had designated a GP as the overall clinical lead and other GP partners had been assigned lead roles.

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

Requires improvement

The provider had not made sufficient improvement to meet the breaches of regulations associated with provision of safe, effective and well-led services identified at our inspection on 23 August 2016. These breaches applied to everyone using this practice, including this population group. The population group ratings remain as requires improvement.

- Not all patients aged over 75 years of age had a named GP and continuity of care.

People with long term conditions

Requires improvement

The provider had not made sufficient improvement to meet the breaches of regulations associated with provision of safe, effective and well-led services identified at our inspection on 23 August 2016. These breaches applied to everyone using this practice, including this population group. The population group ratings remain as requires improvement.

- Not all patients with long term conditions had a care plan documented in their records. Not all GPs were aware of how to access care plan templates or how to complete them.

Families, children and young people

Requires improvement

The provider had not made sufficient improvement to meet the breaches of regulations associated with provision of safe, effective and well-led services identified at our inspection on 23 August 2016. These breaches applied to everyone using this practice, including this population group. The population group ratings remain as requires improvement.

- Children and young patients on the 'at risk' register had a system alert on their care record to highlight additional care needs to clinicians. The alert was not added to other family or household members, where it was appropriate to do so.

Working age people (including those recently retired and students)

Requires improvement

The provider had not made sufficient improvement to meet the breaches of regulations associated with provision of safe, effective

Summary of findings

and well-led services identified at our inspection on 23 August 2016. These breaches applied to everyone using this practice, including this population group. The population group ratings remain as requires improvement.	
People whose circumstances may make them vulnerable The provider had not made sufficient improvement to meet the breaches of regulations associated with provision of safe, effective and well-led services identified at our inspection on 23 August 2016. These breaches applied to everyone using this practice, including this population group. The population group ratings remain as requires improvement.	**Requires improvement** 
People experiencing poor mental health (including people with dementia) The provider had not made sufficient improvement to meet the breaches of regulations associated with provision of safe, effective and well-led services identified at our inspection on 23 August 2016. These breaches applied to everyone using this practice, including this population group. The population group ratings remain as requires improvement.	**Requires improvement** 

Summary of findings

Areas for improvement

Action the service MUST take to improve

- 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, supervision and appraisal necessary to enable them to carry out the duties.

Action the service SHOULD take to improve

- Ensure that alerts for children and adults at risk which are placed on the practice computer are also placed on family or other household members' records, as appropriate.

Sidley Medical Practice

Detailed findings

Our inspection team

Our inspection team was led by:

The inspection team was led by a CQC inspector and included a GP specialist advisor.

Background to Sidley Medical Practice

Sidley Medical Practice provides general medical services to approximately 16,500 patients and operates from two practices in Bexhill-on-Sea. These are known as Sidley Surgery, a purpose built premises in a residential area with a link to an adjacent pharmacy, and Albert Road Surgery that is located in the town centre and based in a converted residential property.

Patients can access services provided from either location:

Sidley Surgery, 44 Turkey Road, Bexhill-on-Sea, East Sussex, TN39 5HE.

Or

Albert Road Surgery, 24 Albert Road, Bexhill-on-Sea, East Sussex, TN40 1DG.

There are six GP partners (four male, two female) and six salaried GPs (all female). The practice is accredited to provide both teaching and training. It supports medical students and provides training opportunities for qualified doctors seeking to become GPs. At the time of the inspection there was one trainee GP working at the practice.

In addition there are nine members of the nursing team; six practice nurses (one male, five female) and three health care assistants (female). There is a senior management team overseeing day to day operations. This includes a senior GP partner, a self employed consultant acting as an interim practice manager, a deputy practice manager and an operations manager. There are 24 members of reception/administration staff supporting the practice.

Both practices are open Monday to Friday between 8am and 6:30pm with a lunchtime closure from 1pm to 2pm; during this time patients can call the normal surgery phone number and a duty doctor is available. Pre-booked extended hours appointments are offered at the Albert Road Surgery every Saturday from 8am to 11am.

Appointments can be booked over the telephone, online or in person at the surgery. Patients are provided information on how to access an out of hours service by calling the surgery or viewing the practice website.

Data available to the Care Quality Commission (CQC) shows the practice is located in an area that is considered to be in the fifth most deprived area nationally. People living in more deprived areas tend to have greater need for health services. Statistically, this practice area has a higher number of people with a long-standing health condition when compared to the national average and the number of people suffering income deprivation is higher than the national average.

This practice serves a higher than average number of patients who are aged over 65 years when compared to the national average. The number of patients aged from birth to 18 years is slightly lower than the national average.

The practice offers a number of services for its patients including; family planning, minor surgery, hypertension clinics, drug and alcohol misuse services, smoking cessation, and travel vaccines.

The practice has a General Medical Services (GMS) contract with NHS England. (GMS is one of the three contracting

routes that have been available to enable commissioning of primary medical services). The practice is part of the NHS Hastings and Rother Clinical Commissioning Group. The practice list is currently closed to new patients.

Why we carried out this inspection

We undertook a comprehensive inspection of Sidley Medical Practice on 23 August 2016 under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The practice was rated as requires improvement. The full comprehensive report following the inspection on August 2016 can be found by selecting the 'all reports' link for Sidley Medical Practice on our website at www.cqc.org.uk.

We undertook a follow up focused inspection of Sidley Medical Practice on 16 June 2017. This inspection was carried out to review in detail the actions taken by the practice to improve the quality of care and to confirm that the practice was now meeting legal requirements.

How we carried out this inspection

During our visit we:

- Spoke with the Deputy Practice manager and a GP partner.
- Collected written feedback from various members of staff.
- Reviewed governance processes and arrangements.
- The GP advisor reviewed an anonymised sample of the personal care or treatment records of patients to assess whether treatment was delivered in line with best practice.
- Looked at information the practice used to deliver care and treatment plans.

Requires improvement

Are services safe?

Our findings

At our previous inspection on 23 August 2016, we rated the practice as requires improvement for providing safe services as the arrangements in respect of infection control, significant event reporting and sharing of learning, staff safeguarding training and staff recruitment procedures were not sufficient. In addition patient group directions and patient specific directions had not been completed or authorised in line with legislation.

The practice had made some improvements when we undertook a follow up inspection on 16 June 2017. However, not all breaches of regulation had been addressed and we identified further risks at the time of inspection.

Safe track record and learning

There was a system in place for reporting and recording significant events, although not all staff were aware of their responsibilities.

- The practice had designated a GP partner to lead on significant events.
- Not all staff were aware of the process for significant event reporting although there was an understanding to raise an event to a line manager.
- Significant events and incidents were discussed monthly at clinical meetings, although these often took place on a Monday and some recent meetings had not occurred during bank holidays. We saw two examples of significant events from March and April 2017 that had not been discussed until June 2017. Learning outcomes had been identified but had not yet been fully implemented or actioned. For example, the practice had identified that not all older patients, over the age of 75 years had named GP. This had led to an occasion where continuity of care had not occurred which caused a significant event to be raised. The practice had begun to allocate a named GP to all older patients, commencing with those they deemed the most vulnerable and at highest risk. At the time of the inspection not all patients aged over 75 had a named GP.
- Learning outcomes were identified and documented in clinical meeting minutes. These were shared with individual staff if they were involved or disseminated through their line managers.

Overview of safety systems and process

- Safeguarding policies had been reviewed and were practice specific. An easy access dashboard had been created for staff to access policies including the safeguarding children and adults policies. There were also links to local and NHS England guidance.
- There were currently two lead GPs for safeguarding. One GP for safeguarding adults and one GP for safeguarding children. One of the GPs was due to retire and from July 2017 only one GP would be the lead for both adult and child safeguarding. The policies clearly reflected this and named the correct lead GP. Staff were also aware of who the lead GP for safeguarding was.
- All GPs were trained in child safeguarding to level three and nurses and the paramedic practitioner to at least level two. However, not all clinical staff had received adult safeguarding training and a number of non-clinical staff had not received up to date child or adult safeguarding training.
- Clinicians were made aware of safeguarding and 'at risk' children through a system alert on the practice computer system. However, we noted the alert was recorded on the young patients record only and did not extend to other family or household members (where it would have been appropriate to do so).
- We reviewed medicine and other safety alerts from the Medicines and Health Products Regulatory Agency (MHRA) and found there was an insufficient process for ensuring all were reviewed, documented and actioned. The practice showed us one alert from September 2016 where outcomes were identified and actions taken. A more recent alert in April 2017 regarding a medicine used to treat epilepsy, bipolar disorder and some types of migraine headaches, had no evidence of actions taken. The practice had decided to use this alert to initiate an audit which had yet to be undertaken. The practice was unable to offer any other recorded examples of recent MHRA alerts which had been reviewed and acted on.There was no log of historical alerts which may require action if patients were placed on specific medicines by external clinicians and may be subject to repeated searches. Therefore, patients were placed at risk where they did not receive a review to ensure they were safe to continue taking any medicines subject to an alert.
- The lead nurse for infection prevention and control (IPC) had received training from the IPC lead with the local Clinical Commissioning Group in July 2016.

Requires improvement

Are services safe?

- An infection control audit had been carried out in March 2017 for both practice sites. The practices scored below standard for both sites. Action plans highlighted the identified issues but there was no documented action or staff member yet allocated to carry out the actions and no timescale for improvements to be made. For example, clinical equipment cleaning records were not kept, although the practice told us regular cleaning took place. The practice infection control audit in March 2017 had also highlighted this as an action.
- Cleaning of fabric curtains in treatment rooms had been maintained every six months and the practice had decided to replace these with disposable curtains when the next date for cleaning was due.
- Patient group directions and patient specific directions had been reviewed and were administered in line with legislation.
- Since the last inspection, the practice had placed visible chaperone notices in treatment rooms to advise patients this service was available to them.
- We reviewed three personnel files and found all the appropriate recruitment checks had been undertaken prior to employment for two of them. For example, proof of identification, evidence of satisfactory conduct in previous employments in the form of references, qualifications, registration with the appropriate professional body and the appropriate checks through the DBS. However, one member of clinical staff had commenced their role in March 2017 and references had only been requested in June 2017. Their background check with the disclosure and barring service was from their previous employer and was over three years old.

Monitoring risks to patients

A complete fire drill and evacuation had been undertaken in March 2017. The practice told us the fire drill formed part of the fire safety training for staff. However, the fire drill did not include training in the correct and appropriate use of fire equipment such as fire extinguishers.

Requires improvement

Are services effective?

(for example, treatment is effective)

Our findings

At our previous inspection on 23 August 2016, we rated the practice as requires improvement for providing effective services as the arrangements in respect of clinical audits, care planning, staff training and staff appraisal needed improving.

The practice had made some improvements when we undertook a follow up inspection on 16 June 2017. However, not all breaches of regulation had been addressed and we identified further risks at the time of inspection.

Effective needs assessment

The practice assessed needs and delivered care in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines;

- The practice updated clinicians on local and national guidance updates through regular clinical meetings. We looked at patient records for specific conditions and found they reflected NICE and other guidance for best practice.

Management, monitoring and improving outcomes for people

- The practice showed us four clinical audits which had been undertaken since the last inspection. One of these was a completed audit of two cycles. The audit looked at patients with gestational diabetes (raised blood sugar during pregnancy) and if they had received a follow up blood test after giving birth. The target was set at 100%. During the first audit in 2015 there were 0% of patients who had received the appropriate post-natal follow up. This had increased to 26% by 2017. The increase was still below the 100% target. GPs were aware of the guidance and patients had been invited for review, however, no specific interventions had been identified to make further improvements to patient care.
- One clinical audit on vitamin D deficiency was due to commence a second cycle in June 2017. The first cycle had been carried out in March 2017 and presented at a clinical meeting in April 2017.
- The practice had identified one future clinical audit which had been highlighted through a Medicines and Health Products Regulatory Agency alert from April 2017, but had yet to be undertaken.

Effective staffing

- Staff appraisals had been instigated by the practice manager. We saw of evidence of completed or commenced appraisals for approximately half of all staff. All the remaining staff, who were eligible, were awaiting a date for their appraisal to take place.
- There were gaps in staff training. In particular, fire safety awareness training had not been undertaken by a number of staff. The practice told us they had used the fire drill in March 2017 as their training. Basic life support, infection control and information governance training had not been undertaken by all staff. No staff had undertaken training in whistleblowing. Nurses and the paramedic practitioner had received safeguarding children training to at least level two, although not all staff had received safeguarding adults training and there were some gaps in safeguarding children training for non-clinical staff.

Coordinating patient care and information sharing

We reviewed a sample of care plans for patients with dementia, learning disabilities and mental health conditions and found they contained suitable information and reflected best practice guidance. However, there was still disparity amongst the GPs over using the templates for documenting care plans with some being written directly into the patient notes.

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 23 August 2016, we rated the practice as requires improvement for providing well-led services as the governance arrangements and structure required improving.

We issued a requirement notice in respect of these issues but found arrangements had not improved when we undertook a follow up inspection of the service on 16 June 2017. The practice is rated as inadequate for being well-led.

Governance arrangements

Governance arrangements had not identified a lack of response to the breaches of regulation identified in the previous inspection report findings. The practice failed to demonstrate that there was sufficient leadership capability and capacity to ensure governance systems were operated effectively. Specifically the practice had:

- Failed to act on all feedback within the last CQC inspection report of August 2016.
- Not ensured all staff understood the process for reporting, recording and acting on significant events. The clinical meeting timetable had not been flexible in order to maintain timely discussion of significant event analysis and sharing of learning.
- Not ensured formal pathways and processes to ensure patient safety and medicine alerts were received, reviewed, actioned and recorded.
- Undertaken an infection control audit in March 2017 but had not identified interventions or timescales for completion of actions. Completed actions had not been documented, including records of cleaning of medical equipment.
- Not ensured all background checks were requested prior to the commencement of employment.
- Not ensured there were systems and processes in place to assess, monitor and improve the quality and safety of services through an on-going audit programme in a range of clinical areas.
- Failed to identify not all staff had received appropriate training relevant to their roles and responsibilities.
- Commenced a programme of appraisals but had only achieved 50% of all staff either receiving an appraisal or being offered pre-appraisal paperwork.
- Not ensured the methods for storing and locating patient care plans was communicated to all clinical staff. Whilst we saw good examples of completed care plans for some patients there was still inconsistent use of them amongst GPs.

However, the practice had made improvements in some areas:

- The practice had designated one of the GP partners as overall clinical lead. They had also allocated GP partners with individual responsibility for key areas such as patient safety alerts.
- Practices policies were in the process of being reviewed and updated. The practice manager had created a dashboard on the computer system to ensure easy access to policies for all staff. We reviewed a sample of six policies and found four had been personalised to the practice, had a review date and contained sufficient information. An equality and diversity policy was not available on the day of inspection and the health and safety policy was still to be added to the dashboard, although the practice was able to reference an older one on their intranet system. The practice were able to provide the most up to date equality and diversity and health and safety policies within two days of the inspection.

Leadership and culture

- There was a lack of awareness of the practice vision and business plan amongst staff. For example, the practice was aware of a local housing development that would impact the practice. Whilst the GP partners were in discussions with the clinical commissioning group about the future of the practice and had raised the topic at a patient participation group meeting, staff were uncertain of how this would affect them.
- Not all staff felt involved in discussions about how to run and develop the practice. Many staff stated they felt listened to if they offered a suggestion on how to improve the practice but felt these were then not carried through or acted upon. One suggestion to have a box for repeat prescriptions on the reception counter had been commenced, but staff had requested that prescriptions being handed out should be away from the main counter, which was yet to be actioned.

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 Surgical procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **How the regulation was not being met:** We found the registered provider did not operate effective systems to ensure staff received appropriate support, training, professional development and appraisal. The service provider had failed to ensure that persons employed in the provision of a regulated activity received such appropriate support, training, professional development, supervision and appraisal as was necessary to enable them to carry out the duties they were employed to perform. In particular: • Not all staff had received appropriate training relevant to their role. • Not all staff, who were eligible, had received an appraisal in the preceding 12 months.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **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.** **How the regulation was not being met:** **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 was minimal evidence of quality improvement and monitoring through clinical audit. • Governance arrangements had not identified gaps in appropriate staff training requirements and had not ensured appraisals were carried out for all staff within a specified timescale (where eligible). **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 particular:** • The provider had failed to identify the risks associated with insufficient processes and records for identifying, acting on, reviewing and monitoring patient and medicine safety alerts issued from the Medicine and Healthcare products Regulatory Agency. • The infection control audit action plan was incomplete and records of cleaning of medical equipment were not kept. • Not all staff were aware of significant event processes and reporting. **The registered person had systems or processes in place that operated ineffectively in that they failed to enable**

This section is primarily information for the provider

Enforcement actions

the registered person had maintained securely such records as are necessary to be kept in relation to persons employed in the carrying on of the regulated activity or activities. In particular:

- Pre-employment background checks were not carried out for all staff prior to commencing employment.

The registered person had systems or processes in place that operated ineffectively in that they failed to enable 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. In particular:

- The provider had failed to act on the findings from an inspection undertaken by the Care Quality Commission in August 2016.
- There was a lack of awareness of the practice vision and business plan amongst staff and not all staff felt involved in discussions about how to run and develop the practice.