Dr Helen Clark

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?	Inadequate
Are services caring?	Requires improvement
Are services responsive to people's needs?	Inadequate
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 Beechcroft Medical Centre on Thursday 10 February 2016. Overall the practice is rated as inadequate.

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

- Procedures for reporting, recording, taking appropriate action and sharing learning from significant event analysis (SEAs) were inadequate.
- Patients were at risk of harm because systems and processes were not in place to keep them safe. For example, those relating to fit and proper persons employed, recruitment checks, staffing, safeguarding, chaperoning, infection control, health and safety, equipment, medicines management, dealing with emergencies and patient referrals.
- Risk assessments were poorly recorded and any risks identified were not actioned.
- There was little evidence that audits were driving improvement.
- The appointment system was not effective. Patients did not receive timely care when they needed it as they were unable to book appointments online and they experienced long waiting times to get through to the surgery by telephone to book routine or emergency appointments.
- The practice failed to make every reasonable effort to recruit a male GP to the practice.
- The practice had limited formal governance arrangements.

The areas where the provider must make improvements are:

- Develop and implement a vision and strategy to improve services for patients and ensure governance processes are in place to monitor safety and risk.

Summary of findings

- Introduce processes for reporting, recording, acting on, sharing and monitoring significant events, incidents and near misses and ensure staff are aware of and comply with the requirements of the Duty of Candour in the event of a notifiable safety incident.
- Ensure systems and processes to safeguard adult and children from abuse are established and operated effectively and all staff receive up to date safeguarding training.
- Take action to address identified concerns with infection prevention and control practice and in relation to premises and equipment, maintain standards of hygiene appropriate for the purposes for which they are being used.
- Put systems in place for the secure storage of prescription pads and the monitoring of their use.
- Ensure recruitment arrangements include all necessary employment checks for all staff and undertake a risk assessment on the need for a Disclosure and Barring Service (DBS) check for staff providing a chaperone service. Ensure staff are trained and aware of their responsibilities when acting as a chaperone.
- Ensure annual testing of all electrical equipment and calibration of clinical equipment are carried out and the premises are properly maintained with comprehensive risk assessments carried out in order to identify any shortfalls and take remedial action. For example, in relation to treatment rooms.
- Ensure sufficient numbers of suitably qualified staff are deployed to meet people's care needs and ensure fit and proper persons are employed in clinical roles.
- Ensure appropriate arrangements are in place for managing medical emergencies including: availability of an automated external defibrillator (AED) or undertake a risk assessment if a decision is made to not have an AED on-site and staff training in basic life support.
- Ensure signed Patient Group Directions (PGDs) allowing the practice nurse to administer medicines in line with legislation are up to date.
- Ensure a comprehensive business continuity plan is in place for major incidents.
- Carry out clinical audits including re-audits to ensure improvements have been achieved.
- Ensure an induction programme is in place that prepares staff for their role and ensure staff participate in mandatory training including information governance and are provided with appropriate policies and guidance to carry out their roles in a safe and effective manner and ensure they receive regular appraisal of their performance.
- Ensure the GP actions all referrals in a timely manner.
- Ensure privacy is maintained at the reception desk and dignity is maintained during examinations, investigations and treatments.
- Ensure all clinical staff understand the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005.

The areas where the provider should make improvement are:

- Improve processes for making appointments over the phone and online.
- Ensure they respect people's preferences in relation to who delivers their care and treatment such as a male GP.

This provider cancelled their registration at the end of October 2016.

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 and improvements must be made.

- Staff were clear about the procedures for reporting incidents, near misses and concerns but we found inadequate systems in place for recording incidents and sharing learning with staff.
- Although the practice carried out investigations when there were unintended or unexpected safety incidents, lessons learned were not communicated and so safety was not improved.
- Patients were at risk of harm because systems and processes were not in place to keep them safe. For example, those relating to safeguarding, chaperoning, recruitment checks, infection control, health and safety, fire safety, equipment, medicines management, dealing with emergencies and patient referrals.
- There were not enough staff to keep patients safe and the practice had employed clinical staff who had not received role specific training to enable them to carry out their role.

Are services effective?

Inadequate

The practice is rated as Inadequate for providing effective services and improvements must be made.

- Data showed patient outcomes were higher than national averages and the practice had implemented a robust recall system.
- Despite having a referral system in place, we found significant delays in actioning referrals.
- Staff referred to guidance from the National Institute for Health and Care Excellence (NICE) but there was no clear process in place to monitor that the guidance had been used to assess the needs of the patients.
- There was no evidence that audit; both clinical and non-clinical were driving improvement in performance to improve patient outcomes.
- The appraisal process for staff was inconsistent and overdue. There was little support for any additional training.
- Induction training arrangements were unsatisfactory and we found some staff had not received training relevant to their role.

Summary of findings

- Staff told us they worked with multidisciplinary teams to understand and meet the range and complexity of people's needs but we found record keeping for this was absent.
- Staff sought patients' consent to care and treatment in line with legislation and guidance but we found the training inadequate.

Are services caring?

Requires improvement

The practice is rated as requires improvement for providing caring services and improvements must be made.

- Despite data from the National GP Patient Survey showing patients rated the practice higher than others for many aspects of care such as listening to and treating patients with care and concern, there were issues around patients being treated with dignity and respect for example, in relation to privacy in consultation rooms.
- The practice did not ensure that the consultation rooms and the private room offered to patients were fit for purpose.

Are services responsive to people's needs?

Inadequate

The practice is rated as inadequate for providing responsive services and improvements must be made.

- The practice was unable to demonstrate how they worked with the local CCG to plan services for patients in the area.
- Patients reported considerable difficulty in accessing a named GP and poor continuity of care.
- Appointment systems were not working well so patients did not receive timely care when they needed it.
- The practice was not well equipped to treat patients. There was no hearing loop or baby changing facilities available. There were not enough seats for patients to sit in the waiting room at busy times.
- There was a designated person responsible for handling complaints but staff did not fully understand how to progress concerns and complaints from patients. There was no evidence that learning was shared with staff or that all complaints were dealt with adequately. Information about how to complain was available.
- The practice was not responsive to patients requesting a male GP.
- Information in different languages was available on the practice website.

Are services well-led?

Inadequate

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

Summary of findings

- The practice did not have a clear vision and strategy. Staff were not clear about their responsibilities in relation to the vision or strategy.
- Although there was a leadership structure in place, not all staff felt supported by management.
- The practice had a number of policies and procedures to govern activity, but most of these were over six years old and had not been reviewed since.
- The practice did not hold regular governance meetings and issues were discussed at ad hoc meetings.
- Staff told us they had not received regular performance reviews and did not have clear objectives.

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 safe, effective, responsive and well led and requires improvement for caring. The concerns which led to these ratings apply to everyone using the practice, including this population group. However, there were some examples of good practice:

- Nationally reported data showed that outcomes for patients for conditions commonly found in older people were higher than national average for example;
- The percentage of patients with atrial fibrillation who were currently treated with anticoagulation therapy was 100%, compared to a national average of 98%.
- Longer appointments and home visits were available for older people when needed but patients were unable to access timely care.
- Evidence to show how the practice worked with multi-disciplinary teams including palliative care team in the case management of older people and end of life care was not provided on request.
- The practice was unable to identify how many carers were registered with the practice and provide evidence of what support was available to them.

People with long term conditions

Inadequate

The provider is rated as inadequate for safe, effective, responsive and well led and requires improvement for caring. The concerns which led to these ratings apply to everyone using the practice, including this population group. However, there were some examples of good practice:

- The practice had a recall system in place that resulted in them achieving high QOF targets for long term conditions. For example;
- The percentage of patients with diabetes on the register, in whom the last blood pressure reading measured in the last 12 months was 140/80 mmHG or less was 81%, compared to a national average of 78%.
- Longer appointments and home visits were available when needed but patients did not receive timely care.

Summary of findings

- All these patients had a named GP, care plans in place and an annual review to check their health and medicines needs were being met. However, we found the GP was not actioning referrals in a timely way.
- The practice was unable to demonstrate how they worked with relevant health and social care professionals to deliver a multidisciplinary package of care for those with complex needs including palliative care patients.

Families, children and young people

Inadequate 

The practice is rated as inadequate for safe, effective, responsive and well led and requires improvement for caring. The concerns which led to these ratings apply to everyone using the practice, including this population group. However, there were some examples of good practice:

- The practice was unable to demonstrate what systems were in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances.
- Childhood immunisation rates for vaccinations given to under two year olds ranged from 30% to 42% and this was lower than the CCG average that ranged from 44% to 68%. Childhood immunisation rates for the vaccinations given to five year olds ranged from 16% to 80% and this was lower than the CCG average ranging from 55% to 81%.
- Access to appointments was inadequate and we saw patient complaints highlighting problems with accessing appointments when they were required, including a patient waiting for two weeks for an antenatal referral.
- 58% of patients described their experience of making an appointment as good compared to the CCG average of 66% and national average of 73%.
- The practice held bimonthly meetings with the health visitors but the practice was unable to provide evidence to show examples of joint working with midwives or school nurses.
- The practice's uptake for the cervical screening programme was 80%, which was comparable to the national average of 81%.
- The mother and baby facilities at the practice were inadequate.

Summary of findings

Working age people (including those recently retired and students)

Inadequate

The practice is rated as inadequate for safe, effective, responsive and well led and requires improvement for caring. The concerns which led to these ratings apply to everyone using the practice, including this population group. However, there were some examples of good practice:

- The age profile of patients at the practice is mainly those of working age, students and the recently retired but the services available did not fully reflect the needs of this group.
- Although the practice offered telephone consultations, extended opening hours and commuter clinics, access to appointments were inadequate as patients were unable to access treatment in a timely way.
- Data published in 2014/2015 showed 67% of patients were satisfied with the surgery's open hours compared to the CCG average of 71% and national average of 74%.
- Patients could book request prescriptions and appointments online but there were issues regarding online patient access.
- Health promotion advice was offered but there was limited accessible health promotion material available through the practice.

People whose circumstances may make them vulnerable

Inadequate

The practice is rated as inadequate for safe, effective, responsive and well led and requires improvement for caring. The concerns which led to these ratings apply to everyone using the practice, including this population group. However, there were some examples of good practice:

- The practice did not provide evidence to show how many patients living in vulnerable circumstances including those with a learning disability were on the register.
- The practice did not provide evidence to show how it worked with multi-disciplinary teams in the case management of vulnerable people.
- Not all staff had received training in safeguarding relevant to their role.
- Some staff did not know how to recognise signs of abuse in vulnerable adults and children, but they were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies out of normal working hours.

Summary of findings

People experiencing poor mental health (including people with dementia)

Inadequate 

The practice is rated as inadequate for safe, effective, responsive and well led and requires improvement for caring. The concerns which led to these ratings apply to everyone using the practice, including this population group. However, there were some examples of good practice:

- The practice had a recall system in place that resulted in the achievement of high QOF targets for patients experiencing poor mental health. For example;
- Data showed that 97% of patients with mental health problems had a comprehensive care plan documented in the last 12 months and this was comparable to a national average of 88%.
- 82% of patients diagnosed with dementia had their care reviewed face to face in the last 12 months and this was comparable to a national average of 84%.
- The practice worked with multi-disciplinary teams in the case management of people experiencing poor mental health but not always those with dementia.
- It carried out advance care planning for patients with dementia.
- The practice was unable to demonstrate what system was in place to follow up patients who had attended accident and emergency where they may have been experiencing poor mental health.

Summary of findings

What people who use the service say

The national GP patient survey results published on 2 July 2015 showed the practice was performing lower than local and national averages in some areas. 375 survey forms were distributed and 90 were returned. This represented 1.8% of the practice's patient list.

- 57% found it hard to get through to this surgery by phone compared to a CCG average of 32% and a national average of 26%.
- 85% were able to get an appointment to see or speak to someone the last time they tried (CCG average 77%, national average 85%), however, 80% said the last appointment they got was convenient compared to the CCG average of 87% and national average of 91%.
- 77% described the overall experience of their GP surgery as fairly good or very good (CCG average 77%, national average 84%).
- 61% said they would definitely or probably recommend their GP surgery to someone who has just moved to the local area (CCG average 68%, national average 77%).

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 34 comment cards of which 27 were mostly positive about the standard of care received where they felt they were treated with compassion. Seven of the comment cards highlighted issues with getting routine or urgent appointments as well as difficulty getting through to the surgery by phone to the extent that by the time they got through, there were no available appointments left. Some patients reported they would wait at least 45 minutes before speaking to someone on the phone. The comment cards also highlighted issues with some reception staff attitude and privacy at the reception desk as well as the lack of space in the surgery.

We spoke with two patients during the inspection and three members from the Patient Participation Group (PPG). Two of these patients were happy with the care they received, however, all the patients we spoke to including members of the PPG told us that they had difficulty getting through to the surgery on the phone and experienced long waits to be connected. They were also unable to book appointments online as they could not access the system that enabled them to do so. Patients told us that having got through to the surgery on the phone that all available appointments would have gone. Two of the patients told us that they preferred to go into the surgery in order to book appointments. One patient told us they had to wait up to three months to see their preferred GP and another told us that they were unable to secure an urgent appointment with the GP for a week and ended up seeking treatment at the hospital.

Areas for improvement

Action the service MUST take to improve

- Develop and implement a vision and strategy to improve services for patients and ensure governance processes are in place to monitor safety and risk.
- Introduce processes for reporting, recording, acting on, sharing and monitoring significant events, incidents and near misses and ensure staff are aware of and comply with the requirements of the Duty of Candour in the event of a notifiable safety incident.
- Ensure systems and processes to safeguard adult and children from abuse are established and operated effectively and all staff receive up to date safeguarding training.
- Take action to address identified concerns with infection prevention and control practice and in relation to premises and equipment, maintain standards of hygiene appropriate for the purposes for which they are being used.
- Put systems in place for the secure storage of prescription pads and the monitoring of their use.

Summary of findings

- Ensure recruitment arrangements include all necessary employment checks for all staff and undertake a risk assessment on the need for a Disclosure and Barring Service (DBS) check for staff providing a chaperone service. Ensure staff are trained and aware of their responsibilities when acting as a chaperone.
- Ensure annual testing of all electrical equipment and calibration of clinical equipment are carried out and the premises are properly maintained with comprehensive risk assessments carried out in order to identify any shortfalls and take remedial action. For example, in relation to treatment rooms.
- Ensure sufficient numbers of suitably qualified staff are deployed to meet people's care needs and ensure fit and proper persons are employed in clinical roles.
- Ensure appropriate arrangements are in place for managing medical emergencies including: availability of an automated external defibrillator (AED) or undertake a risk assessment if a decision is made to not have an AED on-site and staff training in basic life support.
- Ensure signed Patient Group Directions (PGDs) allowing the practice nurse to administer medicines in line with legislation are up to date.
- Ensure a comprehensive business continuity plan is in place for major incidents.
- Carry out clinical audits including re-audits to ensure improvements have been achieved.
- Ensure an induction programme is in place that prepares staff for their role and ensure staff participate in mandatory training including information governance and are provided with appropriate policies and guidance to carry out their roles in a safe and effective manner and ensure they receive regular appraisal of their performance.
- Ensure the GP actions all referrals in a timely manner.
- Ensure privacy is maintained at the reception desk and dignity is maintained during examinations, investigations and treatments.
- Ensure all clinical staff understand the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005.

Action the service SHOULD take to improve

- Improve processes for making appointments over the phone and online.
- Ensure they respect people's preferences in relation to who delivers their care and treatment such as a male GP.

Dr Helen Clark

Detailed findings

Our inspection team

Our inspection team was led by:

a CQC Lead Inspector**.** The team included a GP specialist adviser and a practice nurse specialist adviser.

Background to Dr Helen Clark

Beechcroft Medical Centre is located in Wembley, Middlesex and holds a General Medical Services (GMS) contract and is commissioned by NHSE London. The practice is staffed by two GP partners, both female who work full time doing eight and seven sessions a week respectively. The practice also employs one full time practice manager, one nurse practitioner, one practice nurse, a healthcare assistant (HCA), three reception staff, a medical secretary and an administrator.

The practice is open between 8.30am and 6.30pm on Monday, Tuesday, Thursday and Friday and open between 8.30am and 2.00pm on Wednesday. Outside of these hours the answerphone redirects patients to their out of hours provider. Commuter appointment slots are offered from 6.30pm to 8.45pm on Thursday. Extended surgery hours are offered on Monday from 6.30pm to 7.00pm.

The practice has a list size of 5000 patients and is located in an area where the majority of the population is working age. Approximately 63% of the practice population was in paid work or full time education.

The practice provides a wide range of services including treatment of disease, disorder or injury, diagnostic and screening procedures, maternity and midwifery services and surgical procedures. The practice provides care to two nursing homes in the area and provides one clinical session a week for ward rounds to approximately 50 patients. The practice is also a teaching practice and takes medical students.

The practice was inspected on 20 December 2013 and was found to have breached the regulation on suitability of staffing. The practice had failed to perform all the required recruitment checks to ensure that staff were suitable to work at the practice. In particular, the service had not carried out criminal record checks for all clinical staff employed at the practice. A follow up inspection was carried out on 26 June 2014 and the practice was found to have met this standard.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme.

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

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 10 February 2016. During our visit we:

Detailed findings

- Spoke with a range of staff including two GP partners, practice manager, nurse practitioner, HCA, medical secretary and four receptionists.
- We spoke with patients who used the service.
- Observed how patients were being cared for and talked with carers and/or family members
- Reviewed an anonymised sample of the personal care or treatment records of patients.
- Reviewed comment cards where patients and members of the public shared their views and experiences of the service.

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

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

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

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

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

Inadequate

Are services safe?

Our findings

Safe track record and learning

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

- Staff told us they would inform the practice manager of any incidents and there was a recording form available on the practice's computer system.
- The practice told us that they carried out an analysis of the significant events which were discussed at their monthly meetings. We saw limited evidence that significant events were being shared with staff, as staff told us they had regular meetings and issues were discussed however, although requested, minutes of these meetings were not provided.

Prior to this inspection, the practice did not submit any evidence of their significant events and stated they had none. However, when we reviewed safety records, we found there had been significant events and incidents but not all had been recorded. We found evidence of one recorded significant event and another which had not been discussed with staff. For example, we were informed that a week prior to our inspection, a patient had been verbally aggressive to the reception staff resulting in them being removed from the practice list. The practice had not recorded this incident in the significant events log and there was no evidence provided to us to show this had been investigated or discussed at their practice meeting. Two of the staff we spoke to on the day had not been made aware of this incident and this aligned with the lack of information sharing within the practice.

We did not see any evidence to show patients received reasonable support, truthful information, a verbal and written apology or told about any actions to improve processes to prevent the same thing happening again when there were unintended or unexpected safety incidents. We saw evidence that safety alerts were being circulated amongst staff.

Overview of safety systems and processes

The practice did not have clearly defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from abuse, which included:

- Arrangements to safeguard children and vulnerable adults from abuse were inadequate. There were inconsistencies with what staff and the GP told us regarding safeguarding. For example, staff told us that there was a safeguarding register and they could access safeguarding policies on their computer system but when we spoke to the GP she was not aware of any safeguarding policy being in place. We were unable to establish this as we were not provided with a policy on request. The nurse practitioner told us there were alerts on records for known at risk children whereas the GP told us there was no such system in place as she knew all these patients. The practice told us that they discussed safeguarding at their weekly meetings and we saw a blank meeting minutes template that highlighted safeguarding as a topic of discussion. However, the practice did not provide us with evidence of meeting minutes where these were discussed. There was a lead member of staff for safeguarding and the GP told us that although she provided reports for other agencies, she did not attend regular safeguarding meetings and case conferences due to a heavy workload. We observed posters in the consultation rooms with details of external safeguarding contacts. However, two of the staff we spoke with were unable to demonstrate sufficient knowledge on safeguarding despite having received the training. We found the lead GP had been trained to Safeguarding children Level 2 and was overdue training on Safeguarding Level 3. We also found two other clinicians had only been trained to Safeguarding children Level 1 and we did not see any evidence that showed seven clinical and non clinical staff had received training in Safeguarding Adults. We noted safeguarding training was not included in the induction training or policy.
- There was no chaperone poster in the waiting room advising patients that chaperones were available if required. All staff who acted as chaperones were not trained for the role and were unable to describe the correct procedures for chaperoning. Most of the staff had not received a Disclosure and Barring Service check (DBS check) and there were no risk assessments in place for staff who had no DBS checks in place. (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).

Inadequate

Are services safe?

- The practice did not maintain appropriate standards of cleanliness and hygiene. Although they had a cleaner who attended daily, we found the standards of cleanliness unsatisfactory. We observed the waiting areas to be clean and tidy but observed the walls to be visibly dirty and unkept. The carpets in the clinical rooms were stained and we found some of the equipment such as the privacy screen in the treatment room outdated and dirty. We found the carpeted clinical room was used for dressings and smear tests. We observed the privacy curtain in the other clinical room was made of fabric and there was no evidence to show that curtains were changed and cleaned regularly. Two of the downstairs toilets including one in the clinical room had a bath and shower and we noted odour coming from both rooms. There were conflicting reports regarding who the lead for infection control was. For example, the nurse practitioner told us the lead GP was the infection control clinical lead and she was the named nurse for infection control but when we spoke to the GP she told us that it was the nurse practitioner who was the lead for infection control. Non clinical staff were also not aware who the infection control lead was. There was no evidence that they were working closely with infection prevention teams to keep up to date with best practice. We found one of the clinical staff undertaking urinalysis testing had not received immunisations required for their role. There was no evidence of an annual infection control audit or infection control risk assessment. Staff had received up to date infection control training but when we requested evidence of a current infection control protocol, we were not provided with one.
- The arrangements for managing medicines, including emergency drugs and vaccinations, in the practice did not keep patients safe (including obtaining, prescribing, recording, handling, storing and security). Although the practice told us that they had monthly meetings with their prescribing advisor and carried out prescribing audits for the CCG, they failed to provide us with evidence of any completed audits or meeting minutes. They had a repeat prescribing policy in place but this had not been reviewed since 2009. Prescription pads were not securely stored and there were no systems in place to monitor their use. The practice told us that prescription pads were stored securely in the treatment rooms and doors were locked when not attended, however, we found blank prescription pads were left in the printer. The treatment room used to store the prescription pads did not have a lock on it. Non clinical staff told us that they topped up the printers with prescriptions when needed.
- One of the nurses had qualified as an Independent Prescriber and could therefore prescribe medicines for specific clinical conditions. She received support from her peers in the CCG, read journals and attended regular update training. She last attended immunisation update training in 2015. We found vaccines were stored in a fridge in the nurse's room which was kept locked when not in use. Records showed vaccines were stored at appropriate temperatures and we saw a protocol attached to the record for out of range actions. However, we found Patient Group Directions (PGDs) that had been adopted by the practice to allow nurses to administer medicines in line with legislation were unsigned and out of date.

- We reviewed 10 personnel files and found appropriate recruitment checks had not been undertaken prior to employment for the most recently recruited staff. For example, the practice had employed a clinical staff member without any evidence to support their role such as mandatory training records, competency assessments and immunisation records. We found they had not completed all the required recruitment checks for all their staff and this included proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service. Gaps in employment had not been explored and there were no signed contracts in place.
- There were failsafe systems in place to ensure results were received for all samples sent for the cervical screening programme. The nurses would record all samples sent into a book and would monitor the results coming back and follow up with the hospital.

Risks to patients were not assessed and were not adequately managed.

- There were inadequate procedures in place for monitoring and managing risks to patient and staff safety. Health and safety policies were incomplete and overdue a review since 2013 and we were not provided with any adequate health and safety risk assessments when requested. We found the premises were not

properly maintained for example, we found broken tiles on the side of the bath situated in the patients toilet and observed they were coming away from the side of the bath and had sharp edges exposed. There was also no emergency call button situated in this toilet facility.

- The practice did not have a designated fire marshal and did not carry out regular fire drills. Staff told us that the last fire drill had been carried out by the practice manager a week prior to inspection but this had not been documented. They were unable to recall the last time they had carried out a fire drill prior to the most recent one. We found some staff including clinical staff had not received any fire safety training since commencing employment with the practice and some were overdue update training since 2013. The practice had smoke detectors but did not have a fire alarm and there was no fire policy or fire risk assessment in place. The practice staff told us that they would shout in the event of a fire to alert everyone.
- There were inadequate procedures in place to ensure all electrical equipment was safe to use and working properly. The practice did not provide us with any evidence to show that electrical equipment had undergone any safety checks. The practice did not have other risk assessments in place to monitor safety of the premises such as control of substances hazardous to health and infection control and legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings). We found evidence that a Legionella risk assessment had been carried out in 2013 by an external contractor and had been due for review in April 2015. This risk assessment had identified several high risk areas for the practice to action but the practice was unable to provide us with evidence to show they had taken action to minimise the risks.
- Arrangements were not in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system in place for all the different staffing groups but we found the practice did not have sufficient staff to cover the reception desk and to take telephone calls to meet patient demand during their peak hours. As a result, patients faced long waiting times on the phone and eventually were unable to get urgent appointments when they needed them. We also found the practice did not have suitable cover for sickness absence.

Arrangements to deal with emergencies and major incidents

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

- There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency.
- Not all staff received annual basic life support training. We found some staff had last received basic life support training in 2013.
- The practice had oxygen with adult and child masks but there was no defibrillator available on the premises. There was no risk assessment carried out to mitigate this risk. We found conflicting reports about what the procedure was in the event of an emergency. For example, the practice told us that in the event of a medical emergency, they would dial 999 and an ambulance would take 5-10 minutes to arrive, but there was usually a clinician on site. However, the health care assistant told us that she was sometimes expected to see patients when there were no clinicians on site. We found that she had not received basic life support update training in the last three years. Following the inspection the provider told us that as far as they were aware, the health care assistant was never left alone on site.
- A first aid kit and accident book were available but we found the accident book was incomplete and did not record information such as actions taken when an accident occurred. For example, there was an incident relating to a person falling onto the floor while trying to sit down on their chair resulting in injury to their wrist. We found that although this had been recorded in the accident book, the actions taken and any recommendations had not been documented.
- Emergency medicines were easily accessible to staff in a secure area of the practice but not all staff knew of their location. All the medicines we checked were in date, checked monthly and fit for use.

Inadequate

Are services safe?

- We asked to see the practice business continuity plan for major incidents however the practice did not provide us with this evidence.

Inadequate

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 peoples' needs.
- However, we did not see evidence that the practice monitored these guidelines through risk assessments, audits and random sample checks of patient records.

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent published results were 99% of the total number of points available, with 7% exception reporting. (Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects). This practice was not an outlier for any QOF (or other national) clinical targets. Most recent published data showed;

- Performance for diabetes related indicators were comparable or above the national average.For example:
  - The percentage of patients with diabetes on the register in whom the last HbA1c was 64mmol/l or less was 86%, compared to a national average of 77%.
  - The percentage of patients with diabetes on the register with a record of a foot examination in the preceding 12 months was 94%, compared to a national average of 88%.
- The percentage of patients with hypertension having regular blood pressure tests were comparable to the national average. For example:
  - The percentage of patients with hypertension in whom the last blood pressure reading measured 150/90mmHg in the preceding 12 months was 88%, compared to a national average of 83%.
- Performance for mental health related indicators was comparable to the national average. For example:
  - The percentage of patients with mental health conditions who had a comprehensive care plan documented in their notes in the preceding 12 months was 97%, compared to a national average of 88%.

    We found their QOF scores were higher than the national averages as a result of their birthday recall system for long term conditions. This was a system developed and implemented by the nurse practitioner where patients were prompted to attend their reviews a month before their birthday in order to be reviewed in their birth month. We found this system resulted in their achievement of high QOF figures.

    There was no evidence of quality improvement activity such as completed clinical audits in the last two years.
- The practice told us that they undertook QOF audits and used their inbuilt audit system for regular reviews. However, we found these were not completed two cycle audits. They appeared to be searches of their computer system where they reviewed the areas where significant QOF points had been lost and analysed why this was the case. There was no clear process to show how the audit was repeated and monitored to demonstrate the stated improvements.

  For example, the practice conducted a review of their QOF Atrial fibriallation 2014/2015 figures. Their analysis showed that a coding error had occurred due to the implementation of a new IT system which resulted in them achieving a QOF target of 37% instead of 70%. The practice concluded that with proactive follow up of appropriate patients, they would be on track to achieve full points this year. The review document indicated that their current score was now 67% out of a target of 70% but there was no other evidence provided to support that. The practice told us that QOF was a standing item

at their clinical meeting agenda and was reviewed regularly by the practice manager and lead GP, however, we did not see any evidence of this as no clinical meeting minutes were provided.

- There was no evidence provided to show that the practice participated in local audits, national benchmarking, accreditation and peer review.

Effective staffing

Staff did not have sufficient skills, knowledge and experience to deliver effective care and treatment.

- We found the practice induction programme inadequate. They had an induction policy which was created in 2008 and was reviewed in January 2016. We found this policy was not fit for purpose as it referred to other policies such as fire safety, health and safety and infection control which were incomplete and had not been reviewed within the last two years. We also found training such as safeguarding and confidentiality training was not included in their induction policy. When we looked at staff files, we found no evidence of an induction checklist for all the staff despite their staff induction policy making reference to this. We also found that not all staff had received fire safety training.
- The practice could not demonstrate how they ensured role-specific training and updating for relevant staff for example, for those undertaking new patient and NHS health checks, blood pressure monitoring and admission avoidance reviews. We found the practice had recruited one member of staff from an administration role into a clinical role without ensuring they had received the required accredited training. When we looked at the staff records, we found no evidence to support their role as a clinician such as training logs or competency assessments.
- Nursing staff 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 and discussion at practice meetings.
- The system for identifying learning needs of staff through appraisals was inadequate. We looked at six staff files and saw appraisals were not being carried out annually and most appraisals had last been undertaken in 2013. Staff told us that they had access to appropriate training to meet their learning needs and to cover the scope of their work for example, the nurse practitioner had recently attended immunisation update training.

Coordinating patient care and information

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 were also available.
- The GP did not share relevant information with other services in a timely way, for example when referring patients to other services.

The practice had implemented a system to ensure all urgent two week referrals and non urgent referrals to the hospital were followed up. However, despite this system being in place, we found the GP was not actioning referrals in a timely way. We found there was a three week delay with actioning referrals and this aligned with patient complaints regarding having to chase up referrals that had been outstanding for nearly a month. The GP told us the delay was due to the lack of time to action them caused by clinics not running on time.

Staff told us that they worked together with other health and social care services to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. For example, the practice had a high diabetic population so the the diabetic specialist nurse held monthly joint clinics with the nurse practitioner. These clinics were half an hour patient consultations. Despite joint working and and attending MDT meetings to review care plan, we found record keeping was absent and we were not provided with any evidence to support this on request.

Consent to care and treatment

There was limited evidence to show that staff sought patients' consent to care and treatment in line with legislation and guidance.

Inadequate

Are services effective?

(for example, treatment is effective)

- We found the clinicians understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005 however, we found only two staff had received training which was now overdue an update.
- When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance.We saw the clinicians were able to demonstrate an understanding of the Gillick competencies in young people.
- Where a patient's mental capacity to consent to care or treatment was unclear, the GP or practice nurse assessed the patient's capacity and, recorded the outcome of the assessment.
- The process for seeking consent was not monitored through records audits.

Supporting patients to live healthier lives

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

- These included patients 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, smoking and alcohol cessation. Patients were then signposted to the relevant service.
- The practice offered a smoking cessation service and the health care assistant was the smoking cessation advisor.

The practice's uptake for the cervical screening programme was 80%, which was comparable to the national average of 81%. There was a policy to offer telephone reminders for patients who did not attend for their cervical screening test. The practice demonstrated how they encouraged uptake of the screening programme by using an interpreter service and language line, using information in simple languages for those with a learning disability and ensuring they had a female sample taker available. The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening.

Childhood immunisation rates for the vaccinations given were lower than CCG averages. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 30% to 42% and this was lower than the CCG average that ranged from 44% to 68%. Childhood immunisation rates for the vaccinations given to five year olds ranged from 16% to 80% and this was lower than the CCG average ranging from 55% to 81%.

Patients had access to appropriate health assessments and checks. These included health checks for new patients and NHS health checks for people aged 40–74. Appropriate follow-ups for the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.

Requires improvement

Are services caring?

Our findings

Kindness, dignity, respect and compassion

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

- Curtains were provided in consulting rooms and a privacy screen was provided in other rooms. However the practice did not adequately maintain the privacy and dignity of their patients. For example, the treatment room door did not lock, and the patient couch was situated by the window which was overlooked a number of residential homes. The window blinds in this room were broken and did not adequately screen the window. Following the inspection the provider told is that the nearest properties were 50m away and fences, trees and hedges provided additional screening. We also found the main lights were not working in this room. Staff had not taken any action to mitigate this.
- We noted that consultation and treatment room doors were closed during consultations but conversations taking place in these rooms could be overheard from the waiting room. We also found conversations at the reception desk could be overheard due to the layout of the practice. There was a television in the corner of the waiting room however, the volume was turned down low and did not cover the conversations taking place in the consulting rooms.
- The arrangements for patients who wanted to discuss sensitive issues in private were unsatisfactory. Patients were offered the use of a small cubicle that was of restricted size, it had no lighting in it so once the door was shut, the room was in complete darkness. We also observed that there was insufficient space to fit two chairs inside this cubicle and any conversations taking place could be overheard in the waiting area.

Twenty-seven of the 34 patient Care Quality Commission comment cards we received were positive about the service experienced. Patients said they felt staff involved them in their care and responded compassionately when they needed help and provided support when required. Seven of the comment cards highlighted issues with accessing appointments as well as difficulty getting through to the surgery on the phone, staff attitude, lack of privacy at the reception desk and lack of space inside the surgery.

We spoke with three members of the Patient Participation Group (PPG). They also told us they were treated compassionately and found the GP was good at listening to them and also found some members of staff helpful. However, they also highlighted issues with accessing appointments and getting through to the surgery on the phone.

Results from the national GP patient survey showed patients felt they were treated with compassion, dignity and respect. The practice was in line with CCG and national averages for its satisfaction scores on consultations with GPs and nurses. For example:

- 90% said the GP was good at listening to them compared to the CCG average of 85% and national average of 88%.
- 88% said the GP gave them enough time (CCG average 81%, national average 86%).
- 95% said they had confidence and trust in the last GP they saw (CCG average 92%, national average 95%)
- 83% said the last GP they spoke to was good at treating them with care and concern (CCG average 80%, national average 85%).
- 84% said the last nurse they spoke to was good at treating them with care and concern (CCG average 83%, national average 90%).
- 82% said they found the receptionists at the practice helpful (CCG average 83%, national average 86%).

Care planning and involvement in decisions about care and treatment

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

Requires improvement

Are services caring?

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

- 88% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 82% and national average of 89%.
- 82% said the last GP they saw was good at involving them in decisions about their care (CCG average 77% , national average 84%.
- 82% said the last nurse they saw was good at involving them in decisions about their care (CCG average 77% , national average 84%.

Staff told us that translation services were available for patients who did not have English as a first language and a double appointment would be arranged for a patient requiring translation. We saw notices in the reception area informing patients this service was available.

Patient and carer support to cope emotionally with care and treatment

Notices in the patient waiting room told patients how to access a number of support groups and organisations.

The practice told us that they maintained a carer's register. However, we were unable to establish how many carers were listed on the practice register and what support was in place for them because they did not provide us with this information on request following the inspection.

The GP told us that bereavement support was offered. The practice told us that if families had suffered bereavement they were signposted to a local bereavement service.

Inadequate

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We were not provided with evidence to demonstrate how the practice worked with the local CCG to plan services and to improve outcomes for patients in the area.

- Patients over 75 years of age had a named GP and home visits were available for older patients and patients who would benefit from these.
- Commuter clinics were offered on a Thursday from 6.30pm to 8.45pm for working patients who could not attend during normal opening hours.
- Double appointments were offered for patients where appropriate.
- Flexible telephone appointments whereby patients could book to speak to the GP or nurse at their convenience as well as same day appointments were offered. However, access to appointments was inadequate. We found patients who required same day or urgent appointments had difficulty accessing these as a result of being unable to get through to the practice phone in the morning.
- The diabetic nurse specialist held monthly joint clinics with the nurse practitioner. These clinics were half an hour patient consultations.
- Patients were able to receive travel vaccinations available on the NHS as well as those only available privately.
- The practice had a high proportion of patients who did not have English as their first language. Many of the staff were multilingual and translation services were available if required and double appointments were offered. For patients whose first language was not English, staff told us they could provide information in alternative languages if required.
- There were no specific baby changing or breast feeding facilities for the practice. The private room offered to patients was not fit for purpose.
- The practice also told us that on busy days,there were insufficient chairs for patients to sit and therefore most of the patients had to stand up whilst waiting for their appointments.
- There was no hearing loop system available for patients with hearing difficulties.
- There was disabled access with a ramp access at the practice entrance and a disabled toilet was available for patients on the ground floor but we found there was no emergency pull cord.

Access to the service

The practice was open between 8.30am and 6.30pm Monday to Friday. Extended surgery hours were offered on Monday from 6.30pm to 7.00pm and Thursday from 6.30pm to 8.45pm. The answerphone directed patients to the out of hours provider between 6.30pm and 8.30am Monday to Friday and between 2.00pm and 8.30am on Wednesday.

Patients did not have access to a male GP and gender specific GP requests could not be accommodated. We found this issue had been raised by members of the PPG but the practice management had decided that a GP's suitability for the role rather than their gender took priority. Following the inspection the provider told us patients who wished to access a male GP could do so through the local GP hub.

Pre-bookable appointments could be booked up to four weeks in advance, 48 hour appointments and urgent appointments were also available for people that needed them, however, we found patients were unable to access timely care. Patients were unable to get through to the surgery by phone when they required urgent appointments, particularly in the mornings. Patients told us that by the time they got through to the surgery, urgent appointments were no longer available. We found there were insufficient staff at the reception desk to handle calls during their peak hour.

The practice told us that they had access to the overflow facility at the local hub where patients could be referred for routine or urgent appointments in the evenings and weekends or when they did not have capacity at busy times. However, patients told us that most of the time they would have to attend the surgery in person to book appointments and some would end up visiting the hospital for treatment as a result of difficulty getting appointments at the surgery.

Results from the national GP patient survey showed that patient's satisfaction with how they could access care and treatment was lower than local and national averages.

Inadequate

Are services responsive to people's needs?

(for example, to feedback?)

- 67% of patients were satisfied with the practice's opening hours compared to the CCG average of 71% and national average of 74%.
- 42% patients said they could get through easily to the surgery by phone (CCG average 67%, national average 73%).
- 58% patients described their experience of making an appointment as good (CCG average 66%, national average 73%).

Listening and learning from concerns and complaints

The practice had an inadequate system in place for handling complaints and concerns.

- The practice had a designated responsible person who handled all complaints in the practice. We looked at 13 complaints received in the last two years and found they were not always satisfactorily handled. For example, we saw four complaints where patients had made complaints regarding reception staff attitude. We found these complaints were recorded but no action was taken as a result and no apologies were offered or any outcome recorded.
- There was no evidence that the practice reviewed NHS Choices comments. We were provided with limited evidence to show that lessons were learnt from concerns and complaints and action was taken as a result to improve the quality of care. For example, the provider told us some staff had been sent on a customer service training course.

We found information was available to help patients understand the complaints system through the practice leaflet and the complaints procedure which was in reception, but this was in English only. The provider told us when they acknowledged a complaint they offered information in different languages. Patients we spoke with were not aware of how to make a complaint or the process involved.

Are services well-led?

Inadequate

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

Our findings

Vision and strategy

The practice did not have a specific vision to deliver high quality care and promote good outcomes for patients.

- The practice did not have a mission statement which was displayed in the waiting areas and staff were unable to demonstrate understanding of what the practice values were.
- The practice did not have a robust strategy and were unable to provide us evidence of supporting business plans which reflected the vision and values.

Governance arrangements

The practice did not have an overarching governance framework which supported the delivery of the strategy and good quality care.

- We found there was no clear staffing structure as some staff were not aware of their own roles and responsibilities. We found evidence of some staff carrying out duties outside their expertise and we also found most of the staff did not have a job description.
- We found practice policies were incomplete and overdue a review, for example we found some policies had last been reviewed in 2008.
- The practice did not have a comprehensive understanding of the performance of their practice. We found that although they had an understanding of their QOF performance, they were unable to provide us with a programme of continuous clinical and internal audit which was used to monitor quality and to make improvements. The GP was unable to demonstrate any improvements made as a result of audit.
- Their arrangements for identifying, recording and managing risks, issues and implementing mitigating actions were not robust. The practice was unable to provide any evidence that demonstrated this.

Leadership and culture

The lead GP was visible in the practice however they did not have the capacity to run the practice and prioritised the provision of clinical care.

We were not assured the provider was aware of and complied with the requirements of the Duty of Candour. Staff we spoke to on the day were unable to demonstrate knowledge of the whistleblowing policy. Although the partners encouraged a culture of openness and honesty, we found some staff were reluctant to raise concerns due to close relationships within the practice.

The practice did not have systems in place for knowing about notifiable safety incidents.

When there were unexpected or unintended safety incidents:

- The practice did not demonstrate that it gave affected people reasonable support, truthful information or a verbal and a written apology.
- Written records of verbal interactions as well as written correspondence were incomplete. For example, in relation to significant events, accident records and verbal complaints.

There was a leadership structure in place however, not all staff felt supported by management.

- Staff told us the practice held regular team meetings but we were not provided with meeting minutes upon request.
- Staff told us that they did not feel comfortable raising issues to management because of the nature of some of the relationships within the practice. The practice did not have any team away days.

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

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

- The practice had gathered feedback from patients through the patient participation group (PPG). However, we found they did not meet regularly. For example, they used to meet every month and this was changed to every three months. At the time of inspection, the PPG had not held a meeting for six months. However, at their previous meeting, they had gathered feedback from patients who had concerns that they were unable to get urgent appointments with the GP and were not aware that the practice had a nurse practitioner available who

Are services well-led?

Inadequate

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

could see patients for a variety of issues. It was then agreed that the practice would advertise her role on the practice website and create posters in the waiting room to let patients aware of the role of the nurse practitioner.

- We were not provided with evidence of feedback from staff gathered through an annual staff survey, staff meetings or appraisals. Although some staff told us that they would not hesitate to give feedback and discuss any concerns, some other staff told us they found this difficult due to the risk of impartiality as a result of close relationships within the practice.

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 Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect The registered person did not ensure patients were treated with dignity and respect. **How the regulation was not being met:** The treatment room did not provide sufficient privacy to the patient. The blinds in the treatment room were broken and not fit for purpose. As a result, activity taking place in the treatment room could be seen from the outside and there was no privacy for the patient. We also found the lights in this room were not working. The treatment room doors had no locks. Conversations taking place around the practice could be overheard. The room identified for confidential conversations was not fit for purpose. The cubicle was small and restrictive, there was no working lighting and once the door was shut, the patient was in complete darkness. The practice failed to make every reasonable effort that they respected people's preferences about who delivered their care and treatment, such as requesting staff of a specified gender. This was in breach of regulation 10(1)(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing The registered person must ensure sufficient numbers of suitably qualified, competent, skilled and experienced persons are deployed **How the regulation was not being met:**

This section is primarily information for the provider

Requirement notices

The practice did not have sufficient staff to cover the reception desk during their peak hours to ensure patients were able to access advice and arrange timely appointments without severe delays in answering.

The practice did not have suitable cover for sickness absence. Patients were redirected to alternative services if the practice was short staffed and this was occurring frequently. Some patients would seek treatment at the hospital as a result.

The practice did not have an adequate induction programme that prepared staff for their role. There was no evidence that mandatory training was carried out at the start of employment and staff had not received an annual appraisal for over two years.

This was in breach of regulation 18(1) (2)(a)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 Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Regulation 12(1) (2)(a)(b), (h), (i) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Safe care and treatment**

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment **Regulation 15 (1) (a) (b) (c) (e) (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Premises**

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Regulation 17(1) (2) (a) (b) (c) (d) and Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Good governance**

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed **Regulation 19 (1)(a) (b), (2), (3) (a) and Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Staffing**