Abbey Road Surgery

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

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Abbey Road Surgery on 27 September 2016. This was to check that improvements had been made following the breaches of legal requirements we identified from our comprehensive inspection carried out on 29 July 2015. Overall the practice is rated as inadequate.

Our previous inspection in July 2015 found breaches of regulations relating to the safe, effective, responsive and well-led domains. The overall rating of the practice in July 2015 was requires improvement.

The areas identified as requiring improvement during our inspection in July 2015 were as follows:

- Ensure recruitment arrangements include all necessary employment checks for all staff. This includes making sure all nursing staff have a criminal records check through the Disclosure and Barring Service (DBS). Where non-clinical staff perform chaperone duties, the practice must risk assess whether a DBS check is required.
- Complete the actions identified in the infection control audit and review systems in particular relating to hand washing and the use of disposable towels. Carry out a risk assessment for the management, testing and investigation of legionella and implement any recommended checks to the water system. Use the correct disposal bins for sharps used for the administration of cytotoxic medications.
- Have essential equipment such as oxygen available for use in an emergency.
- Develop a system for the management of high risk medications that includes regular review and monitoring of the patient.
- Continue to review the telephone and appointments system in response to patients' concerns about access to the practice.

Following our inspection on 27 September 2016, our key findings across all the areas we inspected were as follows:

Summary of findings

- Patients were at risk of harm because systems and processes were not in place to keep them safe. For example, the practice did not have effective systems in place for the effective management of national safety alerts.
- We found an inconsistent approach towards the management of significant events and complaints. There was no evidence of learning and communication with all relevant staff.
- The practice had regularly monitored the Quality and Outcomes Framework and had made significant improvements to their performance across several areas
- Staff worked with other health care professionals to understand and meet the range and complexity of patients' needs.
- Not all governance structures, systems and processes were effective and enabled the provider to identify, assess and mitigate risks to patients, staff and others.
- Patient comments highlighted that they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment. However, the practice performed below average for most areas in the National GP Patient Survey. The practice did not offer extended opening hours.
- The practice did not have a clear leadership structure. Staff members were unable to describe the vision and values of the practice and not all staff members felt supported by management.

The areas where the provider must make improvements are:

- Systems and processes must be established and operated effectively to ensure good governance and leadership.
- Ensure systems and processes for the management of patient safety alerts, significant events and complaints are effective, including actions taken and sharing of learning with relevant staff.
- Ensure that systems designed to assess the risk of and to prevent, detect and control the spread of infection are fully implemented and monitored in all relevant areas. Including infection control training for all staff members and the management of clinical waste in accordance with national guidelines.
- Complete an assessment on the control of substances hazardous to health.
- Ensure formal supervision of the nurse prescriber in line with the practice clinical supervision policy.
- Implement formal governance arrangements including systems for assessing and monitoring risks and the quality of the service provision.

The areas where the provider should make improvements are:

- Ensure electrical equipment is checked on a regular basis to ensure it is safe to use.
- Ensure steps are taken to make improvements to the National GP Patient Survey results; including access to routine pre-bookable appointments and access to the practice by telephone.
- Review and make improvements to the baby changing area and disabled patient toilet facilities provided in line with the requirements of the Equality Act 2010.
- Ensure all policies are reviewed and are up-to-date.
- Develop a practice business plan to include the practice vision, aims and objectives, with the involvement of all staff members.
- Ensure an appropriate system is in place for the safe monitoring of blank prescriptions
- Consider developing a quality improvement plan to ensure continuous improvement

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.

Summary of findings

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Inadequate

The practice is rated as inadequate for providing safe services.

- The practice was unable to demonstrate how safety alerts were being shared with all of the relevant staff and if the required action was being taken. We found evidence that patients were at risk of harm because systems and processes were not in place to ensure MHRA alerts were being acted on.
- The practice did not have an effective system in place for identifying, sharing and learning from significant events.
- The practice maintained appropriate standards of cleanliness and hygiene. We observed the premises to be visibly clean and tidy. However, the infection control lead had not accessed any recent training or updates to keep up to date with best practice. Some staff members had not completed infection control training and infection control audits were limited to the treatment room only.
- Blank prescription forms and pads were securely stored however there was no system in place to monitor their use.
- The practice had a clinical supervision policy in place however this was not being followed and the nurse prescriber did not receive any formal clinical supervision.
- When there were unintended or unexpected safety incidents, patients received support and a verbal and written apology. However, patients were not always told about any actions to improve processes to prevent the same thing happening again.
- The practice had clearly defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from abuse.

Are services effective?

Good

The practice is rated as good for providing effective services.

- Data from the Quality and Outcomes Framework showed the practice had made significant improvements in this area and patient outcomes were at or above average for the locality and compared to the national average.
- Clinical audits demonstrated quality improvement.
- Staff worked with other health care professionals to understand and meet the range and complexity of patients' needs.
- There was evidence of appraisals and personal development plans for all staff.

Summary of findings

Are services caring?

Requires improvement

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

- Data from the National GP Patient Survey results published in July 2016 showed patients rated the practice lower than others for some aspects of care. For example, 72% said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 83% and the national average of 85%.
- 82% said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 90% and the national average of 91%.
- The practice offered flexible appointment times based on individual needs.
- 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 easy to understand and accessible.
- Staff maintained patient and information confidentiality and patients commented on being treated with kindness and respect.
- The practice held a register of carers with 101 carers identified which was approximately 1.5% of the practice list. The practice had carer information packs available in the waiting area and displayed information on a carers' notice board.

Are services responsive to people's needs?

Requires improvement

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

- The practice had a system in place for handling complaints and concerns. However, learning from complaints was not always shared with staff. The practice did not provide all complainants with information about the Parliamentary and Health Service Ombudsman when responding to complaints and the practice had not acted on key themes and trends identified from patient complaints.
- Practice staff reviewed the needs of its local population and engaged with the NHS England Area Team and East and North Hertfordshire Clinical Commissioning Group to secure improvements to services where these were identified. For example, the practice participated in the local area winter

Summary of findings

resilience scheme and offered more appointments. This service had given patients the opportunity to attend the practice for an urgent appointment rather than travel to the local A&E department.
- The practice worked closely with the local drug and alcohol service.
- Patients said they found it easy to make an appointment with a named GP and there was continuity of care, with urgent appointments available the same day.

Are services well-led?

Inadequate

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

- The practice lacked systems and processes to operate effectively and safely and to ensure good governance.
- The practice did not have a vision and staff members were not aware of any practice specific aims or objectives to deliver high quality care and promote good outcomes for patients.
- Some staff members told us that they did not feel supported by the management.
- The practice had a number of policies and procedures to govern activity. However, we found that practice specific policies and procedures were not being followed in some areas.
- Not all governance structures, systems and processes were effective in enabling the provider to identify, assess and mitigate risks to patients, staff and others.
- The practice proactively sought feedback from patients, which it acted on. The patient participation group had been recently formed and was being supported towards becoming active.

Summary of findings

The six population groups and what we found

We always inspect the quality of care for these six population groups.

Older people

Inadequate

The practice is rated as inadequate for providing safe and well-led services and requires improvement for providing caring and responsive services. The issues identified as inadequate and requiring improvement affected all patients including this population group.

- The practice offered proactive, personalised care to meet the needs of the older people in its population, this included enhanced services for avoiding unplanned admissions to hospital and end of life care.
- The practice was responsive to the needs of older people, and offered home visits and urgent appointments when required.
- The practice worked closely with a multidisciplinary rapid response service in place to support older people and others with long term or complex conditions to remain at home rather than going into hospital or residential care.
- Named GPs carried out a weekly visit to a local care home for continuity of care. We spoke to a senior member of staff at the home who told us the practice provided a good service. They described the practice as accessible and responsive to needs of their residents.
- The practice provided health checks for patients aged over 75 years and had completed 450 health checks since April 2015, which was 70% of this population group.

People with long term conditions

Inadequate

The practice is rated as inadequate for providing safe and well-led services and requires improvement for providing caring and responsive services. The issues identified as inadequate and requiring improvement affected all patients including this population group.

- The nurse practitioner had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority.
- Performance for diabetes related indicators was below the CCG and national average. The practice had achieved 70% of the total number of points available, compared to the local and national average of 89%. Figures provided to us by the practice showed the practice had achieved 92% of the total number of points available between 2015/2016.

Summary of findings

- 73% of patients diagnosed with asthma, on the register, had received an asthma review in the last 12 months which was comparable to the local and national average of 75%.
- Longer appointments and home visits were available when needed.
- All patients with a long-term condition had a named GP and a structured annual review to check their health and medicines needs were being met. For those patients with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Inadequate

The practice is rated as inadequate for providing safe and well-led services and requires improvement for providing caring and responsive services. The issues identified as inadequate and requiring improvement affected all patients including this population group.

- There were systems in place to identify and follow up children living in disadvantaged circumstances and identified as being at possible risk, for example, children and young people who had a high number of A&E attendances. Immunisation rates were high for all standard childhood immunisations.
- The practice's uptake for the cervical screening programme was 81%, which was comparable to the CCG average of 83% and the national average of 82%.
- Appointments were available outside of school hours and the premises were suitable for children and babies.
- The practice offered a range of family planning services. Baby vaccination clinics and ante-natal clinics were held at the practice on a regular basis. A community midwife held a clinic at the practice on a weekly basis.

Working age people (including those recently retired and students)

Inadequate

The practice is rated as inadequate for providing safe and well-led services and requires improvement for providing caring and responsive services. The issues identified as inadequate and requiring improvement affected all patients including this population group.

- The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care.

Summary of findings

- The practice carried out routine NHS health checks for patients aged 40-74 years.
- The practice was proactive in offering on line services such as appointment booking, an appointment reminder text messaging service and repeat prescriptions, as well as a full range of health promotion and screening that reflects the needs of this age group.
- A health and wellbeing specialist from the local public health team held a weekly session at the practice and provided information and advice about diet management and also provided motivational and behavioural support. Patients were also signposted patients to local services.
- The practice provided an electronic prescribing service (EPS) which enabled GPs to send prescriptions electronically to a pharmacy of the patient's choice.

People whose circumstances may make them vulnerable

Inadequate

The practice is rated as inadequate for providing safe and well-led services and requires improvement for providing caring and responsive services. The issues identified as inadequate and requiring improvement affected all patients including this population group.

- The practice held a register of patients living in vulnerable circumstances including those with a learning disability and offered longer appointments for those patients.
- The practice regularly worked with other health care professionals in the case management of vulnerable patients.
- Vulnerable patients had been told how to access various support groups and voluntary organisations.
- The practice had a system in place to identify patients with a known disability.
- The practice had developed shared care services and worked closely with a local drug and alcohol service.
- Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.
- The practice held a register of carers with 101 carers identified which was approximately 1.5% of the practice list.

Summary of findings

People experiencing poor mental health (including people with dementia)

Inadequate

The practice is rated as inadequate for providing safe and well-led services and requires improvement for providing caring and responsive services. The issues identified as inadequate and requiring improvement affected all patients including this population group.

- 81% of patients diagnosed with dementia had their care reviewed in a face to face meeting in 2014/2015, which was comparable to the local average of 86% and national average of 84%.
- The practice held a register of patients experiencing poor mental health and offered regular reviews and same day contact.
- The practice referred patients to the Improving Access to Psychological Therapies service (IAPT) and encouraged patients to self-refer.
- Performance for mental health related indicators was below the CCG and national average. The practice had achieved 88% of the total number of points available compared to 96% locally and 93% nationally. Figures provided to us by the practice showed the practice had achieved 100% of the total number of points available between 2015/2016.
- The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations.
- Staff had a good understanding of how to support patients with mental health needs and dementia.

Summary of findings

What people who use the service say

We looked at the National GP Patient Survey results published in July 2016. The results showed the practice was performing below local and national averages. There were 313 survey forms distributed and 116 were returned. This represented a 37% response rate and approximately 1% of the practice's patient list.

- 28% of patients found it easy to get through to this practice by phone compared to the local average of 63% and national average of 73%. The practice told us that they had changed their telephone system in June 2016 and the new system provided advice and more options along with an improved telephone queuing system.
- 58% of patients were able to get an appointment to see or speak to someone the last time they tried compared to the local average of 71% and national average of 76%.
- 66% of patients described the overall experience of this GP practice as good compared to the local average of 82% and national average of 85%.
- 50% of patients said they would recommend this GP practice to someone who has just moved to the local area compared to the local average of 76% and national average of 79%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 13 comment cards. All comment cards were positive about the standard of care received. Patients said staff acted in a professional and courteous manner and described the services provided by all staff as very caring, accommodating and friendly. One patient did comment on having to wait a long time to get an appointment.

We spoke with 10 patients during the inspection. Eight patients told us that it was very difficult to get an appointment at a time convenient to them. Seven patients told us that it was very difficult to contact the practice on the telephone and six patients told us that they would regularly have to wait beyond their appointment time to be seen.

The practice had completed a patient survey in June 2016 and had received 266 responses. Results from this survey showed 93% of respondents said they were able to see a GP or nurse practitioner within 48 hours. 70% of respondents said they were able to contact the practice by telephone. 86% of respondents said they were seen within 30 minutes of their appointment time.

The practice had gathered patient feedback using the NHS Friends and Family Test (FFT). The FFT asks people if they would recommend the services they have used and offers a range of responses. The practice had received 49 responses to the FFT between May and July 2016. The results showed 44 people were either extremely likely or likely to recommend the service, two patients were neither likely nor unlikely and three people were either extremely unlikely or unlikely to recommend the service.

Areas for improvement

Action the service MUST take to improve

- Systems and processes must be established and operated effectively to ensure good governance and leadership.
- Ensure systems and processes for the management of patient safety alerts, significant events and complaints are effective, including actions taken and sharing of learning with relevant staff.
- Ensure that systems designed to assess the risk of and to prevent, detect and control the spread of infection are fully implemented and monitored in all relevant areas. Including infection control training for all staff members and the management of clinical waste in accordance with national guidelines.
- Complete an assessment on the control of substances hazardous to health.
- Ensure formal supervision of the nurse prescriber in line with the practice clinical supervision policy.

Summary of findings

- Implement formal governance arrangements including systems for assessing and monitoring risks and the quality of the service provision.

Action the service SHOULD take to improve

- Ensure electrical equipment is checked on a regular basis to ensure it is safe to use.
- Ensure steps are taken to make improvements to the National GP Patient Survey results; including access to routine pre-bookable appointments and access to the practice by telephone.
- Review and make improvements to the baby changing area and disabled patient toilet facilities provided in line with the requirements of the Equality Act 2010.
- Ensure all policies are reviewed and are up-to-date.
- Develop a practice business plan to include the practice vision, aims and objectives, with the involvement of all staff members.
- Ensure an appropriate system is in place for the safe monitoring of blank prescriptions
- Consider developing a quality improvement plan to ensure continuous improvement

Abbey Road Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector and included a regional GP specialist advisor, a nurse specialist advisor and an Expert by Experience.

Background to Abbey Road Surgery

Abbey Road Surgery provides primary medical services, including minor surgery, to approximately 8,500 patients in Waltham Cross, Hertfordshire. Services are provided on a General Medical Services (GMS) contract (a nationally agreed contract). Abbey Road Surgery was purpose built in 1992. All patient consultations are held on the ground floor. The practice told us that they had submitted plans for an extension to the premises and this had been accepted. However, the work did not go ahead as planned due to operational issues.

The practice serves a higher than average population of those aged between 5 to 9 years, 15 to 19 years and 40 to 54 years. The practice serves a lower than average population of those aged between 20 to 34 years and 60 to 74 years. The practice told us that approximately 50% of the registered patients were from outside of the UK, with many of these patients not having English as their first language. The area served is more deprived compared to England as a whole. The practice is located within one of the most deprived areas in Hertfordshire.

The practice team consists of four GP Partners; three of which are male and one is female. There is one salaried GP and one nurse practitioner, who is qualified to prescribe certain medicines. The practice currently has a vacancy for a practice nurse and currently uses two regular locum nurses. The non-clinical team consists of a practice business manager, one reception supervisor, seven receptionists, one secretary and four members of the administration team.

The practice is open to patients between 8.30am and 6:30pm Mondays to Fridays. Patients are able to access urgent clinical telephone advice between 8am and 8.30am. Appointments with a GP are available from approximately 9am to 11.30am and from 3pm to 5.30pm daily. Emergency appointments are available daily. A telephone consultation service is also available for those who need urgent advice.

Home visits are available to those patients who are unable to attend the surgery and the Out of Hours service is provided by Hertfordshire Urgent Care and can be accessed via the NHS 111 service. Information about this is available in the practice, on the practice website and on the practice telephone line.

Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This was to check that improvements had been made following the breaches of legal requirements we identified from our comprehensive inspection carried out on 29 July 2015.

How we carried out this inspection

Before inspecting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We contacted NHS East and North

Detailed findings

Hertfordshire Clinical Commissioning Group (CCG), Healthwatch and the NHS England area team to consider any information they held about the practice. We carried out an announced inspection on 27 September 2016. During our inspection we:

- Spoke with three GPs, the nurse practitioner, the practice manager, the secretary, four members of the administration team, the reception supervisor and two receptionists.
- Spoke with 10 patients and observed how staff interacted with patients.
- Reviewed 13 CQC comment cards where patients and members of the public shared their views and experiences of the service.
- Received feedback from two members of the Patient Participation Group (PPG). (This is a group of volunteer patients who work with practice staff on making improvements to the services provided for the benefit of patients and the practice).

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

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

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

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

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

Inadequate

Are services safe?

Our findings

During our previous inspection in July 2015 we found breaches of regulations relating to staff recruitment checks and disclosure and barring checks for staff members performing chaperoning duties. We found the provider had not completed a Legionella risk assessment and did not use the correct disposal bins for sharps used for the administration of cytotoxic medications. We found the provider had not acted on areas identified in the infection control audit and did not have access to essential emergency equipment such as oxygen. We found the provider did not have a system for the management of high risk medications that included the regular review and monitoring of these patients.

During our inspection on 27 September 2016 we found the following:

Safe track record and learning

- The practice had recorded 10 significant events over the past two years. Although the practice carried out some investigations of unintended or unexpected safety incidents, lessons learned were not always communicated to all of the relevant staff members at the practice. For example, one of the significant events was in relation to patient documentation being sent out in the post with insufficient postage, which had resulted in a two month delay. We spoke with a member of the administration team about this and they told us that they were unaware of this incident.
- The practice had a policy in place for the management of significant events however we found evidence that senior staff were not routinely following this policy. For example, we found two significant events which the practice had received as patient complaints. One of these complaints was in relation to a sudden death and the second complaint was in relation to a significant prescribing error. The practice had not treated these complaints as significant events. In addition to this, we spoke with GPs about significant events and they provided us with examples of previous significant events. However, there was no evidence that the significant events described by the GPs had been recorded or managed as significant events by the practice.
- During our previous inspection in July 2015 we found that the provider did not always follow their protocol for reporting, recording and monitoring significant events, incidents and accidents to ensure learning was identified and shared with all of the relevant staff members.

We reviewed safety records, incident reports, MHRA (Medicines and Healthcare products Regulatory Agency) alerts and patient safety alerts. Although the practice received safety alerts, the practice was not able to demonstrate how these safety alerts were being shared with all of the relevant staff and if required action was being taken.

We found evidence that patients were at risk of harm because systems and processes were not in place to ensure MHRA alerts were being acted on. We completed two searches on the clinical system to assess how the practice had managed historical safety alerts. In August 2012, a MHRA alert was issued highlighting the risk of the interaction between high doses of simvastatin with amlodipine. We found four patients had been prescribed these higher risk medicines used to reduce the risk of heart attack and stroke. We found no evidence that the practice had assessed the risks associated with prescribing these medicines to these patients. In February 2016, a MHRA alert was issued highlighting the risks of the interaction between ACE/A2RB medication and Spironolactone. We found 11 patients had been prescribed these medicines which required monitoring and three of these patients had not received a blood test in the preceding 13 months.

Overview of safety systems and processes

The practice had systems, processes and practices in place to keep patients safe and safeguarded from abuse, however during our inspection we found some of these systems and processes to be inadequate:

- Arrangements were in place to safeguard children and vulnerable adults from abuse that reflected relevant legislation and local requirements and policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. There was a GP lead for safeguarding adults and children. The GPs provided reports where necessary for other agencies. Staff demonstrated they understood their responsibilities and had received training relevant to their role. All GPs and nurses were trained to an appropriate level to manage safeguarding children (level three) and adults.

Inadequate

Are services safe?

- The practice displayed notices in the waiting area and treatment and consulting rooms which advised patients that chaperones were available if required. All staff who acted as chaperones were trained for the role and a risk assessment was in place for all staff including circumstances in which staff acted as a chaperone without having a disclosure and barring check (DBS check). (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).
- The practice maintained appropriate standards of cleanliness and hygiene. We observed the premises to be visibly clean and tidy. The nurse practitioner had been appointed as the infection control lead September 2016, the previous infection control lead had left the practice August 2016. We were told that this person had completed infection control training in 2013 however there was no evidence to confirm this and the infection control training certificate for this person was dated 2005. The practice completed an infection control audit on a monthly basis, however these audits were limited to the treatment room only. We also found three members of the non-clinical staff had not completed infection control training. During our previous inspection in July 2015 we found that the required actions identified from infection control audits had not being discussed with staff members or acted on.
- Clinical waste was being collected from the practice by an external contractor on a weekly basis however this waste was not being labelled. We found that the baby changing area did not meet infection control and safety standards. The straps attached to the baby changing mat were damaged and there was no safety information available. There were no antiseptic wipes that could be used in the absence of paper towels and there was no waste bin for used nappies. We also found that the disabled toilet did not have a call bell to alert staff in the event of an emergency.
- All single use clinical instruments were stored appropriately and were within their expiry dates. Where appropriate equipment was cleaned daily and spillage kits were available.
- The arrangements for managing medicines, including emergency medicines in the practice kept patients safe. This included arrangements for obtaining, prescribing, recording, handling, storing and the security of medicines. Processes were in place for handling repeat prescriptions which included the review of high risk medicines.
- Blank prescription forms and pads were securely stored however there was no system in place to monitor their use. The relevant staff members were unaware of the required process.
- The nurse practitioner had qualified as an Independent Prescriber and could therefore prescribe medicines for specific clinical conditions. They received mentorship and support from the GPs for this extended role. However, this supervision was informal and ad-hoc. The practice had a clinical supervision policy in place however this was not being followed and the nurse prescriber did not receive formal clinical supervision.
- Patient Group Directions had been adopted by the practice to allow the nurses to administer medicines in line with legislation.
- We reviewed five personnel files and found appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service (DBS).

Monitoring risks to patients

There were procedures in place for monitoring and managing risks to patient and staff safety in some areas. However, during our inspection we found examples where risks to patients were not being managed effectively.

- There was a health and safety policy available along with a poster in the staff area which included the names of the health and safety lead at the practice. The practice had up to date fire risk assessments. Fire alarms were tested weekly and the practice carried out fire drills and checked fire equipment on a regular basis. All clinical equipment was checked in April 2016 to ensure it was working properly. However, the practice did not have a process in place to ensure electrical equipment was checked on a regular basis.
- The practice had completed a Legionella assessment. (Legionella is a term for a particular bacterium which can contaminate water systems in buildings) and were completing the required water temperature checks. The

practice had a policy in place for the Control of Substances Hazardous to Health (COSHH) and COSHH data sheets were available however the practice had never completed a COSHH risk assessment.

- Arrangements were in place for planning and monitoring the number of staff and skill mix of staff needed to meet patients' needs. There were individual team rotas in place to ensure that enough staff members were on duty. The practice had a system in place for the management of planned staff holidays and staff members would be flexible and cover additional duties as and when required during other absences. The practice used locum nurses and would complete the necessary recruitment checks on those individuals.

Arrangements to deal with emergencies and major incidents

The practice had adequate arrangements in place to respond to emergencies and major incidents.

- There was an instant messaging system on the computers and telephone handsets which alerted staff to any emergency.
- All staff received annual basic life support training.
- The practice had a defibrillator available and oxygen with adult and children's masks. A first aid kit and accident book were available.
- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the emergency medicines we checked were in date. A first aid kit and accident book was available.
- The practice had a business continuity plan in place for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff. A copy of this plan was kept off the premises.

Good

Are services effective?

(for example, treatment is effective)

Our findings

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 had systems in place 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 people's needs.
- The practice monitored that these guidelines were followed through risk assessments and random sample checks of patient records.
- The practice engaged with the local East and North Hertfordshire Clinical Commissioning Group (CCG) and accessed CCG guidelines for referrals and also analysed information in relation to their practice population. For example, the practice would receive information from the CCG on accident and emergency attendance, emergency admissions to hospital, prescribing rates and public health data.

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). Data from 2013/2014 showed the practice had achieved only 64% of the total number of points available. The most recent published results showed the practice achieved 89% of the total number of points available, with 8.5% exception reporting which was comparable with the local average of 8% and national average of 9%. (Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects). Data from 2014/2015 showed;

- The percentage of patients aged 45 years or over who have a record of blood pressure in the preceding five years was in line with the CCG and national average. The practice had achieved 90% of the total number of points available, compared to CCG average of 90% and national average of 91%.
- 73% of patients diagnosed with asthma, on the register, had received an asthma review in the last 12 months which was comparable to the local and national average of 75%.
- 81% of patients diagnosed with dementia had their care reviewed in a face to face meeting in 2014/2015, which was comparable to the local average of 85% and national average of 84%.
- Performance for diabetes related indicators was below the CCG and national average. The practice had achieved 70% of the total number of points available, compared to the local and national average of 89%. Overall exception reporting for diabetes related indicators was 10% which was comparable with the local average of 9% and national average of 11%. The practice told us that they were regularly monitoring their QOF performance. Unverified figures provided to us by the practice showed the practice had achieved 92% of the total number of points available between 2015/2016.
- Performance for mental health related indicators was below the CCG and national average. The practice had achieved 88% of the total number of points available (with 12% exception reporting), compared to 96% locally (12% exception reporting) and 93% nationally (11% exception reporting). Unverified figures provided to us by the practice showed the practice had achieved 100% of the total number of points available between 2015/2016.
- Performance for chronic obstructive pulmonary disease (COPD) related indicators was below the CCG and national average. The practice had achieved 60% of the total number of points available, compared to 97% locally and 96% nationally. Unverified figures provided to us by the practice showed the practice had achieved 99% of the total number of points available between 2015/2016.

Clinical audits demonstrated quality improvement.

Good

Are services effective?

(for example, treatment is effective)

- There had been six clinical audits undertaken in the last two years, two of these were completed audits where the improvements made were implemented and monitored.
- Findings from audits were used by the practice to improve services. For example, one of these audits looked at antibiotic prescribing in uncomplicated urinary tract infections (UTIs). This audit examined the rates for correct antibiotic first choice prescribing and treatment duration. This audit was repeated and the results showed that there had been an improvement in prescribing the preferred type of antibiotic and duration of treatment for uncomplicated UTIs.

Effective staffing

- The practice had an induction programme for all newly appointed staff. It covered such topics as safeguarding, equality and diversity, information governance, basic life support, health and safety and fire safety.
- The practice could demonstrate how they ensured role-specific training and updating for relevant staff for example, for those reviewing patients with long-term conditions. Staff taking blood samples, administering vaccinations and taking samples for the cervical screening programme had received specific training which had included an assessment of competence. Staff who administered vaccinations could demonstrate how they stayed up to date with changes to the immunisation programmes, for example by access to on line resources, attendance to educational sessions, conferences and discussions through a locally run nurse forum.
- The learning needs of staff were identified through a system of appraisals and meetings. Staff had access to appropriate training to meet their learning needs and to cover the scope of their work. All of the staff received an appraisal on an annual basis.
- Staff had access to essential training to meet their learning needs and to cover the scope of their work. However some staff had not completed infection control training. Staff training was provided through on line learning, internal and external training sessions and CCG led training days, which took place on a quarterly basis. The practice was also in the process of purchasing an e-learning system which would include a wide range of training modules for all staff members.

Coordinating patient care and information sharing

- The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practice's patient record system and their intranet system. This included care and risk assessments, care plans, medical records and investigation and test results. Information such as NHS patient information leaflets was also available.
- The practice shared relevant information with other services in a timely way, for example when referring patients to other services. The practice made referrals to secondary care through the E-referral System (this is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital).
- The practice had systems in place to provide staff with the information they needed. An electronic patient record system was used by all staff to coordinate, document and manage patients' care. All staff were fully trained on the system. This software enabled scanned paper communications, such as those from hospital, to be saved in the system and attached to patient records.
- Staff worked together with other health and social care services to understand and meet the range and complexity of patient needs and to assess and plan ongoing care and treatment. This included when patients moved between services, including when they were referred to, or after they were discharged from hospital. We were told that multi-disciplinary team meetings took place on a monthly basis for vulnerable patients and for patients requiring palliative care.
- The practice held six weekly meetings with health visitors to support and manage vulnerable children and families.
- The practice worked closely with a multidisciplinary rapid response service in place to support older people and others with long term or complex conditions to remain at home rather than going into hospital or residential care.
- A named GP carried out a weekly visit to a local care home. We spoke to a senior member of staff at the home who told us the practice provided a good service. They described the practice as accessible and responsive to needs of their residents.

Consent to care and treatment

Good

Are services effective?

(for example, treatment is effective)

Staff sought patients' consent to care and treatment in line with legislation and guidance.

- The practice had a consent policy in place and staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005.
- When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance.
- Where a patient's mental capacity to consent to care or treatment was unclear the GP assessed the patient's capacity and recorded the outcome of the assessment.

Supporting patients to live healthier lives

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

- These included patients considered to be in the last 12 months of their lives, carers, those at risk of developing a long-term condition and those requiring advice on their diet, drug and alcohol cessation, travellers and patients experiencing poor mental health. Patients were then signposted to the relevant services.
- Smoking cessation advice was provided by a local public health team at the practice on a weekly basis.
- A health and wellbeing specialist from the local public health team held a weekly session at the practice and provided information and advice about diet management and provided motivational and behavioural support. Patients were also signposted to local services.

The practice's uptake for the cervical screening programme was 81%, which was comparable to the CCG average of 83% and the national average of 82%. The exception report was 7% which was comparable with the local average of 5% and national average of 6%. The practice encouraged uptake of the screening programme by ensuring a female clinician was available and by sending letters to patients who had not responded to the initial invitation.

Bowel and breast cancer screening rates were below local and national averages. Data from 2014/2015 showed that;

- 51% of patients aged 60 to 69 years had been screened for bowel cancer in the last 30 months compared to 60% locally and 58% nationally.
- 58% of female patients aged 50 to 70 years had been screened for breast cancer in the last three years compared to 72% locally and nationally.

However, these were nationally run and managed screening programmes and there was evidence to suggest the practice encouraged its relevant patients to engage with them and attend for screening.

Childhood immunisation rates for the vaccinations given were comparable to local averages. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 93% to 97%, which was comparable to the CCG average of 93% to 98% and five year olds from 91% to 97% which was comparable to the CCG average of 94% to 98%.

Patients had access to appropriate health assessments and checks. The practice offered NHS health checks for people aged 40–74 years and had completed 205 in the last 12 months. New patients had their needs assessed upon registering and were offered a health check.

The practice provided health checks for patients aged over 75 years and had completed 450 health checks since April 2015, which was 70% of this population group. Appropriate follow-ups on the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.

Requires improvement

Are services caring?

Our findings

Kindness, dignity, respect and compassion

We observed members of staff were courteous and very helpful to patients and treated them with dignity and respect.

- Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- We noted that consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- Reception staff knew when patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.
- The practice had an electronic check-in kiosk available which promoted patient confidentiality.

We received 13 CQC patient comment cards. Patients said they felt the practice offered a good service and said staff were helpful, caring, friendly and treated them with dignity and respect.

We received feedback from 10 patients and two members of the patient participation group (PPG). Patients told us that they were satisfied with the care provided by the practice and said their dignity and privacy was respected. Patients told us that staff responded compassionately when they needed help and provided support when required.

Results from the National GP Patient Survey published in July 2016 showed the practice was below local and national averages for its satisfaction scores on consultations with GPs and nurses. For example:

- 77% said the GP was good at listening to them compared to the CCG average of 88% and national average of 89%.
- 79% said the GP gave them enough time compared to the CCG average of 85% and the national average 87%.
- 90% said they had confidence and trust in the last GP they saw compared to the CCG average of 95% and the national average of 95%.
- 72% said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 83% and the national average of 85%.
- 82% said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 90% and the national average of 91%.
- 67% said they found the receptionists at the practice helpful compared to the CCG average of 83% and the national average of 87%.

The practice told us that they had appointed a reception supervisor and had worked with the reception staff in making improvements. Patient comments during the inspection were positive about the receptionists.

Care planning and involvement in decisions about care and treatment

Results from the National GP Patient Survey published in July 2016 showed the practice was performing below local and national averages for patient questions about their involvement in planning and making decisions about their care and treatment. For example:

- 71% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 84% and national average of 86%.
- 63% said the last GP they saw was good at involving them in decisions about their care compared with the CCG average of 78% and the national average of 82%.
- 72% said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average of 84% and the national average of 85%.

The patients we spoke with or who left comments for us told us they felt involved in decision making about the care and treatment they received. They said their questions were answered by clinical staff and any concerns they had were discussed. 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.

The practice had recently created a PPG in 2016 and the practice told us that they would be working closely with PPG members to engage with the practice population in order to identify and make improvements.

The practice had undertaken a patient survey and audits on their performance between May and June 2016, however these reviews focused on demand and capacity only and did not include a review of the patient experience when receiving care and treatment.

Requires improvement

Are services caring?

The practice provided translation services for patients who were hard of hearing or did not have English as a first language. The electronic check-in kiosk was accessible in a number of different languages.

Patient and carer support to cope emotionally with care and treatment

- Notices and an electronic information screen in the patient waiting room told patients how to access a number of support groups and organisations.
- The practice's computer system alerted GPs if a patient was also a carer. The practice held a register of carers with 101 carers identified which was approximately 1.5% of the practice list. A member of the administration team had been the practice's carers lead (a Carers' champion). However, this individual had recently left and the practice was in the process of appointing a new carers lead. The practice had carer information packs available in the waiting area and also displayed information on a carers' notice board.
- Staff told us that if families had suffered bereavement, their usual GP contacted them. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service.

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

During our previous inspection in July 2015 we found the provider had not responded to patient feedback and survey results to improve access to the service. We also found the provider did not follow the practice complaints procedures to ensure all complaints were investigated and responded to in an appropriate and timely manner.

During our inspection on 27 September 2016 we found the following:

Responding to and meeting people's needs

The practice reviewed the needs of its local population and engaged with the NHS England Area Team and East and North Hertfordshire Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. For example, the practice participated in the local area winter resilience scheme and offered more appointments. This service had given patients the opportunity to attend the practice for an urgent appointment rather than travel to the local A&E department.

- The practice worked closely with the local drug and alcohol service. A community drug and alcohol worker carried out a monthly visit to the practice to provide information and support to patients.
- The practice was proactive in offering on line services such as appointment booking, an appointment reminder text messaging service and repeat prescriptions, as well as a full range of health promotion and screening that reflects the needs of this age group.
- The practice provided an electronic prescribing service (EPS) which enabled GPs to send prescriptions electronically to a pharmacy of patients' choice.
- Patients were able to receive travel vaccinations available on the NHS as well as those only available privately. The practice was a registered yellow fever vaccination centre.
- The practice offered a range of family planning services. Baby vaccination clinics and ante-natal clinics were held at the practice on a regular basis. A community midwife held a clinic at the practice on a weekly basis.
- The practice maintained a list which highlighted vulnerable patients to all staff. Practice staff provided flexible and additional support services to these patients.
- The practice referred patients to the Improving Access to Psychological Therapies service (IAPT) and encouraged patients to self-refer.
- There were longer appointments available for patients with a learning disability. Home visits were available for older patients and patients who would benefit from these.
- Same day appointments were available for children and those with serious medical conditions.
- Staff members were aware of the need to recognise equality and diversity and acted accordingly. The practice had a system in place to identify patients with a known disability.

Access to the service

The practice was open to patients between 8.30am and 6.30pm Mondays to Fridays. Patients were able to access urgent telephone advice between 8am and 8.30am. Appointments with a GP were available from 9am to 11.30am and from 3pm to 5.30pm daily. The practice offered 50% of all appointments as book on the same day and pre-bookable appointments could be booked up to four weeks in advance. Urgent appointments were also available for people that needed them.

Results from the National GP Patient Survey published in July 2016 showed that patients' satisfaction with how they could access care and treatment was below local and national averages.

- 54% of patients were satisfied with the practice's opening hours compared to the CCG average of 72% and national average of 78%. The practice did not provide extended opening hours.
- 28% of patients said they could get through easily to the surgery by phone compared to the CCG average 63% and national average of 73%.

The practice told us that they had changed their telephone system in June 2016 and the new system provided advice and more options along with an improved telephone queuing system.

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

The practice had completed a patient survey in June 2016 and had received 266 responses. Results from this survey showed 70% of respondents said they were able to contact the practice by telephone. However, the majority of patients we spoke with on the day of inspection told us that it was very difficult to get through to the practice on the telephone.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. The practice manager was the designated responsible person who handled all complaints in the practice. Information on how to complain was easily available to patients and verbal complaints were being recorded and analysed.

The practice had a comments and complaints leaflet which included information on the Parliamentary and Health Service Ombudsman (the PHSO make final decisions on complaints that have not been resolved by the NHS in England). However, the practice did not provide patients with information on the role of the PHSO when responding to patient complaints as standard. The practice was unable to demonstrate how they ensured learning from complaints being shared with all relevant staff.

We looked at 10 complaints received since April 2015 and found all of these had been dealt with in a timely way. Apologies were offered to patients where necessary. We did find examples of where lessons were learnt from concerns and complaints and action was taken as a result to improve the quality of care. For example, the practice reviewed and changed their appointment booking system as a result of a patient complaint. The practice had also improved their system for managing patients arriving at the practice in the morning to book an appointment following a verbal complaint. However, the practice was unable to demonstrate what action they had taken after they had identified key themes and trends from the complaints received.

Are services well-led?

Inadequate

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

Our findings

During our previous inspection in July 2015 we found the practice had not always followed their protocol for reporting, recording and monitoring significant events, incidents and accidents to ensure learning was identified and shared with practice staff. We found a system was not in place for all staff members to remain up to date with essential training such as safeguarding

vulnerable adults and fire safety. We found that the nursing staff employed were not always supported by receiving appropriate supervision and appraisal. We also found that not all of the policies and procedures in place were relevant to the practice and not all staff members had an awareness of them to support them in their roles.

During our inspection on 27 September 2016 we found major flaws in the leadership and governance of this practice.

Vision and strategy

The practice had a statement of purpose which was to provide GP services under a nationally agreed contract. Staff members were not aware of any practice specific aims or objectives to deliver high quality care and promote good outcomes for patients. The practice did not have a clear leadership structure.

Governance arrangements

We found some evidence of governance processes at the service, but the leadership team had not ensured that this was effective in all areas. For examples:

- There was a clear staffing structure and staff were aware of their own roles and responsibilities.
- Practice specific policies were implemented and were available to all staff. However, we found that practice specific policies and procedures were not being followed in some areas. For example, the practice was not following their procedures for managing complaints, significant events, safety alerts, clinical supervision and infection prevention and control. The majority of the practice policies were due for a review in September 2016. At the time of our inspection a review of the practice policies had not been scheduled.
- The practice did have an understanding of the performance of the practice and this was regularly monitored. However, we found that there were no overarching arrangements in place for identifying, recording and managing risks, issues and implementing mitigating actions. For example, the practice had failed to identify risks in relation to the management of blank prescriptions, substances hazardous to health, the baby changing area and the safe use of electrical equipment. The practice did not complete maintenance checks on the premises.

Leadership and culture

During our previous inspection in July 2015 some of the staff members raised concerns about the behaviour of some senior staff and the culture in the practice. On the day of inspection the partners in the practice did not demonstrate that they had the experience, capacity and capability to run the practice and ensure high quality care.

Some staff members told us that the GP partners were not approachable and staff members did not feel valued by the majority of the GPs in the practice. Clinical staff held regular meetings however non-clinical staff meetings were irregular and the practice did not hold all staff meetings. The partners did not hold any away days or planning meetings with practice staff. Some staff members told us that they did not feel involved in how the practice was run and described the relationship with some GPs as unfriendly.

The provider was aware of and had systems in place to ensure compliance with the requirements of the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment). The practice had systems in place to ensure that when things went wrong with care and treatment:

- The practice gave affected people support and a verbal and written apology.
- The practice kept written records of written correspondence.

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

The practice encouraged and valued feedback from patients. It proactively sought patients' feedback and engaged patients in the delivery of the service.

- The practice had gathered feedback from patients through the Friends and Family Test, an internal patient

Are services well-led?

Inadequate

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

survey, through comments and complaints received and the Patient Participation Group (PPG). The PPG was newly formed and was holding regular meetings with the practice manager. The PPG was planning on attending their first locality meeting in October 2016.

- The practice had gathered feedback from staff through staff meetings, appraisals and discussions. The practice had appointed a reception supervisor to support staff. However, some staff members told us that they did not feel supported by all of the senior staff.

Continuous improvement

The practice was unable to demonstrate that there was a focus on continuous learning and improvement at all levels within the practice. There was a failure to identify and manage significant incidents and risks. The practice was not involved in any pilot schemes to improve outcomes for patients and the practice was unable to provide us with any examples of joint working with other practices.

The practice was a member of a local GP Federation and we were told that staff attended monthly meetings with the local CCG, the nurse practitioner attended the local nurse forum and senior staff attended meetings with peers.

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 12 HSCA (RA) Regulations 2014 Safe care and treatment **How the regulation was not being met:** We found the provider had not assessed the risks of and to prevent, detect and control the spread of infection. We found the provider had not risk assessed the effective management and control of substances hazardous to health. This was in breach of Regulation 12 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **How the regulation was not being met:** We found the provider did not undertake infection control audits in all of the patient areas. There was no evidence of infection control training for some staff members. We found the provider did not provide all complainants with information about the Parliamentary and Health Service Ombudsman when responding to complaints. There was no evidence of learning from complaints being shared with all relevant staff and the practice was unable to demonstrate how they acted on key themes and trends from the complaints received. We found the provider did not have systems and processes in place for effective leadership and the appropriate involvement and support for all staff members.

This section is primarily information for the provider

Requirement notices

The provider was not following their clinical supervision policy and the nurse prescriber was not receiving formal clinical supervision.

This was in breach of Regulation 17 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **How the regulation was not being met:** The provider had not acted on national patient safety alerts. We found the provider did not always identify and manage significant events. We found the provider had not always taken steps to ensure learning from significant events was disseminated to appropriate staff. This was in breach of Regulation 12 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider did not have effective systems and processes in place for the management and sharing of patient safety alerts. There was no record of any action taken in relation to patient safety alerts. This was in breach of Regulation 17 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.