Ashby Clinic

Inspection report

Collum Lane
Scunthorpe
DN16 2SZ
Tel:

Date of inspection visit: 11 October 2022
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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 location	Requires Improvement
Are services safe?	Requires Improvement
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Requires Improvement

Overall summary

This service is rated as Requires improvement overall.

The key questions are rated as:

Are services safe? – Requires improvement

Are services effective? – Good

Are services caring? – Good

Are services responsive? – Good

Are services well-led? – Requires improvement

We carried out an announced comprehensive inspection at Ashby Clinic as part of our inspection schedule as this is a new provider.

Safecare Network Limited (Ltd) is a not-for-profit Federation of 19 North Lincolnshire GP practices, covering approximately 170,000 patients. They provide GP advisory services to community health teams and the ambulance service, specialist assessment for frail and elderly patients, urgent care services delivered from the emergency department in Scunthorpe General Hospital and Diana Princess of Wales hospital Grimsby and out of hours GP services, provided from Ashby Turn primary care centre. They also manage a COVID19 vaccination site at the Ironstone Centre in Scunthorpe and undertake rota management for extended hours services for the Primary Care Network.

The Clinical Director of the provider, Safecare Network Ltd. is the registered manager. A registered manager is a person who is registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We only received feedback about the service from one patient who was extremely positive. We spoke with staff from other organisations who worked with each of the different services and all were positive about the staff and services provided and felt these made a difference to patients.

Our key findings were:

- The service didn't always provide care in a way that kept patients safe and protected them from avoidable harm as systems for recruitment and oversight of health and safety matters was not effective.
- Patients received effective care and treatment that met their needs.
- Staff dealt with patients with kindness and respect and involved them in decisions about their care.
- Patients could access care and treatment in a timely way.
- The way the practice was led and managed promoted the delivery of high-quality, person-centre care but there was a lack of management oversight relating to risk management.

The areas where the provider **must** make improvements as they are in breach of regulations are:

- Ensure care and treatment is provided in a safe way to patients.

Overall summary

- Ensure recruitment procedures are established and operated effectively to ensure only fit and proper persons are employed.

(Please see the specific details on action required at the end of this report).

The areas where the provider **should** make improvements are:

- Take action to gain assurance chaperone training has been completed by staff who are providing this service.
- Take action to improve clinical peer review of consultation records.
- Involve staff in the development and implementation of the vison and strategy.

Dr Sean O'Kelly BSc MB ChB MSc DCH FRCA

Chief Inspector of Hospitals and Interim Chief Inspector of Primary Medical Services

Our inspection team

Our inspection team was led by a CQC lead inspector**.** The team included a specialist adviser and a second CQC inspector.

Background to Ashby Clinic

The provider, Safe Care Network Limited, is a not for profit GP Federation of 19 GP practices based in North Lincolnshire covering approximately 170,000. They manage services from the location based at:

Ashby Clinic

Collum Lane

Scunthorpe

DN16 2SZ

Website: safecarenetwork.co.uk

The services comprise of:

1. Community Response Team

Global House

Kingsway

Scunthorpe

DN17 1AJ

A GP service which provides advisory services to community health teams and the ambulance service: 8am to 8pm, 7 days a week.

This service was visited as part of the inspection.

2. GP out of hours service

Ashby Turn Practice

The Link

Ashby

Scunthorpe

DN16 2UT

Out of hours GP services provided from Ashby Turn Primary Care Centre 6.30pm - 8am weekdays and 24 hours at weekends and bank holidays.

The GP Out of Hours Service is for patients residing in or visiting North Lincolnshire, who are experiencing a medical problem that cannot reasonably be expected to wait for the next opportunity to contact their own practice, in-hours.

This service was visited as part of the inspection.

3. Specialist assessment for the frail and elderly (SAFE)

Safecare was commissioned by North Lincolnshire Clinical Commissioning Group (CCG) to run the SAFE Service in August 2018. This is an innovative service designed to improve the wellbeing of the North Lincolnshire's elderly and frail residents by reviewing their physical, psychological, social and environmental needs holistically. One-off holistic frailty assessments are completed by a GP or a Geriatrician. Assessments are usually provided to patients at home or at Ashby Clinic, Scunthorpe if the patient can attend. The service is open 8.30am - 6pm.

This service was visited as part of the inspection.

4. Urgent Care Service

Urgent care services are delivered from the accident and emergency departments in Scunthorpe General Hospital and the Diana Princess of Wales Hospital, Grimsby between 8am and 8pm. All appointments are face to face and patients are triaged and booked into the service by accident and emergency staff.

The Scunthorpe service was visited as part of the inspection and we spoke to Grimsby staff by telephone.

5. The service manages a vaccination site for COVID19 vaccines until March 2023. This service is based at the Ironstone centre, West Street, Scunthorpe. This service was not inspected.

6. They also provide administrative rota management for practices extended hours for one Primary Care Network based in Ashby Clinic. This service was not inspected.

The service was registered to provide the following regulated activities on 31 January 2018:

Diagnostic and screening

Treatment of disease and disorder

How we inspected this service

We conducted site visits at Ashby clinic, Scunthorpe Hospital, Global House and Ashby Turn Primary Care centre to inspect the out of hours, urgent care, community response and SAFE services.

During the inspection we spoke with people using the service, interviewed staff and reviewed documents.

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?

These questions therefore formed the framework for the areas we looked at during the inspection.

Requires Improvement

Are services safe?

We rated safe as Requires improvement because:

The service did not have clear systems to keep people safe as the service did not have adequate systems to assess and monitor risk and to recruit staff safely.

Safety systems and processes

The service did not have clear systems to keep people safe.

- The provider had not conducted safety risk assessments. They relied on landlords of buildings they rented rooms from to have completed the risk assessments, for example, fire safety and legionella. However, the practice had no systems in place to assure themselves the risk assessments had been completed and acted upon. The practice had safety policies, however, the policies relating to fire and health and safety had not been updated since 2019.
- The service had systems to safeguard children and vulnerable adults from abuse. Training had been provided to level 3 and, of the 44 staff, 43 had completed adults and 42 children's safeguarding training.
- The service worked with other agencies to support patients and protect them from neglect and abuse. Staff took steps to protect patients from abuse, neglect, harassment, discrimination and breaches of their dignity and respect.
- The practice policy and procedure for recruitment had not been reviewed since 2019 and had not always been followed. For example, application forms had not been completed when specifically asked for in the policy. Full employment history had not been obtained and the policy stated gaps in employment history must be checked. The policy stated two references must be taken up but only one reference was evident on the 4 staff files checked. Immunisation status had not been checked for all clinical staff. Evidence that registration with regulatory bodies had been checked was not always evident and there was a lack of awareness to check the information for employers on the General Medical Council (GMC) site. Evidence that training certificates had been checked was not always available. Disclosure and Barring Service (DBS) checks were undertaken where required. (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 had no system in place to assure themselves that staff employed by other organisations as part of a service level agreement had been recruited safely.
- All staff received up-to-date safeguarding and safety training appropriate to their role. They knew how to identify and report concerns. Staff who acted as chaperones were provided as part of the service level agreement with landlords, but the provider had not assured themselves staff had been trained for this role or had a DBS check in place. One member of staff who had provided chaperone services told us they had not received training in this area. The chaperone policy stated staff must be trained in this area.
- An Infection Prevention and Control (IPC) audit had been completed at the out of hours service just prior to the inspection and the outcomes had been shared by the landlord with Ashby clinic. An action plan with timescales for improvement had not been put in place at the time of inspection although minimal issues had been identified. Records of cleaning were maintained at the out of hours service. At the other locations where services were provided cleaning and IPC was part of the service level agreement but there was no system in place for the provider to assure themselves standards were maintained as expected. At the urgent care service at Scunthorpe hospital we observed privacy curtains had not been changed in a treatment room since 2019 and in assessment room since 2021. We reported this to hospital staff.
- The provider had not carried out environmental risk assessments. They relied on landlords to complete these as part of their service level agreement but had not assured themselves that these had been completed and any issues identified had been addressed..

Risks to patients

There were systems to assess, monitor and manage risks to patient safety.

Requires Improvement

Are services safe?

- There were arrangements for planning and monitoring the number and mix of staff needed.
- There was some evidence that induction plans were in place through emails sent to staff however, there was a lack of evidence of induction had been completed.
- Staff understood their responsibilities to manage emergencies and to recognise those in need of urgent medical attention. However, records showed only 57% of 44 GPs had completed basic life support training and training in sepsis. We were told the GPs completed training within their own practices and it was sometimes difficult to gather this information from them.
- When there were changes to services or staff the service assessed and monitored the impact on safety.
- There were appropriate indemnity arrangements in place
- There were suitable medicines and equipment to deal with medical emergencies which were stored appropriately and checked regularly.

Information to deliver safe care and treatment

Staff had the information they needed to deliver safe care and treatment to patients.

- Individual care records were written and managed in a way that kept patients safe. The care records we saw showed that information needed to deliver safe care and treatment was available to relevant staff in an accessible way.
- The service had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.
- The service had a system in place to retain medical records in line with Department of Health and Social Care (DHSC) guidance in the event that they cease trading.
- Clinicians made appropriate and timely referrals in line with protocols and up to date evidence-based guidance.

Safe and appropriate use of medicines

The service had reliable systems for appropriate and safe handling of medicines.

- The systems and arrangements for managing medicines such as emergency medicines and equipment minimised risks. Processes were in place for the checking medicines and equipment.
- The service did not hold prescription stationery and all prescriptions were generated electronically.
- Staff prescribed to patients and gave advice on medicines in line with legal requirements and current national guidance.

Track record on safety and incidents

The service did not have adequate systems to assess and monitor risk.

- There was a lack of comprehensive risk assessment in relation to safety issues such as fire safety and legionella.
- The service did not have systems in place to monitor services provided under service level agreements to assure themselves risks were being managed effectively.

Lessons learned and improvements made

The service learned and made improvements when things went wrong.

- There was a system for recording and acting on significant events. The provider told us they had not had any serious events in the last 12 months. Staff told us they understood their duty to raise concerns and report incidents and near misses. However, we were told of an incident which had occurred but had not been recorded as an incident. During

the absence of an administrator on annual leave, reports for the specialist assessment service for the frail and elderly had not been completed for a period of two weeks with a risk that urgent recommendations may have been missed. The provider was aware of the incident and confirmed action was being taken to minimise reoccurrence with additional staff to be employed.

- There were systems for reviewing and investigating when things went wrong. The provider had implemented the NHS Serious Incident Framework 2015 to support practice in this area.
- The service acted on and learned from external safety events as well as patient and medicine safety alerts. The service maintained a log of alerts received and actions taken. The provider had a mechanism in place to disseminate alerts to members of the team via email. However, one member of the clinical team told us they had not received any alerts but had received these through their other role at a GP practice.

Good

Are services effective?

Effective needs assessment, care and treatment.

The provider had systems to keep clinicians up to date with current evidence-based practice. We saw evidence that clinicians assessed needs and delivered care and treatment in line with current legislation, standards and guidance (relevant to their service)

- The provider assessed needs and delivered care in line with relevant and current evidence-based guidance and standards such as the National Institute for Health and Care Excellence (NICE) best practice guidelines. The provider was the host of bi-monthly protected learning time (PLT) sessions for clinicians in North Lincolnshire. This provided the opportunity for local clinicians to share knowledge and experience with their peers. The service welcomed guest speakers and ensured national and local updates were shared in a timely manner alongside best practice guidance and new clinical developments.
- Patients' immediate and ongoing needs were fully assessed. Where appropriate this included their clinical needs and their mental and physical wellbeing.
- Clinicians had enough information to make or confirm a diagnosis
- We saw no evidence of discrimination when making care and treatment decisions.
- Staff assessed and managed patients' pain where appropriate.

Monitoring care and treatment

The service was involved in quality improvement activity although this may not always be effective.

- The service had been commissioned to provide a range of services usually on short term contracts in response to the COVID19 pandemic to improve access for patients in North Lincolnshire. The provider had monitored performance in terms of waiting times and numbers of patients seen in the urgent care service which showed improvement in recent months. The service had completed clinical audits of the Specialist Assessment for Frail and Elderly (SAFE) service every 3 months since 2021. These showed consistently high levels of achievement.
- Performance of clinical staff could be demonstrated through peer review of their consultations, prescribing and referral decisions. However, this work had mainly been completed in 2020 with a small number of peer reviews of consultations undertaken in 2022 for 7 GPs. Where scores indicated there may be areas for professional development an action plan for this was not recorded. In some cases, there was no evidence of reassessment since 2020 to enable the provider to assure themselves improvements had been made. During the inspection one clinician was able to confirm their records had been peer reviewed and the outcomes had been shared with them.

Effective staffing

Staff had the skills, knowledge and experience to carry out their roles.

- The provider had not always obtained evidence of qualifications on recruitment, but they had completed checks that clinicians were registered with the relevant regulatory body.
- There was a lack of evidence staff had completed an induction programme.
- Relevant professionals (medical and nursing) were registered with the General Medical Council (GMC)/ Nursing and Midwifery Council and were up to date with revalidation.
- The provider understood the learning needs of staff and provided protected time and training to meet them. Staff were encouraged and given opportunities to develop. The staff had access to an online training system although most GPs used their own practice training systems. The provider was the host of bi-monthly protected learning time (PLT) sessions for clinicians in North Lincolnshire. The provider told us the sessions were well received locally, with high attendance and active participation.

Good

Are services effective?

- An overview of training completion was maintained although this was partly reliant on the clinicians keeping the manager up to date with training completed within their own practice. Training compliance was mixed with records for GPs showing approximately 55% completion for most of the training although safeguarding training had compliance of over 95%. Nurses training showed 60 - 100% training compliance. The administration staff employed directly by the provider had completed all of the training.

Coordinating patient care and information sharing

Staff worked together, and worked well with other organisations, to deliver effective care and treatment.

- Patients received coordinated and person-centred care. Staff referred to, and communicated effectively with, other services when appropriate. For example, the GP supporting the community response team could refer patients the home visiting team.
- Before providing treatment, doctors at the service ensured they had adequate knowledge of the patient's health, any relevant test results and their medicines history. We saw examples of patients being signposted to more suitable sources of treatment where this information was not available to ensure safe care and treatment.
- All patients were asked for consent to share details of their consultation and any medicines prescribed with their registered GP on each occasion they used the service.
- Care and treatment for patients in vulnerable circumstances was coordinated with other services. For example, the clinicians from the specialist assessment for frail and elderly service discussed complex cases at a monthly virtual multi-disciplinary meeting including the occupational therapist, physiotherapist and local authority staff.
- Patient information was shared appropriately (this included when patients moved to other professional services), and the information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way.
- The service monitored the process for seeking consent appropriately.

Staff were consistent and proactive in empowering patients and supporting them to manage their own health and maximise their independence.

- Where appropriate, staff gave people advice so they could self-care.
- Risk factors were identified, highlighted to patients and where appropriate highlighted to their normal care provider for additional support.
- Where patients needs could not be met by the service, staff redirected them to the appropriate service for their needs.

Consent to care and treatment

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

- Staff understood the requirements of legislation and guidance when considering consent and decision making.
- Staff supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.

Good

Are services caring?

We rated caring as Good because:

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- The service sought feedback on the quality of clinical care patients received. A feedback form was given to patients at the end of each contact.
- Feedback from patients was positive about the way staff treated people.
- Staff understood patients' personal, cultural, social and religious needs. They displayed an understanding and non-judgmental attitude to all patients.
- The service gave patients timely support and information.

Involvement in decisions about care and treatment

Staff helped patients to be involved in decisions about care and treatment.

- Interpretation services were available for patients who did not have English as a first language.

Privacy and Dignity

The service respected patients' privacy and dignity.

- Staff recognised the importance of people's dignity and respect.
- Staff knew that if patients wanted to discuss sensitive issues or appeared distressed, they could offer them a private room to discuss their needs.

Good

Are services responsive to people's needs?

Responding to and meeting people's needs

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

- The provider understood the needs of their patients and improved services in response to those needs. The service had been commissioned to improve services for patients during the COVID-19 pandemic and had been responsive in providing short term services at short notice. For example, a hot clinic for patients with suspected or confirmed COVID-19, a home visit service for patients who were shielding and pulse oximeter (checks the level of oxygen in your blood) at home service where equipment was supplied to patients at home to monitor their oxygen levels.
- The facilities and premises were appropriate for the services delivered.
- Reasonable adjustments had been made so that people in vulnerable circumstances could access and use services on an equal basis to others. Services were provided in accessible buildings and home visits were available from the specialist assessment for the frail and elderly team.

Timely access to the service

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

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

Listening and learning from concerns and complaints

The service took complaints and concerns seriously and responded to them appropriately to improve the quality of care.

- Information about how to make a complaint or raise concerns was available. Staff treated patients who made complaints compassionately.
- The service informed patients of any further action that may be available to them should they not be satisfied with the response to their complaint.
- The service had complaint policy and procedures in place. The service learned lessons from individual concerns, complaints and from analysis of trends. It acted as a result to improve the quality of care. For example, where there had been a data breach the provider had investigated and shared the learning with all the staff.

Requires Improvement

Are services well-led?

We rated well-led as Requires improvement because:

The service did not have clear systems to keep people safe as the service did not have adequate systems to assess and monitor risk and to recruit staff safely.

Leadership capacity and capability;

Leaders had the capacity and skills to deliver high-quality, sustainable care.

- Services had mainly been commissioned on a short-term basis in response to COVID-19 and to improve access for patients across North Lincolnshire and more latterly North East Lincolnshire. This had created challenges for forward planning and developing improvement plans.
- The services were provided in different buildings across Scunthorpe. GPs usually worked alone or with one other GP and were supported during the sessions by staff from other organisations. A small administration team of three staff worked at the main site with the operations manager. GPs worked on a zero hours contract on a sessional basis, one or two sessions per a week.
- Leaders were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges and were addressing them.
- Some staff told us they did not always feel leaders were visible and approachable and they did not always feel involved in the development of the service. However, others thought leaders were approachable and they felt supported.
- The provider had processes to develop leadership capacity and skills.

Vision and strategy

The service had a clear vision and credible strategy to deliver high quality care and promote good outcomes for patients.

- There was a clear vision and set of values. The service had a realistic strategy and supporting business plans to achieve priorities.
- The service developed its vision, values and strategy with external partners. However, some staff told us they did not feel involved and did not know what the vision and strategy was.
- The service monitored progress against delivery of the strategy.

Culture

The service had a culture of high-quality sustainable care.

- A small number of staff told us they did not feel respected, supported and valued. However, most staff told us they enjoyed working for the service.
- The service focused on the needs of patients.
- Leaders and managers acted on behaviour and performance inconsistent with the vision and values.
- Openness, honesty and transparency were demonstrated when responding to incidents and complaints.
- Staff told us they could raise concerns and were encouraged to do so. They had confidence that these would be addressed.

Requires Improvement

Are services well-led?

- There were processes for providing staff with the development they need. This included appraisal and career development conversations. Staff had received annual appraisals in the last year. Staff were supported to meet the requirements of professional revalidation where necessary. Clinical staff, including nurses, were considered valued members of the team. They were given protected time for professional time for professional development and evaluation of their clinical work.
- The service promoted equality and diversity. Staff had received equality and diversity training.

Governance arrangements

There were responsibilities, roles and systems of accountability to support good governance and management.

- Structures, processes and systems to support good governance and management were clearly set out, understood and effective. The governance and management of partnerships, joint working arrangements and shared services promoted interactive and co-ordinated person-centred care.
- Staff were clear on their roles and accountabilities.
- Leaders had some policies and procedures to ensure safety but had not always assured themselves that they were operating as intended. For example, there were no systems to monitor services provided under a service level agreement and to assure themselves health and safety matters were risk assessed and findings acted on. Policies such as recruitment had not been adequately implemented and there were no systems for the provider to ensure themselves staff employed under a service level agreement had been safely recruited and had the required training. Policies and procedures had not been regularly reviewed with most having last been reviewed in 2019.
- The service used performance information, which was reported and monitored, and management and staff were held to account
- The information used to monitor performance and the delivery of quality care was accurate and useful. There were plans to address any identified weaknesses.
- The service submitted data or notifications to external organisations as required.
- There were arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

Managing risks, issues and performance

There was no clarity around processes for managing risks, issues and performance.

- There was a lack of systems to identify, understand, monitor and address current and future risks including risks to patient safety, such as safety and environmental risk assessments, IPC, staff training and safety alerts. The provider had a risk log which contained two identified risks one relating to staffing and one relating to changes in management.
- The service had processes to manage current and future performance. Performance of clinical staff could be demonstrated through audit of their consultations, prescribing and referral decisions. However, this work had mainly last been completed in 2020 with a small number of audits of consultations undertaken in 2022 for 7 GPs. Where scores indicated there may be areas for professional development an action plan for this was not recorded. In some cases, there was no evidence of reassessment since 2020 to enable the provider to assure themselves improvements had been made.
- Leaders had oversight of safety alerts, incidents, and complaints.
- The provider had plans in place for major incidents.

Appropriate and accurate information

The service acted on appropriate and accurate information.

Requires Improvement

Are services well-led?

- Quality and operational information was used to ensure and improve performance. Performance information was combined with the views of patients.
- Quality and sustainability were discussed in relevant meetings.

Engagement with patients, the public, staff and external partners

The service involved patients, the public, staff and external partners to support high-quality sustainable services.

- The service encouraged and heard views and concerns from the public, patients and external partners and acted on them to shape services and culture. Feedback was sought from patients after each contact and comments were positive.
- A small number of staff told us they did not feel listened by the management or involved in the development of the service and felt communication could be improved.
- The service was transparent, collaborative and open with stakeholders about performance. We spoke with staff form other organisation who worked with the GPS and they told us the services provided were responsive, of good quality and effective.

Continuous improvement and innovation

There was some evidence of systems and processes for learning, continuous improvement and innovation.

- There was some evidence of learning and improvement and the service made use of internal and external reviews of incidents and complaints. Learning was shared and used to make improvements.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 CQC (Registration) Regulations 2009 Statement of purpose Regulation 12 HSCA (RA) Regulations 2014, Care and treatment must be provided in a safe way for service users **How the regulation was not being met:** The registered person had not done all that was reasonably practicable to mitigate risks to the health and safety of service users receiving care and treatment. In particular: • The provider had not conducted safety and environmental risk assessments. They had no systems in place to assure themselves risk assessments completed by another organisation, as part of a service level agreement, had been completed and findings acted upon. • Safety alerts had not been shared with with all staff. • There was a lack of evidence GPs had completed all the required training such as induction, basic life support and sepsis awareness. • There was a lack of evidence to demonstrate oversight of performance of clinical staff. • The practice policies relating to fire and health and safety had not been updated since 2019. • At the locations where cleaning services and management of infection prevention and control was part of a service level agreement there was no system in place for the provider to assure themselves standards were maintained as expected. • Immunisation status had not been checked for all clinical staff. This was in breach of Regulation 12(1)(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

Diagnostic and screening procedures

Treatment of disease, disorder or injury

Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed

Regulation 19 HSCA (RA) Regulations 2014

Requirements. Persons employed for the purposes of carrying on a regulated activity must be fit and proper persons

How the regulation was not being met

The registered person's recruitment procedures did not ensure that only persons of good character were employed. In particular:

- The providers policy and procedure had not been fully implemented in that full employment history had not been obtained and two references had not been taken up.
- The provider had no system in place to assure themselves that staff provided as part of a service level agreement employed by other organisations had been recruited safely.

The registered person's recruitment procedures did not ensure that potential employees had the necessary qualifications, competence, skills and experience before starting work. In particular:

- Evidence that training certificates had been checked was not always available.

The registered person employed persons who must be registered with a professional body, where such registration is required by, or under, any enactment in relation to the work that the person is to perform. The registered person had failed to ensure such persons were registered. In particular:

- Evidence that registration with regulatory bodies had been checked was not always evident and there was a lack of awareness to check the information for employers on the General Medical Council (GMC) site.

This was in breach of Regulation 19(1)(2) and (4) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.