

Hove Park Villas Surgery

Quality Report

The Surgery
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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.

Summary of findings

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Summary of findings

Overall summary

Hove Park Villas Surgery is a GP practice with approximately 4,000 registered patients situated in the Hove area of Brighton. The practice provided a range of services for patients, which included new patient health checks and clinics for family planning and child health. Patients of Hove Park Villas Surgery were signposted to and well supported by local community support groups.

The majority of the patients we spoke with gave positive feedback about the practice and staff. The practice regularly sought feedback from patients. We reviewed the results of feedback taken in May 2014. This showed patients were consistently pleased with the service they had received.

There was an inconsistent approach to safety. The practice had responded to safeguarding concerns and had processes and procedures to keep patients safe. Effective systems were not always in place to ensure patients were protected from the associated risks of infection control and medicines management. Learning from incidents and complaints was limited and not shared widely or recorded appropriately.

The care and treatment patients with long term conditions received was not always supported by effective systems to achieve positive outcomes. Robust monitoring processes, including clinical audit, and continuous improvements were not always followed. There was some evidence of multi-disciplinary working and collaborative care. The practice delivered care and treatment mostly in line with recognised best practice and guidelines.

Patients were treated with dignity and respect. All of the patients we spoke with reported that they felt supported and well cared for. Staff demonstrated a compassionate and caring attitude and had built good relationships with their patients.

The practice had a basic understanding of the different patient groups within the practice and the local Brighton and Hove population and were responsive to their needs. There was good access to appointments for the GP and nurse. Patients were supported to access the right care at the right time.

Overall the practice was not well led. Robust governance systems which ensured the practice continuously improved the quality of their services and safeguarded high standards of care were not clear and had not been reviewed. There was a lack of effective arrangements to systematically identify and manage risk. The approach to service delivery and improvement was focused on the short term.

Hove Park Villas Surgery did not always proactively assess and monitor patient needs for the specific population groups. However, patients in all of these groups were seen by the practice and there was evidence which demonstrated the practice offered appropriate support to patients from some of these groups.

We found that the practice was not meeting three of the essential standards of quality and safety in relation to Assessing and monitoring the quality of service provision; Requirements relating to workers and Supporting workers. We have asked the practice to send us a report, setting out the action they will take to meet these safety standards. We will check to make sure that action is taken.

During our inspection we looked at how well services are provided for specific groups of people and what good care looks like for them. The population groups we reviewed were:

- Older people
- People with long-term conditions
- Mothers, babies, children and young people
- The working-age population and those recently retired
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing a mental health problems

We found the practice provided a responsive service for some patients within each population group.

The Surgery, 18 Hove Park Villas, Hove, East Sussex, BN3 6HG.

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

There was an inconsistent approach to safety. Policies and procedures were in place to protect children and vulnerable adults from the risk of abuse. Learning from some significant events had led to improvements in the safety of the practice. We found that investigations and associated audits relating to the significant events were not always robust or recorded consistently.

There were systems to reduce the risk and spread of infection. However, improvements were needed because patients were not protected against all the risks associated with healthcare associated infections: appropriate arrangements were not in place to monitor the effectiveness of infection control procedures and processes.

Patients were not totally protected against the risks associated with medicines because the practice did not have appropriate arrangements in place for handling and keeping medicines safely. Records were not readily available to show that checks on medication and equipment were always carried out.

Staffing levels and skill mix in the practice were reviewed to keep patients safe. The right staffing levels were mostly maintained to support safe, effective and compassionate care and levels of staff well-being. Records relating to staff recruitment did not meet the essential standards of quality and safety.

Are services effective?

The practice was not always effective. There was inconsistency in the quality of care patients received and outcomes were below the national and clinical commissioning group (CCG) Quality and Outcomes Framework (QOF) results in 2012/13. The QOF was introduced in 2004 as part of the general medical services contract and is a voluntary scheme for GP practices in the UK. Through this scheme the practice was rewarded for how well they cared for patients. The monitoring and management of patient long term conditions was not always assessed appropriately and delivered in line with current guidelines. Results observed from the practice quality and outcomes monitoring system confirmed that practice performance in the management of long term conditions could be improved.

Summary of findings

The practice ensured that all clinical staff received appropriate professional development. We found that non-clinical staff had not received appropriate supervision and an annual appraisal. Staff were not always supported to participate in training that would allow further development to deliver good quality care.

We found that some audits had been undertaken to identify improvements in the services provided for patients. However, clinical audits were not used to effectively assess GP and nursing staff performance. The practice did not proactively use these audits to continuously improve the quality of care and support that patients received.

There was a multi-disciplinary approach to care and treatment. This included evidence of engagement with other health and social care providers and joint working arrangements to support individual patients.

Are services caring?

Patients of the practice were well cared for. Feedback from patients was consistently positive about the way staff interacted with them. Most of the patients we spoke with reported that their choice and preferences were always taken into consideration. We observed patients being treated with dignity and respect. Staff were able to demonstrate how they built positive relationships with patients who used the practice in order to provide individual support.

Are services responsive to people's needs?

The practice was not always responsive to patient needs. They had a basic understanding of the different patient groups within the practice and local Brighton and Hove population. We found that there was a reactive approach to meeting the needs of patients in vulnerable circumstances.

There was good access to appointments for the GP and nurse. Patients were able and supported to access the right care at the right time. The appointment system was easy to use and patients were mostly able to book an appointment or speak with the nurse or GP within 48 hours.

Patients were encouraged and supported to provide feedback or make a complaint about their care. Most of the patients we spoke with told us that they would have no concerns about raising a complaint and felt confident it would be investigated thoroughly. There was no clear reporting and recording system in place to

Summary of findings

monitor complaints or the effectiveness of the investigations or actions taken. We reviewed three complaints and found one had not been responded to in a timely manner or in line with the practice's complaints policy

Are services well-led?

The practice was not well led. Governance arrangements and their purpose had not been reviewed and were unclear. There was a lack of effective arrangements to systematically identify and manage risk. We found that where risks and issues had been identified these were not always dealt with in a timely fashion and lessons were not always learned or robustly documented. The approach to service delivery and improvement was focused on the short term.

Staff did not have clear objectives linked to the practice vision and strategy. A few staff reported that they had not always felt supported and valued. Other staff reported that they were able to communicate with the senior GP in an open, honest and transparent way.

Summary of findings

The six population groups and what we found

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

Older people

Hove Park Villas Surgery had a higher than average number of patients over 65 years compared with Brighton and Hove Clinical Commissioning Group (CCG) and the England average. The practice worked closely with local nursing homes to ensure patients received consistent care from a named GP. Patients of this age group were not always supported to actively manage their long term conditions. Only 58% of patients over 65 years had received an annual influenza vaccine. This was significantly lower than the CCG and England average.

People with long-term conditions

Patients with long term conditions were not always well supported to manage their health, care and treatment. We were unable to evidence whether the practice proactively monitored the prevalence of long term conditions across the practice population. Clinicians in the practice signposted some patients with long term conditions to local community support groups. For example those with alcohol misuse concerns or mental health conditions.

Mothers, babies, children and young people

Hove Park Villas Surgery had higher levels of patients under the age of 18 years than the CCG and England average. The practice supported mothers and children with their health needs and a baby clinic was held on a weekly basis. The practice did not provide midwifery services for their registered patients. However, there was an agreement in place with another local GP practice to provide patients with midwifery and maternity care. The practice had chaperone and safeguarding vulnerable children policies which supported the needs of young patients in the practice.

The working-age population and those recently retired

Access to appointments for this group of patients was limited due to the opening hours of the practice. Further consideration had been given to the provision of extended hours in order to provide working age patients with access to appointments outside of the normal working day. At the time of inspection the provision of additional hours was not possible due to the number of GPs working at the practice. Alternative access to appointments for working age patients was available through telephone consultations.

Summary of findings

People in vulnerable circumstances who may have poor access to primary care

Hove Park Villas Surgery did not always proactively assess and monitor the practice population needs, including patients in vulnerable circumstances. Some patients from this group were supported by the practice and local community groups and services. Patients were able to access the services of the practice without fear of stigma and prejudice.

People experiencing poor mental health

The practice supported services for patients with mental health problems. They worked collaboratively with local specialist organisations to provide support to patients with mental health conditions.

Summary of findings

What people who use the service say

We spoke with 10 patients during the inspection. We also received three comments cards from patients who had visited the practice in the previous two weeks. We also reviewed feedback information from 19 other patients registered with the practice. 100% were very complimentary about the service they had received. Many of the patients reported that staff were caring and they felt well looked after. Patients told us that the staff listened carefully to their concerns and took the time to advise them of treatment options and self-care. Six

patients shared feedback about the reception area not offering privacy and confidentiality. They also told us that the information on the website and answerphone message was out of date.

We looked at the results of the 2013 national GP survey that collected the views of patients who used the practice. 93% of patients rated the practice as good or very good. Feedback left by most patients on the national NHS Choices website also showed a high satisfaction rate with the practice.

Areas for improvement

Action the service **MUST** take to improve

- Review clinical governance processes and procedures to ensure continuous learning and improvement is identified, recorded and actions taken are evaluated.
- Undertake incident, significant event and complaints reviews to evaluate the effectiveness of learning and actions taken.
- Undertake a review of training, supervision and appraisal for all staff.
- Review recruitment and induction procedures to ensure that staff employed are fit and appropriately qualified to provide care and treatment to patients.

- Develop an effective and comprehensive monitoring and risk assessment process to identify, assess and manage the risks relating to the health, safety and welfare of patients and staff.
- Appropriate checks should be undertaken for staff who were trained chaperones within the practice.

Action the service **COULD** take to improve

- Respond to complaints in line with the practice policy and in a timely way.
- Provide clear and up to date information to patients relating to opening hours.
- Consider extended hours provision to further improve the access and appointments availability for the working age population.

Hove Park Villas Surgery

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 CQC inspection manager, a GP specialist advisor, a second CQC inspector and an expert by experience. Experts by experience are members of the inspection team who have received care and experienced treatments from similar services.

Background to Hove Park Villas Surgery

Hove Park Villas Surgery is located in the Hove Park area of Brighton. The practice occupies a house in a residential area and provides reasonable access for patients with a disability and those with pushchairs and young children. This was the first inspection since registration.

Patients were supported by two GPs, a nurse, a phlebotomist (a member of staff who had received specialist training to collect blood from patients), a practice manager and administration staff. The practice was a member of the local Brighton and Hove Clinical Commissioning Group (CCG). The practice population had a lower level of deprivation than the CCG and England average. Consequently, the income deprivation affecting children was also significantly lower than the CCG and England average. In Brighton and Hove the prevalence of smokers in the population and patients with mental health conditions was higher than the England average.

Outside normal surgery hours patients were able to access emergency care from an alternative out of hours provider.

Hove Park Villas Surgery, 18 Hove Park Villas, Hove, East Sussex, BN3 6HG.

Why we carried out this inspection

We inspected this practice as part of our new inspection programme to test our approach going forward. This provider had not been inspected before and that was why we included them.

How we carried out this inspection

Prior to the inspection we contacted the local clinical commissioning group, NHS England area team and Healthwatch to seek their feedback about the service provided by Hove Park Villas Surgery. We also spent time reviewing information that we hold about this practice.

On the day of inspection we spoke with 10 patients and six staff. We also reviewed three comment cards. All had visited the practice in the previous two weeks. We also considered the feedback from 19 other patients who shared their views and experiences.

We carried out an announced visit on 27 May 2014. As part of the inspection we looked at the management records, policies and procedures. We also observed how staff cared for patients and talked with them. We spoke with carers and family members. We interviewed a range of staff including the senior GP partner of the practice, a locum GP, the practice manager, a nurse and administration staff.

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

Detailed findings

- 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
- Mothers, babies, children and young people
- The working-age population and those recently retired
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing a mental health problems

We also spoke with patients who used the service. We observed how people were being cared for and reviewed personal care or treatment records of patients.

Are services safe?

Summary of findings

There was an inconsistent approach to safety. Policies and procedures were in place to protect children and vulnerable adults from the risk of abuse. Learning from some significant events had led to improvements in the safety of the practice. We found that investigations and associated audits relating to the significant events were not always robust or recorded consistently.

There were systems to reduce the risk and spread of infection. However, improvements were needed because patients were not protected against all the risks associated with healthcare associated infections: appropriate arrangements were not in place to monitor the effectiveness of infection control procedures and processes.

Patients were not totally protected against the risks associated with medicines because the practice did not have appropriate arrangements in place for handling and keeping medicines safely. Records were not readily available to show that checks on medication and equipment were always carried out.

Staffing levels and skill mix in the practice were reviewed to keep patients safe. The right staffing levels were mostly maintained to support safe, effective and compassionate care and levels of staff well-being. Records relating to staff recruitment did not meet the essential standards of quality and safety.

Our findings

Learning from incidents

Patients were at risk of not receiving safe quality care and treatment because robust and consistent systems were not in place to learn from significant incidents and improve services. The practice had a significant event policy. We found that some staff were unaware of the policy and recording processes to use when an incident occurred. We saw evidence that two incidents had been recorded since March 2014. The GP and nurse told us about one incident and the subsequent investigations. Learning had been identified and shared with all the staff. However, we found that the learning and actions had not been fully implemented. We noted records of other incidents which were not recorded as having been discussed at practice meetings and therefore there was an increased risk that learning had not always been identified and shared.

Staff reported that incidents were not always identified, recorded, investigated and appropriate action taken. They also reported that learning from incidents was not always discussed at the weekly practice clinical meetings or shared with the wider staff team. One member of staff told us they were wary of raising concerns and issues because they were not always dealt with quickly enough and they did not receive feedback about any action taken. We were unable to evidence that significant events were reviewed regularly at clinical governance meetings to analyse trends. The practice was unable to provide evidence of a complete significant event audit cycle which reviewed the effectiveness of actions implemented after a defined period.

Safeguarding

Children and adults were protected from the risk of abuse, because the practice had taken reasonable steps to identify and prevent abuse from happening. They had systems in place to identify patients who may be at risk. We spoke with the GP safeguarding lead. They described how practice policies and procedures included the early identification of need and help offered from other services. The safeguarding lead also had links with the local authority and clinical commissioning group (CCG) safeguarding teams.

All staff had received an appropriate level of training for protecting vulnerable children and adults. The practice safeguarding policies included information to guide staff.

Are services safe?

These were up to date and available on the practice computer system. We spoke with staff about identifying and preventing abuse. They were able to describe the different types of abuse and the procedure to be followed if they suspected or witnessed any concerns. All staff said they would speak with either the GP safeguarding lead or the practice manager. One member of staff described a situation where they had identified a concern relating to patient. They had reported this to the safeguarding lead which led to action being taken to protect the patient from further risk of abuse. The practice provided safeguarding people from abuse information for patients in the waiting room. This included who they should contact in the event of identifying a concern or to report signs of abuse. There was a practice whistleblowing policy and all staff were able to explain the process of whistleblowing and who they could take their concerns to.

Monitoring safety and responding to risk

The practice was not operating an effective system to minimise the risks to the health, safety and welfare of patients and staff. A robust systematic process for the monitoring of risk was not evident in the practice. We saw a risk assessment for fire safety on the day of inspection. The risk assessment for the control of substances hazardous to health (COSHH) was submitted to CQC after the inspection along with the data sheets for substances and chemicals used in the practice. Staff we spoke with on the day of inspection were not aware of the COSHH principles and impact upon their roles. Risk assessments and audits to monitor and promote safe care in relation to areas such as infection control, cleanliness and maintenance of the facilities; the use and maintenance of equipment and records management were not routinely undertaken.

Patients were protected against the risk of unsafe use and management of medicines because the practice effectively implemented and acted upon all relevant medicine related patient safety communications. Medical safety alerts were received by the senior GP. These were circulated to the partners of the practice, the nurse and practice manager. The alerts were also added to the locum GP pack.

Medicines management

Patients were mostly protected against the risks associated with medicines because the practice had appropriate arrangements in place to manage medicines. There was no one person with responsibility for the management of medicines in the practice. There were up to date medicines

management policies and staff we spoke with were familiar with them. Medicines were kept securely with appropriate staff access. Expiry date checks were undertaken but these had not been recorded consistently to ensure the checks had occurred on a regular basis. The nurse told us that the fridge temperature checks were also undertaken on a daily basis to ensure they were stored at the correct temperatures. We saw the records for these checks. These were inconsistently completed. The practice could not ensure that vaccines had been stored within the minimum and maximum temperatures recommended by the manufacturer, and so potentially they would not be fit for use.

There were equipment bags ready for the doctor to take on home visits. The nurse told us the bags were checked to ensure the contents were intact and in date by the GP. They were unable to provide evidence of these checks. Any medicine related issues were reported by the nurse to the practice manager and GP. These were discussed at weekly clinical meetings. There were standard operating procedures (SOP) for using certain drugs and equipment.

Cleanliness and infection control

Systems were in place which mostly reduced the risk and spread of infection. However, the practice had not ensured that their processes and procedures were in line with the requirements outlined in the Department of Health publication, 'The Code of Practice for health and adult social care on the prevention and control of infections and related guidance'. The practice had an infection control lead who showed us copies of infection control policies and procedures. We noted these were not the same documents as those provided by the practice manager. This presented an increased risk to patients because staff could be following inconsistent guidance and processes. Infection control audits had not been routinely completed. However, we noted an infection control audit had been completed in May 2014, after the announcement of the CQC inspection and corrective action taken. We spoke with a practice nurse about infection control training. Staff told us that they had received hand washing training. However, there were no records to support this and on going annual training had not been planned for or undertaken. Hand washing guidance was available above all of the sinks in the treatment rooms and toilets. There were soap and hand towels at every sink throughout the practice. Staff had a good supply of gloves and other personal protective equipment and knew when they should be used.

Are services safe?

The treatment and consulting rooms had clutter free work surfaces, which were easy to clean. Furniture and seating within the waiting room was well maintained and the chairs were made of an impermeable and wipe clean material. Patients were mostly cared for in clean and hygienic environment. We noted that all areas of the practice were visibly clean and tidy. We reviewed the cleaning contract and procedures used within the practice and found them to be mostly in line with the code of practice. We noted that there was a cleaning schedule for staff to follow. However, cleaning products for use in different areas of the building were not described in the schedule to ensure clinical and non-clinical areas were appropriately cleaned by staff. We asked to see copies of the cleaning monitoring records. There were checks available for the nurse's treatment room and toilet but no other areas of the building. The nurse told us they checked the cleaning of the practice on the three days they worked. There were no records of these checks or any others completed when the nurse was not working in the practice. We spoke with patients about the cleanliness of the practice. All of them told us that they were happy with the standards of hygiene and felt the practice was always clean and tidy.

Staffing and recruitment

Effective recruitment and selection processes were not in place. The practice manager told us about the pre-employment or pre-registration checks that were completed before staff and GPs were allowed to work for the practice. This was to ensure that staff were of good character, and were appropriately qualified and fit for work. We spoke with the newest member of staff who told us about the checks the practice manager had completed at the start of their employment.

We reviewed the practice recruitment policy. We found that the practice had not always followed their own recruitment policy which included carrying out appropriate checks on staff before they began employment and recording this information appropriately. We reviewed five of the staff files. We found that the information and records required in accordance with Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) were not always in place. For example the photographic identity of all applicants, a full previous employment history and documentary evidence of qualifications were not recorded in the staff files. Information within the staff files was inconsistent. We found most files did not include copies

of the interview notes, a curriculum vitae or application form, copies of references taken, an occupational health check, an induction checklist and evidence of a Disclosure and Barring Service (DBS) check as appropriate. We spoke with the practice manager about the lack of DBS checks. They told us that they had not risk assessed which non-clinical staff required a DBS check. This included staff who had been trained to undertake chaperone duties to support patients.

The practice had made efforts to ensure there were enough qualified, skilled and experienced staff to meet patients needs. The practice management team were aware of the need for succession planning in order to manage staff retirement in the short to medium term. The practice had a low staff turnover and the majority of practice staff worked part time which allowed for some flexibility in the way the practice was managed. For example, covering annual leave and sickness absence. We spoke with the practice nurse who told us their annual leave was mostly covered by a locum nurse to ensure the levels of service remained consistent for patients. One of the GP partners was currently on maternity leave. The practice had made arrangements to cover these hours using a regular locum who knew the practice. This ensured consistency for patients. The practice manager told us they had recruited two new locums to cover the maternity absence as a job share for the longer term. This offered more flexibility to the practice and allowed for increased capacity to react to changes in service levels or demand. The practice manager told us about a staffing needs analysis that had been undertaken. We asked to see the actions identified from this analysis and which had been implemented. The practice manager told us that no changes had been initiated as a result of the analysis.

Dealing with Emergencies

The practice had a business continuity plan in place to deal with emergencies that might interrupt the smooth running of the practice. This ensured that a satisfactory level of service to patients would be maintained and disruption kept to a minimum. Appropriate equipment, drugs and oxygen were available to support patients in a medical emergency. The equipment was checked regularly to ensure it was in working condition. We saw evidence of these checks.

Are services safe?

Equipment

The practice mostly had systems in place to monitor the safety and effectiveness of equipment. Checks were performed on oxygen cylinders and fire extinguishers. We saw all portable appliance testing, water safety, fire safety

and other equipment checks had been undertaken with appropriate certification and validation checks in place. We saw evidence that repairs had been identified and were being actioned.

Are services effective?

(for example, treatment is effective)

Summary of findings

The practice was not always effective. There was inconsistency in the quality of care patients received and outcomes were below the national and clinical commissioning group (CCG) Quality and Outcomes Framework (QOF) results in 2012/13. The QOF was introduced in 2004 as part of the general medical services contract and is a voluntary scheme for GP practices in the UK. Through this scheme the practice was rewarded for how well they cared for patients. The monitoring and management of patient long term conditions was not always assessed appropriately and delivered in line with current guidelines. Results observed from the practice quality and outcomes monitoring system confirmed that practice performance in the management of long term conditions could be improved.

The practice ensured that all clinical staff received appropriate professional development. We found that non-clinical staff had not received appropriate supervision and an annual appraisal. Staff were not always supported to participate in training that would allow further development to allow them to deliver good quality care.

We found that some audits had been undertaken to identify improvements in the services provided for patients. However, clinical audits were not used to effectively assess GP and nursing staff performance. The practice did not proactively use these audits to continuously improve the quality of care and support that patients received.

There was a multi-disciplinary approach to care and treatment. This included evidence of engagement with other health and social care providers and joint working arrangements to support individual patients.

Our findings

Promoting best practice

Care and treatment was delivered in line with recognised best practice standards and guidelines. The practice kept up to date with new guidance, legislation and regulations. Clinicians followed the relevant National Institute for Health and Care Excellence (NICE) guidelines.

Patients may be at risk of receiving inappropriate care and treatment because not all clinical staff had a sound understanding of the MCA, which would enable them to identify and support patients who lacked the capacity to make an informed decision. The practice had a Mental Capacity Act 2005 (MCA) policy. This included the principles of the MCA and also how to conduct an appropriate assessment. We noted MCA guidance displayed in the practice for staff to follow. Staff we spoke with were able to describe the basic principles of the MCA and how this impacted upon their role and interaction with patients. We spoke with the nurse who was unclear about the principles of the MCA and how this impacted upon her role and the care and treatment of patients.

Management, monitoring and improving outcomes for people

The practice did not always ensure effective monitoring of clinical performance or that adequate service provision of was in place to support patients. The practice participated in national and local health management programmes which rewarded them for how well they care for patients. This includes Quality and Outcomes Framework (QOF), local and direct enhanced services. The QOF is part of the General Medical Services (GMS) contract for general practices. It is a voluntary incentive scheme which rewards practices for how well they care for patients. The 2013/14 QOF data showed the practice had improved their achievement in the management of some long term conditions from 2012/13. We spoke with the senior GP of the practice who reported that the lower achievement in 2012/13 was due to the absence of another partner and a locum who did not have an interest in the practice's QOF achievement and recording the care and treatment appropriately on the practice system. They explained that work had been undertaken to improve these results further. We also noted that the practice had clinical templates and protocols to share with locum GPs around the

Are services effective?

(for example, treatment is effective)

management of QOF and patient long term conditions. However, these were not always effectively used by the locum GP or monitored by the practice to ensure consistent recording of clinical data on the practice system.

The long term health outcomes of patients may be at risk because the routine monitoring of individual medical conditions was not always undertaken and information was not used to understand and ensure the quality of services provided. The practice was not proactive in monitoring the quality of care provided and did not always identify and learn continuously from poor clinical performance. The senior GP acknowledged this. Some monitoring of data was used to improve performance and clinical outcomes for patients. Clinical audits had been undertaken and actions taken to address poor performing clinical indicators. For example an audit had been undertaken to identify patients who used specific medications and did not have an appropriate monitoring blood test recorded on the computer system. The review highlighted that 20% of patients had not received the test and these were overdue. The practice took action to invite these patients to attend the practice for the blood test. The audit was still being completed at the time of inspection so were unable to measure the effectiveness of the action taken.

In another example the practice had identified that the results relating to the screening and management of diabetes indicators in QOF were much lower than the CCG and England average. The senior GP identified that lower achievement was partly due to the recording of this activity being incorrect on the practice system. We noted action had been taken to correct this. For those patients on the diabetes register, an alert had also been placed on their computerised record to remind clinicians of the overdue checks and to increase opportunistic interventions when patients come in to the practice for other appointments.

Staffing

Staff told us they had received an induction at the start of their employment to ensure they were familiar with the practice procedures. Locum GPs also received training and a comprehensive induction pack when first working at the practice. We saw evidence of this. Staff reported they had received training in infection control, fire safety and

safeguarding during the induction period. The nurse told us the induction process and checklist had been reviewed in the previous 12 months. We saw evidence of induction training within some of the staff files we reviewed.

There was no effective system of clinical governance and audit to evaluate the performance of all individual members of staff in order to improve the quality of service provided. Non clinical staff had not received regular appraisals in the previous five years. The nurse told us that they had received an appraisal in the last year but this had not been recorded or actions taken. They explained that they did not have regular supervision meetings with the GP but they were able to speak with them informally at any time. We noted that the GP had received an appraisal and completed their revalidation in March 2013. Revalidation is a process by which doctors demonstrate at regular five-yearly intervals that they are up-to-date and fit to practise.

Staff were supported to participate in training. However, we found there were limitations which did not always allow them to develop further knowledge, skills and experience to enable them to deliver good quality care. We found the GP had undertaken safeguarding and Mental Capacity Act (MCA) training in the previous 12 months. Other clinical staff had been supported to undertake some further training to develop their role and maintain continued professional development. Non-clinical staff had received training in basic life support and dealing with difficult patients. A recent staff meeting had been held for all staff. During this meeting they received MCA and safeguarding training and an infection control update. Staff we spoke with told us that access to training was limited due to the low levels of staff and ability to release them for training.

Working with other services

Multidisciplinary working and collaborative approaches to care were in place for patients in vulnerable circumstances. The practice attended three monthly integrated primary care meetings to discuss patients at risk and how the practice could work with other community services to support patient care and treatment. For example, patients who were reaching the end of their life were reviewed to ensure all relevant nursing, carer and emotional support was in place for themselves and their family. The senior GP and practice manager also attended a two monthly CCG meeting.

Are services effective?

(for example, treatment is effective)

Health, promotion and prevention

Suitable information was available to patients which informed them of medical conditions, self-help and access support from other services. The practice displayed health promotion leaflets in the waiting room and on the

reception area television screen. The Hove Park Villas Surgery website also contained links to other webpages which provided advice and support for health and well-being.

Are services caring?

Summary of findings

Patients of the practice were well cared for. Feedback from patients was consistently positive about the way staff interacted with them. Most of the patients we spoke with reported that their choice and preferences were always taken into consideration. We observed patients being treated with dignity and respect. Staff were able to demonstrate how they built positive relationships with patients who used the practice in order to provide individual support.

Our findings

Respect, dignity, compassion and empathy

Patients privacy, dignity and independence were respected. GPs and staff had received training in patient confidentiality and had signed agreements. We observed them taking care to protect patient privacy and to keep information about patients confidential and secure. However, the practice reception and waiting area were open plan and reception staff could be overheard by patients in the waiting room when talking to other patients in the surgery or over the phone. Patients who required privacy when attending the practice were invited to wait in a private room, if available. The staff we spoke demonstrated excellent patient care during the inspection. The senior GPs aims and objectives emphasised a caring approach and this was supported by caring staff.

Patient information about records and information was displayed in the waiting room. This explained what information the practice held about them, how that information was used, and how patients could access their records.

Before the inspection took place we asked patients who used the practice to complete comment cards regarding the care and treatment they had received. We received three completed cards. The practice manager had also asked a number of patients for feedback via email. We received responses from 19 patients. All of the comments were positive and demonstrated that patients were extremely satisfied with the care they had received. Six of the patients we spoke with shared feedback about the reception area not offering privacy and confidentiality. They also told us that the information on the website and answerphone message was out of date.

We looked at the results of the 2013 national GP survey that collected the views of patients who used the practice. Patients were positive about the service they received. 90% of patients rated the practice as good or very good. 87% of patients would recommend Hove Villas Park Surgery to their friends and families. 85% of patients rated their experience of making an appointment as good or very good.

Involvement in decisions and consent

We spoke with 10 patients on the day of inspection. The majority of patients told us they felt they had been listened

Are services caring?

to and that their treatment and care met their needs. We also received comments about the friendliness and helpfulness of staff and GPs. Patients were invited to share feedback with the practice by filing in forms displayed in the reception area. We observed staff attending to patients in reception and on the phone to be respectful, friendly and caring.

Patients were offered a choice of GP when booking appointments. The majority of patients we spoke with were able to see the same GP at each appointment. The second GP partner of the practice was on maternity leave. We heard reception staff explaining this to patients who were offered a choice of appointment with the locum GP or senior GP at the time of booking.

All the patients we spoke with said they had enough time during the consultation to be involved in decisions about their treatment. The GP was aware of what action to take if

they judged a patient to lack capacity to give their consent. They told us they recorded best interest decisions, consulted carers with legal authority to make healthcare decisions and sought specialist advice if needed

Consent was not consistently recorded to enable clinicians to undertake informed reviews with patients during their future treatment or care. We asked the senior GP and practice nurse about the recording of consent. The GP told us that they recorded consent in the patient notes but they could not be certain that the nurse and other GPs did the same. The nurse told us that they tried to remember to record consent in the free text area of the patient electronic notes. They explained that used consent templates at another practice and had asked the GP if these could be used at Hope Park Villas Surgery. The templates had not been implemented at the time of the inspection.

Are services responsive to people's needs?

(for example, to feedback?)

Summary of findings

The practice was not always responsive to patient needs. They had a basic understanding of the different patient groups within the practice and local Brighton and Hove population. We found that there was a reactive approach to meeting the needs of patients in vulnerable circumstances.

There was good access to appointments for the GP and nurse. Patients were able and supported to access the right care at the right time. The appointment system was easy to use and patients were mostly able to book an appointment or speak with the nurse or GP within 48 hours.

Patients were encouraged and supported to provide feedback or make a complaint about their care. Most of the patients we spoke with told us that they would have no concerns about raising a complaint and felt confident it would be investigated thoroughly. There was no clear reporting and recording system in place to monitor complaints or the effectiveness of the investigations or actions taken. We reviewed three complaints and found one had not been responded to in a timely manner or in line with the practice's complaints policy.

Our findings

Responding to and meeting people's needs

There were some gaps in how well the practice understood the needs of different groups. At the time of our inspection Brighton and Hove had some of the highest prevalence rates for patients with mental health needs. The practice had developed local arrangements with support services for patients with mental health conditions. The practice held Flu clinics from September and offered blocked appointments for local learning disability care homes to bring residents all at the same time in order to reduce their waiting times. However, the practice had not always considered the wider population of Brighton and Hove and how they would provide services for patients from those groups who may need access to primary care services. For example, the practice had not considered how they would register a homeless person of no fixed abode. We spoke with the practice manager about this. They told us they would probably refer the patient to a local walk in centre providing GP services.

The practice had improved accessibility to patients with mobility difficulties by adding an access ramp to the front door of the building. For example, patients using wheelchairs or patients with pushchairs and young children. The practice was located on one level and treatment and consultation rooms were on the ground floor and accessible from the waiting room. Toilet facilities were available for all patients of the practice.

The practice manager told us patients who had a hearing impairment were offered the services of a sign language support team. They also explained that patients who could not speak English often attended with a companion who acted as a translator. The practice also had access to a telephone interpreting service to ensure all patient needs were met appropriately.

At the time of inspection the practice did not have a functioning patient participation group (PPG). A PPG is a group of patients registered with the surgery who have an interest in the services provided. The aim of the PPG is to represent patient views, to work in partnership with the surgery and to improve the services patients receive. However, the practice manager had developed a virtual group of patients to seek feedback from. The practice manager had sent emails to the virtual group in May 2014 to establish whether they would like to be part of a PPG.

Are services responsive to people's needs?

(for example, to feedback?)

Access to the service

There were a range of appointments available to patients every day between the hours of 9am-1pm and 3pm-6pm. This included urgent and routine appointments, telephone consultations and appointments with the nurse three days per week. We noted that the practice website and NHS Choices website advised that the practice was open and appointments were available from 8.30am. On the day of inspection the practice opened at 9am. The practice manager told us the practice opened from 9am. The inaccuracy of information may cause confusion to patients. The practice had considered extended hours provision to improve the service available to patients of working age. We were told by the practice manager that the practice was unable to provide extended hours appointments to patients due to Hove Park Villas Surgery being a small practice and having a low number of GPs.

Patients we spoke with on the day of inspection were able to access an appointment with the GP normally within 48 hours. We spoke with reception staff about accessing appointments. We asked when the next available appointment was available with a named GP or any GP. The first routine appointment available was available on the following day. Patients could book an urgent appointment or receive telephone advice on the day of inspection. We asked about availability for a blood test and the first available appointment time was six days later. Appointments with the nurse were available three weeks later due to annual leave. The practice had made

alternative nursing provision for patients to attend a local emergency clinic for dressing changes or wound care during this time. Patients could also attend another local surgery for specific nurse treatments.

Concerns and complaints

Patients we spoke with felt their comments and complaints would be listened to and acted on, without the fear that they would be discriminated against. The practice had a complaints policy and procedure and this was displayed on the notice board in the waiting area, in a patient information leaflet and on the practice website. Staff we spoke with were aware of the complaints process and told us how they would support a patient wishing to make a comment or complaint. The practice survey indicated a high level of satisfaction with the service, resulting in very few complaints being made.

The practice took account of complaints and comments to improve the service but these were narrowly focussed and learning was not widely disseminated. We noted that patient complaints were mostly investigated and resolved. We looked at the complaints records and responses to patients. The practice had not always investigated the concerns and responded in accordance with their complaints policy. We were unable to evidence a robust complaints log and found learning points and actions were not always discussed at practice meetings and recorded. Staff reported that the practice manager did not always ensure that complaints were responded to and actions were completed in a timely manner.

Are services well-led?

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

Summary of findings

The practice was not well led. Governance arrangements and their purpose had not been reviewed and were unclear. There was a lack of effective arrangements to systematically identify and manage risk. We found that where risks and issues had been identified these were not always dealt with in a timely fashion and lessons were not always learned or robustly documented. The approach to service delivery and improvement was focused on the short term.

Staff did not have clear objectives linked to the practice vision and strategy. A few staff reported that they had not always felt supported and valued. Other staff reported that they were able to communicate with the senior GP in an open, honest and transparent way.

Our findings

Leadership and culture

There was no clear leadership within the practice that ensured the vision and short term strategy was embedded throughout the organisation. The vision was clear to the senior GP and practice manager who had considered the succession planning for staff nearing retirement. We were unable to clearly identify the leadership priorities and goals. The practice was able to demonstrate a degree of team working and mostly operated in an open and transparent way.

The senior GP and practice manager described a short term vision and strategy to deliver high quality care and expand the practice. Staff were focussed on providing a caring service to patients. All of the staff we spoke with on the day of inspection knew of their responsibility and influence to provide high quality care but were unaware of the vision to expand the practice.

Governance arrangements

Non clinical staff were sometimes unclear of their area of responsibility and who to approach for advice. For example, some of the reception team reported that were often left to manage themselves and operational issues that arose. The senior GP, nurse and practice manager told us that regular management and clinical meetings were held but we were unable to evidence the minutes of the meetings on the day of inspection. The practice manager told us that the minutes of the meetings were hand written in a note book. They were unable to access these and subsequently submitted information for CQC to review. The information received was limited and meant we were unable to establish what was discussed at each clinical meeting. The practice had not used these notes to clearly establish what was agreed and actions taken during these meetings. Therefore actions were not always identified and taken to ensure improvements in the quality of care provided to patients.

We reviewed a number of policies and procedures on the day of inspection. We noted from the computer audit records that these had been created within the previous two weeks. Staff reported that many of the practice policies had been implemented in the previous two weeks and had not been reviewed since 2008. We were given evidence to

Are services well-led?

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

support this. The new policies were updated and accessible via the practice computer system. However, it was too early to assess the effectiveness of the new practice policies and procedures.

Systems to monitor and improve quality and improvement

There was a reactive approach to service delivery and improvements were focused on the short term. Although the practice achieved lower Quality and Outcomes Framework (QOF) results in 2012/13 for the quality and productivity domain we noted that these had improved in 2013/14. We spoke with the senior GP of the practice who reported that the lower achievement was due to the absence of another GP partner and a locum who did not have an interest in the practice's QOF achievement. They also explained the clinicians had not always recorded patients care and treatment appropriately on the practice system. We asked the senior GP about staff provision to support the future improvements in clinical performance. They told us that they felt under pressure with the additional workload and had not always been proactive in managing the lower achievement in QOF and monitoring the quality of care.

The practice had reviewed its data on emergency admissions and accident and emergency (A&E) attendance, participated in external peer review and implemented a plan to reduce avoidable A&E attendance. For example the practice had referred patients to the falls clinic and undertook a review to identify further support from a befriending service.

Patient experience and involvement

Patients who used the practice and their representatives were asked for their views about their care and treatment and they were acted on. The practice had actively sought feedback from patients who used the service in a variety of ways. The practice results for the national GP patient survey, conducted in 2013, were higher than the clinical commissioning group (CCG) and national average. Patients of the practice reported high levels of satisfaction with their involvement in their care and treatment.

Staff engagement and involvement

Staff were able to raise concerns and issues with the senior GP and they were visible in the practice. The reception staff felt very well supported by the GP and their immediate team. Some staff reported that they felt wary of making suggestions or raising concerns with the practice manager because previous issues had not always been actioned or responded to in a timely manner. Staff sometimes felt unsupported by the practice manager as they were not always at the practice and could not be easily contacted.

Formal communication processes such as appraisal and staff meetings for non-clinical staff were not regularly held or appropriate records kept. Staff reported attending staff meetings in the past with no formal agenda or minutes of the discussions. They also reported that information was not shared with them if they had been unable to attend the meetings. A few staff did not feel totally supported and valued in their roles.

Learning and improvement

The practice did not continuously strive to learn and improve high standards of care. All staff had recently received mandatory training basic life support and safeguarding. The practice had not undertaken a training review to identify future training for staff. There was no system for recording mandatory training or monitoring systems to identify when staff were due for an update. Clinical staff had opportunities to attend professional development training but these were limited due to the low levels of staff and ability to release them for training. The nurse told us they did not feel that the practice appraisal system was a meaningful and effective process for recognising achievements and looking forward in terms of individual development.

Identification and management of risk

The practice had carried out some risk assessments. However, there were no effective arrangements to systematically identify and manage risks relating to the environment and the health and safety of patients, visitors and staff members. For example, the practice had not undertaken routine risk assessments in relation to infection control or the cleanliness and maintenance of the building.

Older people

All people in the practice population who are aged 75 and over. This includes those who have good health and those who may have one or more long-term conditions, both physical and mental.

Summary of findings

Hove Park Villas Surgery had a higher than average number of patients over 65 years compared with Brighton and Hove Clinical Commissioning Group (CCG) and the England average. The practice worked closely with local nursing homes to ensure patients received consistent care from a named GP. Patients of this age group were not always supported to actively manage their long term conditions. Only 58% of patients over 65 years had received an annual influenza vaccine. This was significantly lower than the CCG and England average.

Our findings

Patients over the age of 75 years had a named GP to ensure they received consistent care from the practice. Patients over the age of 65 years were not all routinely offered an influenza vaccination to keep them safe from illness in the winter months.

Elderly patients with long term conditions were not always supported to manage their medical conditions effectively. The monitoring and review of patients was not routinely undertaken which meant patients may be at risk of longer term poor health outcomes.

The practice monitored and reviewed accident and emergency attendance for this group of patients to ensure they had and were offering the right support to these patients.

Patients identified as carers were offered additional support from practice and the local carers centre.

Care and treatment received for patients at the end of their lives was multi-disciplinary and collaborative working with community support teams was evident.

The practice did not proactively monitor prevalence or clinical performance in relation to all long term medical conditions and patients may be at risk of longer term poor health outcomes.

People with long term conditions

People with long term conditions are those with on-going health problems that cannot be cured. These problems can be managed with medication and other therapies. Examples of long term conditions are diabetes, dementia, CVD, musculoskeletal conditions and COPD (this list is not exhaustive).

Summary of findings

Patients with long term conditions were not always well supported to manage their health, care and treatment. We were unable to evidence whether the practice proactively monitored the prevalence of long term conditions across the practice population. Clinicians in the practice signposted some patients with long term conditions to local community support groups. For example those with alcohol misuse concerns or mental health conditions.

Our findings

Some patient annual reviews had been undertaken in a timely way to ensure long term conditions were monitored and managed in line with best practice and national guidance.

Care reviews involving the patient and their carers were undertaken. For example, learning disability health checks were regularly completed.

Most of the patients we spoke with who had long term conditions told us that their care and treatment was good. Other patients reported that they were not always invited for their annual checks.

Staff understood the needs of patients and were able to respond to these. Health promotion advice and information relating to specific health conditions was available in the waiting room of the practice. This included advice on self-management. Clinicians in the practice also signposted patients with long term conditions to local support groups.

We saw evidence that the practice undertook a limited number of audits to improve outcomes for patients with long term conditions. The results were reviewed against national and local data to determine changes that could be made to care and treatment.

Mothers, babies, children and young people

This group includes mothers, babies, children and young people. For mothers, this will include pre-natal care and advice. For children and young people we will use the legal definition of a child, which includes young people up to the age of 19 years old.

Summary of findings

Some patient annual reviews had been undertaken in a timely way to ensure long term conditions were monitored and managed in line with best practice and national guidance.

Care reviews involving the patient and their carers were undertaken. For example, learning disability health checks were regularly completed.

Most of the patients we spoke with who had long term conditions told us that their care and treatment was good. Other patients reported that they were not always invited for their annual checks.

Staff understood the needs of patients and were able to respond to these. Health promotion advice and information relating to specific health conditions was available in the waiting room of the practice. This included advice on self-management. Clinicians in the practice also signposted patients with long term conditions to local support groups.

We saw evidence that the practice undertook a limited number of audits to improve outcomes for patients with long term conditions. The results were reviewed against national and local data to determine changes that could be made to care and treatment.

Our findings

Safeguarding children and adults was important to the practice. There was a safeguarding lead who described how practice policies and procedures included the early identification of need and early help offered with other services. Information about patients identified at risk or families with concerns was reviewed and discussed at practice meetings.

Children and young patients were treated in an age appropriate way. The practice consent policy offered advice and guidance in relation to obtaining consent from children who had the capacity to make informed decisions about their care and treatment.

Vulnerable patients or anyone who required support during their consultations with a clinician could be supported by trained chaperones, in line with their local policy.

The practice held a weekly baby clinic which provided primary and pre-school vaccinations and health promotion advice.

GPs worked with midwives and health visitors to support pregnant women and families with young children. The practice had a system in place to follow up when immunisations and child health check appointments were missed.

Working age people (and those recently retired)

This group includes people above the age of 19 and those up to the age of 74. We have included people aged between 16 and 19 in the children group, rather than in the working age category.

Summary of findings

Access to appointments for this group of patients was limited due to the opening hours of the practice. Further consideration had been given to the provision of extended hours in order to provide working age patients with access to appointments outside of the normal working day. At the time of inspection the provision of additional hours was not possible due to the number of GPs working at the practice. Alternative access to appointments for working age patients was available through telephone consultations.

Our findings

The practice had a range of appointments between 9am and 6pm Monday to Friday. This included on the day appointments and telephone consultations. Alternative systems had been introduced to allow all patients who were unable to attend the practice due to work commitments to book appointments and order their prescriptions online.

People in vulnerable circumstances who may have poor access to primary care

There are a number of different groups of people included here. These are people who live in particular circumstances which make them vulnerable and may also make it harder for them to access primary care. This includes gypsies, travellers, homeless people, vulnerable migrants, sex workers, people with learning disabilities (this is not an exhaustive list).

Summary of findings

Hove Park Villas Surgery did not always proactively assess and monitor the practice population needs, including patients in vulnerable circumstances. Some patients from this group were supported by the practice and local community groups and services. Patients were able to access the services of the practice without fear of stigma and prejudice.

Our findings

Safeguarding children and adults was important to the practice. There was a safeguarding lead who described how practice policies and procedures included the early identification of need and early help offered with other services.

Patients with a learning disability were well supported by staff in the practice. This included block booking flu clinic appointments for patients from local care homes so they could all be brought to the practice together. The practice also provided a chaperone service.

Carers of patients from the practice were offered support packs. These included information about additional support they could access from the practice or within the community. Practice staff were able to signpost patients to a local carers centre.

The practice did not proactively identify their population needs for patients in vulnerable circumstances. For example, the practice had not considered how they would treat and register patients with no fixed address. Patients whose language was not English were supported by the practice. Patients and staff could arrange support from a local translation service or signing support group. This ensured clinicians were able to identify the concerns and provide suitable support and treatment.

There were robust safeguarding policies and procedures for protecting vulnerable adults and children from abuse. The safeguarding lead had excellent links with local authority safeguarding team and CCG lead.

People experiencing poor mental health

This group includes those across the spectrum of people experiencing poor mental health. This may range from depression including post natal depression to severe mental illnesses such as schizophrenia.

Summary of findings

The practice supports services for patients with mental health problems. They worked collaboratively with local specialist organisations to provide support to patients with mental health conditions.

Our findings

Safeguarding children and adults was important to the practice. There was a safeguarding lead who described how practice policies and procedures included the early identification of need and early help offered with other services.

Patients with mental health conditions were supported by the practice and local community services and groups. For example, the practice worked closely with local mental health support workers to ensure patients with a mental health condition were supported appropriately in the community.

There was evidence that support for patients with mental health needs was individual to their circumstances. For example, patients had individual care and treatment plans.

Multi-disciplinary meetings were held with external organisations and services to support patients with mental health needs.

There was no effective monitoring of care and treatment outcomes for patients with mental health conditions. The monitoring and review of clinical performance for patients was not routinely undertaken which meant patients may be at risk of longer term poor health outcomes.

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and Monitoring the Quality of Service provision. How the regulation was not being met: The practice failed to protect service users and others who may be at risk of inappropriate, unsafe care and treatment, by means of regularly assessing and monitoring the quality of services provided. They also failed to ensure effective systems were in place to identify, assess and manage risks relating to the health, welfare and safety of service users and others. Regulation 10 (1) (a) and (b). The practice failed to have regard to the complaints and comments made by service users. Regulation (2) (b) (i). The practice failed to, where necessary, make changes to the treatment or care provided relating to the analysis of incidents that resulted in, or had the potential to result in, harm to a service user. Regulation 10 (2)(c)(i).
Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers. How the regulation was not being met: The practice failed to ensure that information specified in Schedule 3 was available in respect of a person employed for the purposes of carrying out the regulated activity, and such other information as appropriate. Regulation 21 (b).
Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting Workers.

This section is primarily information for the provider

Compliance actions

How the regulation was not being met: The practice failed to have suitable arrangements in place to ensure the persons employed for the purposes of carrying on regulated activity were appropriately supported. By means of receiving appropriate training or appraisal.

The practice also failed to ensure appropriate clinical governance and audits were undertaken to monitor the individual performance of staff in order to evaluate and improve the quality of services provided. Regulation 23 (1) (a) and 3 (a)