

# University of Bristol Students' Health Service

## 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

Good



Are services safe?

Requires improvement



Are services effective?

Good



Are services caring?

Good



Are services responsive to people's needs?

Outstanding



Are services well-led?

Good



# Summary of findings

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## Overall summary

### Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at the University of Bristol Students' Health Service on 9th March 2015. Overall the practice is rated as one which provides a good service.

Specifically, we found the practice to require improvement for providing safe services. The practice was good for providing an effective, caring, and well led service and it was outstanding for providing a responsive service. It was good for providing services for four of the population groups. It was outstanding for the population group of people experiencing poor mental health. The older people population group is not applicable to this service.

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

- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment. Information was provided to help patients understand the care available to them.
- The practice had actively sought feedback from patients.
- The service had recognised the specialist population group of their patients (Students) and a lot of their information and activity was shared using social media as the preferred medium of communication for their patients. For example they have Facebook and Twitter accounts and produce a regular blog focussing on key aspects of health and wellbeing particularly pertinent to the student population and health issues.
- Patients with long term conditions had open access to their 'i-cloud' care plans for long term conditions. The practice held multidisciplinary team meetings to discuss the needs of complex patients, for example vulnerable people.

# Summary of findings

- The practice used innovative and proactive methods to improve patient outcomes, working with other local providers to share best practice. For example the practice introduced a new methotrexate medication monitoring system in 2014, which enabled 100% of patients to be up to date with blood monitoring (patient safety), and resulted in one GP securing a new EMISweb national code for 'Patient held methotrexate record issued' EMISNQA385.
- The practice worked closely with other organisations and with the local community in planning how services were provided to ensure that they meet people's needs.
- The premises and services had been adapted to meet the needs of patient with disabilities, such as providing a space at the end of the reception counter for disabled access.
- Urgent appointments were available on the day they were requested. However some patients said they sometimes found it difficult to make appointments
- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Staff told us there was an open and honest culture within the practice and they had the opportunity to raise issues at team meetings.
- Risks to patients were assessed and well managed, with the exception of those relating to recruitment checks for staff.
- Training records for some members of staff were not up to date and no clear induction process for staff members was seen.

We saw five areas of outstanding practice:

- The practice initiated a vaccine programme for the Meningitis B vaccination of 4000 students (2 doses each) in October/November 2014, with a vaccine, which is not yet available through the NHS. The programme targeted the age group most at risk and requiring protection. This was the first place (and so far only) in the UK to provide this specific immunisation to large numbers of the population
- The practice carried out health promotion campaigns such as 'Love Hurts' (STI screening) for Valentine's Day and smoking cessation support for 'stop smoking day'. The clinicians visited all of the halls of residences at

the beginning of the academic year in a road show to educate the new students about their health at university, the risks of meningitis and how to look out for each other.

- We saw the practice had a strong focus on the wellbeing of patients in their care. For example running "Wellbeing Awareness days" for senior medical students and working with STITCH in Bristol to reduce self-harm. The increased access to psychiatric appoints for students in term time.
- Mental health in house services set up as a bespoke service recognising the specialist needs of patient population at this service. It offers 'in house' weekly clinics by NHS psychiatrist, a CBT clinic weekly, mindfulness for medical students, self-hypnosis one off session for anxiety and Big White Wall providing 24/7 online support.
- The practice has developed the First Step Eating Disorder service which offers a single point of access where people with an eating disorder can obtain rapid access to assessment and treatment in a familiar environment. This group was offered further support in line with their needs. For example patients followed a pathway where they could see a therapist in the practice who had additional access to specialists without needing re-referral.

The areas where the provider must make improvements are:

- Ensure records of identification checks are included in staff personnel files and use current DBS checks. Ensure risk assessments are in place to assess the need for criminal record checks for non-clinical staff.

In addition the provider should:

- Improve record keeping processes to ensure information is not mislaid; and is recorded and stored appropriately
- Ensure all staff members attend Equality and Diversity training and Mental Capacity Act training.
- Ensure that where poor performance is identified appropriate action is taken and clear records are made and kept to evidence the action taken to address the issue. Ensure learning from complaints includes a record of patient outcomes.

**Professor Steve Field** CBE FRCP FFPH FRCGP

Chief Inspector of General Practice

# Summary of findings

**Professor Steve Field (CBE FRCP FFPH FRCGP)**

Chief Inspector of General Practice

# Summary of findings

## The five questions we ask and what we found

We always ask the following five questions of services.

### Are services safe?

The practice is rated as requires improvement for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded and addressed however safer recruitment processes were not always followed and DBS checks had not always been obtained prior to staff commencing work with the service. Risk assessments were not in place to assess the need for criminal record checks for non-clinical staff. Risks to patients were assessed and well managed. There were enough staff to keep patients safe.

Requires improvement



### Are services effective?

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the specialist service provision at this location. Staff referred to guidance from the National Institute for Health and Care Excellence (NICE) and used it routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included promoting good health. Staff had mostly received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. There was evidence of annual appraisal for all staff. Staff worked with multidisciplinary teams.

Good



### Are services caring?

The practice is rated as good for providing caring services. Data showed patients highly rated the practice for several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information to help patients understand the services available was easy to understand. We also saw staff treated patients with kindness and respect, and maintained confidentiality.

Good



### Are services responsive to people's needs?

The practice is rated as outstanding for providing responsive services. It had reviewed the needs of its specialist local population, particularly with respect to patients with mental health issues, overseas patients, students and vulnerable people. The practice had excellent facilities including a three bed day unit for vulnerable patients who are acutely unwell offering support from staff. It was well equipped to treat patients and meet their needs. Patients said they found it easy to make an appointment and there was continuity

Outstanding



# Summary of findings

of care, with urgent appointments available the same day. The practice had good facilities and was well equipped to treat patients and meet their needs. Learning from complaints was not always based on patient outcomes.

## Are services well-led?

The practice is rated as good for being well-led. It had a vision and a strategy and all staff were aware of this and their responsibilities in relation to it. There was a documented leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity, but some of these were overdue a review. Governance meetings were held termly. The practice proactively sought feedback from patients and had an active patient participation group (PPG). Not all staff had received induction or attended staff meetings and events. We were not able to evidence all staff had read information from minutes communicated by email. All staff had received regular annual appraisal.

**Good**



# Summary of findings

## The six population groups and what we found

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

### People with long term conditions

The practice is rated as good for the care of people with long-term conditions. Nursing staff had lead roles in chronic disease management. For those people with the most complex needs, the GPs worked with relevant health and care professionals to deliver a multidisciplinary package of care.

New patients with a long term health condition when registering were offered an appointment with a GP or nurse specialising in chronic disease management as appropriate. The practice had an integrated clinic for patients with diabetes run by the lead GP, lead nurse for chronic disease management in the practice and a specialist diabetic nurse.

Good



### Families, children and young people

The practice is rated as good for the care of families, children and young people. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with midwives, health visitors and community nurses. GP antenatal care was offered along with six week baby checks.

Good



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

The practice is rated as good for the care of working-age people (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care.

The practice was proactive in offering online services to meet the specific needs of their specialist patient group. They offered a full range of health promotion and screening that reflects the needs for this age group. The practice carried out a health promotion campaigns such as 'Love Hurts' (STI screening) for Valentine's Day and smoking cessation support for 'stop smoking day'. The clinicians visited all of the halls of residence at the beginning of the academic year in a road show to educate the new students about their health at university, the risks of meningitis and how to look out for each other.

The service had recognised the specialist population group of their patients (Students) and a lot of their information and activity was shared using social media as the preferred medium of communication for their patients. For example they have Facebook and Twitter accounts and produce a regular blog focussing on key aspects of health and wellbeing particularly pertinent to the student population and health issues

Good



### People whose circumstances may make them vulnerable

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. It had told vulnerable patients about how to access various support groups and voluntary organisations.

Good



# Summary of findings

Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies.

## **People experiencing poor mental health (including people with dementia)**

The practice is rated as outstanding for the care of people experiencing poor mental health. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health. For example running “Wellbeing Awareness days” for senior medical students; working with STITCH in Bristol to reduce self-harm. The increase of access to psychiatric appointments for students in term time.

The practice had told patients experiencing poor mental health about how to access various support groups. The practice offered a counselling service at the university and patients could attend daily drop-ins, groups and workshops about relevant topics.

**Outstanding**





# Summary of findings

## What people who use the service say

We received 19 comments cards from patients who had visited the practice in the previous two weeks. We also spoke with one representative from the Patient Participation Group (PPG) and reviewed feedback from surveys that had been carried out at the practice.

The PPG representative we spoke with on the day of our visit was positive about the care and support they received at the practice. They told us it was easy to make an appointment and consultations were never rushed. Comments cards were mainly positive and described the service as excellent with staff being helpful and polite. Five of the cards had less positive comments regarding the attitude of reception staff when booking appointments and having difficulty booking appointments.

We viewed the results for the National GP Survey from January 2015. 21 patients had responded to this survey.

We saw 94% of patients said the last GP they saw or spoke with was good at listening to them. 100% of patients said they had confidence and trust in the last GP they saw or with whom they spoke. 88% of patients saw their overall experience of the practice as good.

We viewed the results of the Friends and Family Test from February 2015 for the practice (The Friends and Family Test is an opportunity for NHS patients to provide feedback about services that provide care and treatment). 21 patients had responded to this survey by answering the question 'How likely are you to recommend your GP practice to friends and family if they needed similar care or treatment?' 16 patients responded by saying they were highly likely, two said they were likely, two said they were unlikely and one said they did not know.

## Areas for improvement

### Action the service **MUST** take to improve

- Ensure records of identification checks are included in staff personnel files and use current DBS checks. Ensure risk assessments are in place to assess the need for criminal record checks for non-clinical staff.

### Action the service **SHOULD** take to improve

- Improve record keeping processes to ensure information is not mislaid and recorded and stored appropriately

- Ensure all staff members attend Equality and Diversity training and Mental Capacity Act training.
- Ensure that where poor performance is identified appropriate action is taken and clear records are made and kept to evidence the action taken to address the issue. Ensure learning from complaints includes a record of patient outcomes.

## Outstanding practice

- The practice initiated a vaccine programme for the Meningitis B vaccination of 4000 students (2 doses each) in October/November 2014, with a vaccine, which is not yet available through the NHS. The programme targeted the age group most at risk and requiring protection. This was the first place (and so far only) in the UK to provide this specific immunisation to large numbers of the population
- The practice carried out health promotion campaigns such as 'Love Hurts' (STI screening) for Valentine's Day and smoking cessation support for 'stop smoking day'. The clinicians visited all of the halls of residences at the beginning of the academic year in a road show to educate the new students about their health at university, the risks of meningitis and how to look out for each other.

# Summary of findings

- We saw the practice had a strong focus on the wellbeing of patients in their care. For example running “Wellbeing Awareness days” for senior medical students and working with STITCH in Bristol to reduce self-harm. The increased access to psychiatric appoints for students in term time.
- Mental health in house services set up as a bespoke service recognising the specialist needs of patient population at this service. It offers ‘in house’ weekly clinics by NHS psychiatrist, a CBT clinic weekly, mindfulness for medical students, self-hypnosis one off session for anxiety and Big White Wall providing 24/7 online support.
- The practice has developed the First Step Eating Disorder service which offers a single point of access where people with an eating disorder can obtain rapid access to assessment and treatment in a familiar environment. This group was offered further support in line with their needs. For example patients followed a pathway where they could see a therapist in the practice who had additional access to specialists without needing re-referral. This service provision model had been adopted by the CCG.

# University of Bristol Students' Health Service

## Detailed findings

### Our inspection team

#### Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a second inspector, a practice nurse and a GP.

## Background to University of Bristol Students' Health Service

The University of Bristol Students' Health Service is an NHS General Practice which provides a range of primary medical services to University of Bristol students and their dependants who reside within the practice area. There are around 16,500 patients registered, with 92 patients under the age of 18 and 20% of patients from overseas. The practice's services are commissioned by NHSE Bristol. The service is provided by 10 GPs, four nurse prescribers, three practice nurses and two Health Care Assistants. They are supported by a practice manager, an administration team manager, receptionists, secretaries and an administration assistant.

The practice is in a shared building alongside The University of Bristol student services for counselling, the student crisis team and disability services. Other health services based in the building are the Bristol community partnership health visitors, midwifery services and community nurses.

The practice has one location registered with the Care Quality Commission (CQC) which we inspected at St Michael's Hill, Cotham, Bristol, BS6 6AU.

The practice offers extended opening hours until 7.45pm on Mondays and Thursdays. The practice is open on Saturday mornings. The practice had opted out of the requirement to provide out of hour's GP consultations to its own patients and uses the services of an out of hour's service, contracted by Bristol CCG (BrisDoc). The practice website and practice leaflet offer information for patients regarding the out of hour's service, along with a contact telephone number.

## Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was carried out to check whether the provider was 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.

Please note that when referring to information throughout the report, for example any reference to the National GP Survey, this relates to the most recent information available to the CQC at the time.

# Detailed findings

## How we carried out this inspection

Before visiting the University of Bristol Students' Health Service, we reviewed a range of information we hold about the service. We also reviewed information we had requested from the practice prior to our visit, as well as information from the public domain, including the practice website and NHS choices.

We carried out an announced inspection on 9 March 2015. During and subsequent to our visit we spoke with a range of staff including GPs, practice nurses, receptionists and practice managers. We also spoke with a patient who was a member of the PPG to gain their views about the quality of the service provided at the practice. We reviewed 19 comment cards where patients shared their views and experiences of the service. We reviewed patient surveys which had been carried out at the practice, including the National GP survey.

As part of the inspection we observed how staff cared for patients. We examined practice policies and other relevant 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?

We also looked at how well services are provided for specific groups of people and what good care looks 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).

# Are services safe?

## Our findings

### Safe track record

The practice used a range of information to identify risk. For example, reported incidents and comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses.

We reviewed safety records, incident reports and minutes of meetings where incidents had been discussed in order to maintain a safe track record over the long term.

### Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. Staff logged incidents on a record sheet in the office for discussion at the next significant event meeting, and these were also entered on the intranet (Intradoc). We reviewed a summary of serious adverse events between March 2014 and February 2015, which highlighted the actions taken and lessons learned. Where patients had been affected by something which had gone wrong, in line with practice policy, they were given an apology and informed of the actions taken.

Dedicated meetings were held once a term to review actions from past significant events and complaints. There were records of a significant event meeting from December 2014 and we were able to review the minutes which evidenced discussion and review of the events. The provider found a prescribing error had occurred in June 2014. This was picked up by a GP on 30 January 2015, and then listed on Intradoc for the next significant event meeting, which took place on 17 March 2015. The GP who listed the case noted a new plan for prescribing would be needed. Following consultation a protocol was written to ensure that on the rare occasion liquid medication was prescribed it would be safely done. It was circulated to the whole practice for discussion and we were told would be finalised in due course.

### Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. The staff we spoke with confirmed they had attended safeguarding

training, although some staff members could not confirm when this had taken place. Staff training records seen were not all fully completed. Staff were able to identify who the lead GP was for safeguarding at the practice.

Staff were aware of what should be reported and the process to follow. For example, one staff member discussed the importance of reporting any issues relating to children who used the practice. They told us about the safeguarding process which was in place and said they would ensure any information about children would be seen by the lead GP responsible.

The practice had appointed a dedicated GP who was the lead professional for safeguarding vulnerable adults and children. They had been trained and could demonstrate they had the necessary skills to enable them to fulfil this role.

There was a chaperone policy and clinician gender requests protocol at the practice (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). We were told the health care assistants had completed chaperone training, although we were unable to find evidence of this in staff training records. The chaperone service was advertised in the waiting room.

### Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators. We found they were stored securely and were only accessible to authorised staff. We saw evidence of daily fridge temperature checking in order to ensure medicines stored in the fridge were at the correct temperature. Processes were in place to check medicines were within their expiry date and suitable for use.

The nurses and health care assistants administered vaccines using directions that had been produced in line with legal requirements and national guidance. We spoke to a staff member who confirmed they had attended training in order to administer vaccinations. Patient specific directives were signed by GPs prior to patients receiving their vaccination. There was a named person for the handling and storage of vaccines.

The practice had a process in place which ensured the security of blank prescriptions. All prescriptions were

# Are services safe?

reviewed and signed by a GP before they were given to the patient. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

## Cleanliness and infection control

We observed the premises to be clean and tidy. Cleaning services were contracted to an external company. We were told cleaning audits were carried out by a building manager on a monthly basis. Patient comments cards told us they found the practice clean and had no concerns about cleanliness or infection control. There was a lead nurse for infection prevention and control at the practice.

Staff told us they received training about infection control and received annual updates as part of their mandatory training. Not all staff training records seen demonstrated this. We saw evidence an infection control audit had been carried out in March 2015.

Minutes of practice meetings showed the findings of the audit were discussed at team executive meetings. An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these to comply with the practice's infection control policy. For example, staff told us paper couch rolls were used and couches were cleaned between patients.

There was an established system in place for the collection and return of used instruments. There was also a policy for needle stick injury and staff knew the procedure to follow in the event of an injury. Clinical staff had access to Occupational Health in the university grounds if necessary.

Notices about hand hygiene techniques were displayed in treatment rooms. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms.

## Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us all equipment was tested and maintained regularly. We saw evidence of portable

electrical equipment testing in April 2014. A schedule of testing was in place. We saw evidence of calibration of relevant equipment, for example weighing scales, spirometers and blood pressure measuring devices.

## Staffing and recruitment

Records we looked at contained evidence recruitment checks had been undertaken prior to employment. For example, references, gaps in employment, registration with the appropriate professional body and criminal records checks through the Disclosure and Barring Service (DBS).

However, in four of the files seen there was no photographic proof of identity checks in four of the staff records seen. In three records seen there were DBS checks and in the fourth record the DBS was completed in 2012 and had been transferred from a previous employer. DBS checks undertaken at that time were not portable and therefore not relevant for current employment. We also found risk assessments had not been carried out to establish if non clinical staff required DBS checks.

We asked about the induction programme and were told staff were given a comprehensive induction. In one record seen there was an induction programme which outlined a number of appropriate activities. However there was no evidence to show it had been completed. In two other staff records the induction records were unclear.

The practice had a system in place to analyse arrangements for planning and monitoring the number of staff and skill mix of staff needed to meet patients' needs. We were informed the team leaders are responsible for monitoring staff levels and skill mix within their teams. There is a system in place to escalate upwards or across if necessary to ensure safe staffing numbers. A recent workforce planning meeting in March 2015 had highlighted the need for future workforce planning at the practice. Staff told us there were usually enough staff to maintain the smooth running of the practice although locum GP's were often used to meet staffing requirements.

## Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included checks of the building, the environment, dealing with emergencies and equipment. The practice also had a health and safety policy. We were told by staff a safety inspection was carried out annually

## Are services safe?

and were informed a safety audit was last undertaken in April 2014. This had been completed by external auditors from the University Safety Office. It included an inspection of the premises and an audit score of 96% was achieved.

There was no evidence identified risks were included on a risk log. There were no records to indicate risks were assessed, rated and mitigating actions recorded to reduce and manage the risk. We saw evidence some risks were discussed within team meetings, such as non-clinical staffing and safeguarding.

We saw staff were able to identify and respond to changing risks to patients including the well-being of patients at the practice. For example, staff gave examples of how they responded to patients experiencing a mental health crisis, including supporting them to access emergency care and treatment.

### **Arrangements to deal with emergencies and major incidents**

The practice had arrangements in place to manage emergencies. Staff told us they attended basic life support training annually. Evidence of this was not always available in staff training records seen. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). When we asked different members of staff, they all knew the location of this equipment and records confirmed it was checked regularly to ensure it was safe for use. Staff were able to discuss a recent medical emergency concerning a patient and told us they had attended a debrief session.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Risks identified included power failure, loss of medical records and incapacity of staff. The document also contained relevant contact details to which staff could refer. For example, contact details of a company to contact if the heating system failed.

The practice had carried out a fire risk assessment that included actions required to maintain fire safety. Records showed staff had attended fire training and fire warden training. We saw evidence a fire drill had been carried out in September 2014.

Risk assessments had been completed in relation to Manual Handling, Stress, Violence & Aggression, Medical Oxygen, Lone Working, Maternity, and Working in Administrative areas, Biological and Chemical Hazards. Risks had been assessed and actions recorded to reduce and manage these risks. Risks associated with service and staffing changes (both planned and unplanned) were not included on the practice risk log.



# Are services effective?

(for example, treatment is effective)

## Our findings

### Effective needs assessment

The GPs and nursing staff we spoke with could outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE). The practice told us their practice was audited according to CCG and pharmacy guidance.

We saw evidence that demonstrated this in the form of a sore throat audit from 2015, which was based on NICE guidance and national prescribing guidance. The staff we spoke with and the evidence reviewed confirmed these actions were designed to ensure each patient received support to achieve the best health outcome for them. We found from our discussions with the GPs and nurses, staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate.

The GPs told us they took a lead professional role in specialist clinical areas such as women's health, sexual health, hypertension, drugs and alcohol and diabetes. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support.

The practice manager told us the practice were disadvantaged by QOF being targeted mainly at patient groups they do not see, but they told us each clinical lead person's responsibility aimed to ensure they achieve more than 90% of available QOF points every year (QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). The practice manager told us they had no involvement in the comparison of QOF data as there were no organisational indicators.

We were told it is the responsibility of the clinical lead for each area to monitor their own indicators. We were told the practice was following a catch up system over the next three months before the end of the QOF year. We were told diabetes was one of the indicators; however we found the one stop diabetic clinic did not cover all of the necessary clinical checks, such as foot pressures and foot checks. We

were told the Diabetic Clinic is a Multidisciplinary Team clinic and patient results vary because patients have some of their checks done at hospitals elsewhere in UK, and some at Students' Health Service.

Discrimination was avoided when making care and treatment decisions. Interviews with GPs showed the culture in the practice was that patients were cared for and treated based on need and the practice took account of patient's age, gender, race and culture as appropriate.

### Management, monitoring and improving outcomes for people

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical review and medicines management. The information staff collected was then collated by the practice manager and the administration manager to support the practice to carry out clinical audits.

The practice had a system in place for completing clinical audits in line with the National Institute for Health and Care Excellence guidance, such as antidepressant prescribing and epilepsy. The practice showed us an audit had been completed recently about sore throat prescribing. The audit highlighted changes to treatment or care which had been put in place and the audit had been repeated to ensure outcomes for patients had improved. The aim of the audit was to ensure all patients presenting with sore throats and tonsillitis were prescribed with the correct duration of antibiotics according to current guidance. The practice "was" prescribing correctly when Centor criteria were present in 95%. A re-audit in 2014/2015 showed 98% were correctly prescribed.

There was a protocol for repeat prescribing which was in line with national guidance. In accordance with this guidance, staff regularly checked patients receiving repeat prescriptions had been reviewed by the GP. They also checked the latest prescribing guidance was being used. All routine health checks were completed for patients living with long-term conditions such as diabetes.

The IT system flagged up relevant medicines alerts when the GP was prescribing medicines. We saw evidence to confirm that, after receiving an alert, the GP had reviewed the use of the medicine in question and, where they



# Are services effective?

## (for example, treatment is effective)

continued to prescribe it had outlined the reason why they decided this was necessary. The evidence we saw confirmed the lead GP had an oversight and a good understanding of best treatment for each patient's needs.

The practice introduced a new methotrexate medication monitoring system in 2014, which enabled 100% of patients to be up to date with blood monitoring (patient safety), and resulted in the lead GP securing a new EMISweb national code for 'Patient held methotrexate record issued' EMISNQPA385.

### Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw some records showed mandatory courses had not always been recorded with a completion date, particularly in the case of non-clinical staff.

We noted a good skill mix among the GPs. All GPs were up to date with their annual continuing professional development requirements and all either have been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

All staff received an annual appraisal that identified learning needs from which action plans were documented. The practice told us they used a 360 degree feedback tool for the appraisal process. We saw from records training in new systems and processes had been provided. Those with extended roles such as nurse prescribers were also able to demonstrate they kept up to date by attending external events and subscribing to specialist journals.

Staff told us the practice encouraged staff to attend conferences and meet up with other groups concerned with the provision of primary care services. Staff, including nurse prescribers, told us they received supervision during the year through attendance at team meetings of the team to which they belonged, e.g. GPs, nurses, receptionists and administrative staff during which they discussed systems and practices and any new guidance of which they were aware.

### Working with colleagues and other services

The practice held multidisciplinary team meetings to discuss the needs of complex patients, for example vulnerable people. The complex case conferences were held with the vulnerable students' team and other colleagues from support services at the university. Staff felt this system worked well and remarked on the usefulness of the conferences to ensure a co-ordinated and individualised approach to complex cases.

The practice worked closely with the student counselling service, disability unit, students' union and the Chaplaincy. The practice told us they were able to liaise closely with academic departments at the university and had a good understanding of the university calendar and exam timings. The practice also worked closely with mental health support services such as Psychology and Psychiatry. The practice told us mental health issues were the presenting issue in one in three consultations at the practice.

### Information sharing

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record (EMISWeb) to coordinate, document and manage patients' care. All staff were fully trained to use the system which was evidenced in staff training records. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

### Consent to care and treatment

The practice told us consent to liaise was documented on EMISWeb for all patients, whether with parents, carers, vulnerable student teams or counsellors in order to ensure patients were able to make fully informed decisions. We were told the office staff did not disclose any information to parents without an expressed consent from the patient.

We were told the practice policy for consent was available on Intradoc (intranet). This document stated 'written consent is required for procedures which require regional anaesthesia or sedation' i.e. minor surgery'. Staff members told us implied consent was used for all procedures, such as coil insertion and ingrowing toenail surgery. We saw evidence patient's verbal consent was documented in the electronic notes and clearly stated consent was obtained. However no written consent was obtained as outlined in the service's Consent policy.

# Are services effective?

(for example, treatment is effective)

One GP told us they had training to assess mental capacity, but this was some years ago. We were told there was no current system of training or recording of mental capacity assessments, but additional support would be sought from the psychiatrist and crisis team. We saw no records to show practice staff had attended recent Mental Capacity Act training.

## Health promotion and prevention

We noted a culture among staff at the practice to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, sending out an alcohol questionnaire to patients at Christmas, in order to identify rates of alcohol intake. Staff told us they used health promotion at every opportunity through the use of social media, websites and patient leaflets.

The practice told us they had carried out health promotion campaigns such as 'Love Hurts' (STI screening) for Valentine's Day and smoking cessation support for 'stop

smoking day'. The clinicians visited all the halls of residence at the beginning of the academic year in a 'Road Show' to educate the new students about their health at university, the risks of meningitis and how to look out for each other.

The practice had numerous ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, one GP told us about a single point of access for GPs referring people with drug and alcohol problems. They explained they would continue to offer support whilst the patient was waiting to be seen by a specialist team and involve other colleagues as needed. For example involvement of the vulnerable students' team and the halls of residence warden (with the patient's consent).

Similar mechanisms of identifying 'at risk' groups were used for patients with an eating disorder.

The practice offered a full range of immunisations for adults and children and flu vaccinations in line with current national guidance. The practice offered standard GP antenatal care as well as six week baby checks.

# Are services caring?

## Our findings

### **Respect, dignity, compassion and empathy**

We reviewed the most recent data available for the practice about patient satisfaction. This included information from the national patient survey (January 2015), the Friends and Family Test (February 2015), patient feedback on NHS choices and a patient survey which was carried out at the practice in 2014.

The evidence from all these sources showed patients were mostly satisfied with how they were treated which was with compassion, dignity and respect. For example, data from the national patient survey showed the practice 'does best' for waiting times compared to the CCG average. 96% of patients said they waited 15 minutes or less after their appointment time to be seen compared to the CCG average of 63%. The practice was also above the CCG average for its satisfaction scores regarding opening times with 92% of practice respondents saying they were satisfied with the opening hours at the practice.

Other feedback about the service seen on 'i graduate' showed 93% of patients' experienced overall satisfaction with the practice. The NHS choices website reported the service as five stars with many very positive comments about the care and attention received from the service. The 'in house' patient survey reported 73% of patients felt the service had positively impacted their ability to continue their course.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 19 completed cards and the majority were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. Five of the cards had less positive comments regarding the attitude of reception staff when booking appointments. We spoke with a PPG representative who was also a patient at the practice. They told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

Staff and patients told us all consultations and treatments were carried out in the privacy of a consulting room. Disposable curtains were provided in consulting rooms and treatment rooms to ensure patients' privacy and dignity

was maintained during examinations, investigations and treatments. We noted consultation and treatment room doors were closed during consultations and conversations taking place in these rooms could not be overheard.

### **Care planning and involvement in decisions about care and treatment**

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example, data from the national patient survey showed 78% of practice respondents said the GP involved them in care decisions. 94% felt the GP was good at explaining treatment and results. Patients with long term conditions had open access to their 'i-cloud' care plans for long term conditions. The practice held multidisciplinary team meetings to discuss the needs of complex patients, for example vulnerable people.

CQC comment cards told us health issues were discussed with patients and 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 they wished to receive.

Patient feedback from NHS choices mostly reflected these views with patients saying they were treated with dignity and compassion and their worries and concerns were taken into consideration. Less positive comments reflected those from CQC comments cards and commented on the manner and attitude of reception staff and having difficulty booking appointments.

### **Patient/carer support to cope emotionally with care and treatment**

The survey information we reviewed showed most patients were positive about the emotional support provided by the practice and mostly rated it well in this area. For example, a patient who gave feedback on NHS choices said they had received help to access support services to help them manage their treatment and care. Most of the comment cards we received were also consistent with this survey information. For example, these highlighted staff responded compassionately when they needed help and provided support when required.



# Are services responsive to people's needs?

(for example, to feedback?)

## Our findings

### Responding to and meeting people's needs

We found the practice was responsive to patient's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered.

The practice had implemented changes to the way it delivered services in response to feedback from the 2014 patient survey. The action plan highlighted negative findings from patients and action had been put into place as a result. For example, one comment highlighted there was a lack of representation of Chinese students within the PPG. The action plan stated Chinese representatives had been recruited to the PPG.

However the action plans seen did not clearly state the dates and timescales when actions had been completed. The practice told us they had provided training, from an external provider, for the whole team about working with Chinese students and their particular needs.

The practice initiated a vaccine programme of the Meningitis B vaccination of 4000 students (2 doses each) in October/November 2014, with a vaccine, which is not yet available via the NHS, and thus the first place (and so far only) in the UK to provide this specific immunisation to large numbers of the population.

The practice has developed the First Step Eating Disorder service which offers a single point of access where people with an eating disorder can obtain rapid access to assessment and treatment in a familiar environment. This group was offered further support in line with their needs. For example patients followed a pathway where they could see a therapist in the practice who enabled additional access to specialists without needing re-referral.

### Tackling inequity and promoting equality

The practice had access to online and telephone translation services and a GP at the practice spoke two languages. The practice told us documents were available for patients in other languages. The appointments desk was fitted with a hearing induction loop. We saw the self-check in monitor was available in a number of languages.

The practice had recognised the needs of different groups in the planning of its services, such as vulnerable people, people from overseas and people experiencing mental health issues.

The practice wrote a guide specifically for their overseas student population which was also accessible on the practice website. The guide explained the care which can be received via the NHS and how to qualify for NHS treatment. The students' health service guide explained the facilities and support available for people who had disabilities, facilities for nursing mothers and the services provided. The practice website had accessible leaflets in Chinese which explained anxiety, depression and antidepressants.

Staff told us the practice had contributed to initiating a multi-disciplinary meeting every two weeks to identify actions to be taken to support vulnerable students or those at risk, including disabled students. The meetings were designed to highlight a small number of students who were complex in need and often at risk. The meetings were confidential and staff discussed complex cases where multi-disciplinary working was already happening but where patients' needs were reviewed or discussed in order to benefit them. Staff told us the meetings had contributed to the mental health of patients, as well as ensuring appropriate referrals had been made within the University and externally.

The practice worked closely with patients who use the disability unit. Staff told us the practice had provided prompt referrals where they had identified a support need about which the disability unit could offer advice. We were told this close working had increased over the last two years and had meant patients received an integrated approach between the practice and University support.

The premises and services had been adapted to meet the needs of patient with disabilities, such as providing a space at the end of the reception counter for disabled access. All consulting rooms, treatment rooms and waiting rooms were on the ground floor of the premises. We saw the waiting area was large enough to accommodate patients with wheelchairs, prams and allowed for easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice. Couches in the consulting rooms were of adjustable height. We were not shown evidence staff



# Are services responsive to people's needs?

(for example, to feedback?)

members had attended Equality and Diversity training. We did not see any records which demonstrated equality and diversity was regularly discussed at staff appraisal or clinical team meetings within the practice.

## Access to the service

The practice offers extended opening hours until 7.45pm on Mondays and Thursdays. The practice is open on Saturday mornings. The practice had opted out of the requirement to provide out of hour's GP consultations to its own patients and uses the services of an out of hour's service, contracted by Bristol CCG (BrisDoc). The practice website and practice leaflet offers information for patients regarding the out of hour's service, along with a contact telephone number.

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and how to book appointments through the website. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Information about the out of hour's service was provided to patients on the website and in the practice leaflet.

Patients were generally satisfied with the appointments system. They confirmed they could see a doctor on the same day if required. Comments cards received showed patients in need of treatment on the same day had often been able to make appointments on the day of contacting the practice. For example, one patient wrote they had always been able to make appointments at short notice. Less positive comments highlighted difficulties in making

appointments; one patient commented they found it difficult to get an appointment sometimes. Another patient commented they did not feel they should be forced to disclose information over the phone to reception staff.

## Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. There was a designated responsible person who handled all complaints in the practice. We looked at eight complaints received in the last 12 months and found the summary of complaints detailed the actions which had been taken in response to the complaints. The records showed actions had been taken, for example offering an apology to the patient and discussing the complaint with relevant colleagues.

Records identified learning had been implemented in response to complaints, however in some instances there was no record of the outcome for the patient. For example, a complaint was received from a patient who was not satisfied with the time they had waited to be seen for an ankle injury, due to uncertainty of whether they should be treated by a nurse or GP. The practice had offered an apology to the patient. However, there was no information regarding the outcome for the patient, as the record only stated there was a lack of understanding in the patient population regarding the GP triage system.

One record highlighted the need for a customer care training session in the next reception team meeting. We were told two members of office staff had attended customer care training in February 2013 and in October/November 2014. We saw the complaints were summarised on the Intradoc system but there was no outcome for the patient or evidence the practice reviewed complaints annually to detect themes or trends.



# Are services well-led?

Good 

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

## Our findings

### Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. We found details of the vision and practice values were part of the practice's strategy. The practice vision and values included a mission statement along with objectives, such as identifying patient expectations, providing specialist student services and achieving excellence in clinical care.

For example: through raising awareness of young people's health issues in national media, with an article in The Sunday Times Good University Guide 2015. The service also involved the local radio station who attended and broadcast information throughout the eating disorders awareness week run by the service in 2015. This led to the clinical director being appointed to NICE National Eating Disorders Guidelines committee.

We saw there was an organisational structure for the service in which the clinical director was also the register manager to which the doctors, nursing and practice managers reported. The structure was clear however we saw implementation of the roles meant there were some gaps in the effective management of underpinning systems and activities of the service. For example we were told the practice manager does not manage the practice as other practice managers but manages the administrative aspects of the practice. We were told they were not expected to have an overview of the systems and processes of the service as this was the responsibility of the registered manager / clinical director who is very active in leading and developing clinical projects and lobbying parliament for the wellbeing of students.

### Governance arrangements

The practice had a number of policies and procedures in place to govern activity. However, we did not see evidence to demonstrate that a robust policy review system was in place at the practice. We were told there was an automated electronic system which alerted the practice when a policy was due for review. However policies sent as part of the pre-inspection information were not dated or signed for accountability purposes or to ensure the guidance contained therein was reflective of current best practice.

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead nurse for infection control, and lead nurse for asthma and one of the GP's was the lead professional for safeguarding. We spoke with 14 members of staff and they were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

The clinical director/ registered manager told us the practice manager was not part of the leadership role for overseeing the systems in place to monitor the quality of the service were consistently being used and were effective. We were told the practice manager along with the nursing and administrative manager were part of a management team overseen by the clinical director who took the active leadership role for overseeing the systems in the practice.

We were shown the summary of serious adverse events which had occurred in the last 12 months. The information supplied on this record identified a prescribing error as occurring in June 2014, however the clinical director subsequently told us it had occurred in October 2014 and was picked up in January 2015. We were told significant events were reviewed and discussed at a meeting once a term. The clinical director / registered manager told us they may be discussed at the executive team meeting which is held every two weeks. Review of other significant adverse incidents reported showed recording errors and one entry reported a letter had been destroyed. The log of events for the preceding 12 months described learning implemented, however there was no evidence the learning had been reviewed to ensure risk had been minimised.

We were shown the complaint log and saw there had been two complaints regarding poor staff attitude to patients. We asked to see records to show the action taken by the practice to address the complaints. We were told the staff concerned had been spoken with in 1:1 meetings however no written record of the meetings had been made to evidence action taken to minimise risk of repeated actions.

We were told and saw evidence staff received an annual appraisal each year. We were told there were team meetings throughout the year at which practice and process issues were discussed including any new guidance

# Are services well-led?

Good 

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

of which staff were aware. Staff spoken with told us they could speak with their line manager at any time if they had a concern but did not have regular review meetings with managers about their performance throughout the year.

The clinical director/registered manager took the lead for using the Quality and Outcomes Framework to measure the services performance (QOF is a voluntary incentive scheme which financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). The QOF data for this practice seen at inspection, just before the year end, was low and we were told the practice used a catch up system due to the high turnover of patients at the practice. Data for the previous year showed it was performing in line with national standards and QOF indicators were negotiated and adapted for the specialist nature of this service provision. We did not see QOF data was regularly discussed at monthly team meetings.

The practice had an on going programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. The practice told us they valued clinical audit and results were shared via email and team meetings. We were told audits were carried out which were relevant to the local population and had been negotiated with the CCG. They had recently suggested alternative topics for clinical audit, for example substituting a relevant Coeliac care pathway audit for the suggested dementia care pathway audit. The practice told us they aimed to ensure patients benefitted from the audits and care was provided according to nationally recognised evidence based guidelines. We saw evidence of this in the sore throat prescribing audit from 2014.

## Leadership, openness and transparency

The practice had a structure in place for each department to hold regular meetings, usually once a term, to share information and further develop the service. All of the staff we spoke with confirmed they attended these meetings; however, not all meetings were minuted. This meant if some staff were absent information was shared by email however the practice and registered manager had no way of knowing or evidencing staff had read important information and were implementing it for the safe and effective running of the service. Staff told us full practice meetings were held at least once a year.

Staff told us there was an open and honest culture within the practice and they had the opportunity to raise issues at team meetings. Staff told us they had excellent support from their peers and managers. They also spoke about the positive team spirit from being involved in team activities such as the social and money raising events.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies which were in place to support staff. Staff we spoke with knew where to find these policies if required.

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

The practice had gathered feedback from patients through patient surveys, comment cards and complaints received. Following feedback from a transgender patient the practice reviewed and changed the way they recorded 'Title' status on their clinical database so as not to cause embarrassment or distress to the patient when their details were presented on the call screens. This involved a discussion and negotiation with Avon Primary Care Services Authority, as GP to GP Links software made it obligatory that something was entered in this field, and there were limitations to as to what alternatives could be entered. All transgender patients were now given the option of having their Title recorded as 'Mx'.

The practice told us they recognised the young population was comfortable with online and smartphone communication. Therefore, at registration all patients were given the option to sign up for online access to book appointments, request repeat prescriptions and to receive appointment reminders by text. The practice also communicated key health messages via their website, social media page and online blogs.

The practice had an active patient participation group (PPG) which had steadily increased in size. The PPG included representatives from various population groups. We spoke with a patient who was a member of the PPG. They confirmed there were no formal group meetings and contact was made via email. They were able to give examples of how the group was involved in the work of the practice.

For example, they participated in a national conference run by University of Bristol Students Health Service relating to all aspects of student health in July 2014. The students participated in a workshop about caring for international

# Are services well-led?

Good 

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

students. They had also participated in reviewing and responding to surveys for specific issues relating to the practice. An example being, a recent survey was sent to patients asking them about access to appointments. The response of the PPG to the survey led to more evening and weekend appointments which in turn increased accessibility.

## **Management lead through learning and improvement**

Staff told us the practice supported them to maintain their clinical professional development. We looked at staff files and saw an annual appraisal took place which included a personal development plan. Staff told us the practice was supportive of training and their expressed interest relating to training needs was encouraged. Staff felt able to speak with their line managers if they had concerns.

The practice was voted Top in UK 2014 for Sexual Health (Report Card study). They were also Finalists in 'GP Practice of the Year', and 'Innovators of the Year 2013'.

The practice is a level 1 research practice and is involved in five or more research studies. The practice had research accreditation. The practice gave us an example of a study which took place to assess the provision of Cognitive Behavioural Therapy (CBT) as an adjunct to the normal treatment of depression.

The practice had completed reviews of significant events at meetings, which included a discussion of complaints. Records showed an example where actions were taken following a significant event and these were agreed and documented.



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      | Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed<br><br><b>Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 19.2(b)</b><br><br>How the regulation was not being met:<br><br>People who use services and others were not protected against the risks associated with recruitment processes. The provider must evidence they employ 'fit and proper' staff who are able to provide care and treatment appropriate to their role and to enable them to provide the regulated activity. |
| Family planning services                 |  |
| Maternity and midwifery services         |  |
| Surgical procedures                      |  |
| Treatment of disease, disorder or injury |  |