

The New City Medical Group

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?		Good	
Are services effective?		Requires improvement	
Are services caring?		Good	
Are services responsive to people's needs?		Good	
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 New City Medical Group on 13 September 2016.

Overall, the practice is rated as good.

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

- There was an open and transparent approach to safety and an effective system for reporting and recording significant events. The staff team took the opportunity to learn from internal and external incidents.
- Services were tailored to meet the individual needs of patients and were delivered in a way that ensured flexibility, choice and continuity of care.
- Data from the NHS National GP Patient Survey of the practice, published in July 2016, showed patient satisfaction levels with the quality of GP and nurse consultations, and their involvement in decision making, were good.

- Most risks to patients' safety were effectively managed; however, some risks had not been appropriately assessed, or timely action taken to mitigate identified risks.
- Staff assessed patients' needs and delivered care in line with current evidence based guidance.
- Clinical staff had the skills, knowledge and experience to deliver effective care and treatment. However, the arrangements for supporting staff to complete all of the training the GP provider considered to be mandatory, were not always effective. For example, insufficient protected learning time had been allocated to ensure all staff were able to complete their mandatory training and, because of this, some staff had not completed all of the training they needed to safely carry out their role.
- The practice worked closely with other organisations, when planning how services were provided, to ensure patients' needs were met.

Summary of findings

- There was a strong, visible, patient-centred culture. Patients said they were treated with compassion, dignity and respect and that they were involved in decisions about their treatment.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- Clinical leadership encouraged openness and transparency, and promoted a culture where staff felt well supported.

The areas where the provider must make improvements are:

- Persons employed by the provider in the provision of a regulated activity must receive appropriate training as is necessary to enable them to carry out the duties they are employed to perform.

However, there were also areas where the provider needs to make improvements. The provider should:

- Carry out a recorded risk assessment in relation to any decision made not to obtain a Disclosure and Barring Service check for staff appointed to a particular post.
- Prepare a development plan which clearly sets out how the GP provider intends to enact their vision and strategy.
- Carry out an annual comprehensive infection control audit.
- Hold regular clinical meetings, and ensure they are minuted.
- Develop a planned, structured approach to carrying out clinical audits.

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 good for providing safe services.

Good



- There was an effective system for reporting and recording significant events. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned when things went wrong and shared with staff to support improvement.
- The system for dealing with safety alerts and sharing these with staff was usually effective.
- Overall, there were appropriate systems and processes in place to keep patients and staff safe and most risks to patients' safety were effectively managed. However, the GP provider had decided not to carry out DBS checks on some of the administrative staff, but they had not completed a recorded risk assessment which identified the reasons why they had considered it unnecessary. Other than this shortfall, there was evidence that appropriate employment checks had been carried out on staff.
- Good medicines management systems and processes were in place.
- The premises were clean and hygienic.

Are services effective?

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

Requires improvement



- The practice used the information collected for the Quality and Outcomes Framework (QOF), and their performance against national breast and cervical screening programmes, to monitor and improve outcomes for patients. The QOF data, for 2014/15, showed the practice had obtained 89.8% of the total points available to them for providing recommended care and treatment. This was below the local clinical commissioning group (CCG) average of 95.7%, and the England average of 94.8%.
- Patients' needs were assessed, and care was planned and delivered, in line with current evidence based guidance.
- Staff worked effectively with other health and social care professionals to ensure the range and complexity of patients' needs were met.

Summary of findings

- Staff supported patients to live healthier lives through the health promotion work they carried out. This included providing advice and support to patients to help them manage their health and wellbeing.
- Clinical staff had completed the role specific clinical training they needed to meet patients' needs, and most staff had received an annual appraisal. However, insufficient protected learning time had been allocated to ensure all staff were able to complete their mandatory training and, because of this, some staff had not completed all of the training they needed to safely carry out their role.
- Staff had carried out quality improvement audits, to help improve outcomes for patients.

Are services caring?

The practice is rated as good for providing caring services.

Good



- There was a strong, visible, person-centred culture. Staff treated patients with kindness and respect, and maintained patient and information confidentiality. Patients we spoke with, and those who had completed a Care Quality Commission comment card, were very happy with the care and treatment they received.
- Data from the NHS National GP Patient Survey of the practice, published in July 2016, showed patient satisfaction levels with the quality of GP and nurse consultations, and their involvement in decision making, were very good.
- Information for patients about the range of services provided by the practice was available and easy to understand.
- Staff had made effective arrangements to help patients and their carers cope emotionally with their care and treatment.

Are services responsive to people's needs?

The practice is rated as good for providing responsive services.

Good



- Services were planned and delivered to take into account the needs of different patient groups and to provide flexibility, choice and continuity of care.
- The majority of patients, who provided feedback on CQC comment cards, raised no concerns about telephone access to the practice or appointment availability. Results from the NHS GP Patient Survey of the practice showed that patient satisfaction levels with the convenience of appointments, appointment waiting times and appointment availability, were either above, or broadly in line with, the local CCG and national averages.

Summary of findings

- The practice had good facilities and was well equipped to treat patients and meet their needs.
- Information about how to complain was available and easy to understand. There was evidence the practice treated complaints in a serious manner and took action to address any issues raised.

Are services well-led?

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

- The GP provider had a clear vision of how they wanted the practice to develop. They had carefully considered the challenges the practice faced and were able to demonstrate the steps they were taking to make improvements. However, the practice did not have a documented development plan that clearly set out their strategy and objectives, and how these would be implemented.
- Overall, there were good governance arrangements in place which supported the delivery of good quality care.
- The GP provider was aware of and complied with the requirements of the duty of candour regulation. Clinical leadership encouraged openness and transparency, and promoted a culture where staff felt well supported. All of the staff we spoke to were proud to work for the practice and had a clear understanding of their roles and responsibilities.
- Staff focussed on improvement through the effective processes they had in place to learn from significant events, to help prevent them from happening again.
- The practice actively sought feedback from patients through their patient participation group.

Good



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

The practice is rated as good for older people.

Good



- Nationally reported Quality and Outcomes Framework (QOF) data, for 2014/15, showed the practice had performed above, or broadly in line with, local clinical commissioning group (CCG) and national averages, in relation to providing care and treatment for the clinical conditions commonly associated with this population group.
- The practice offered proactive, personalised care which met the needs of older patients. For example, all patients over 75 years of age had a named GP who was responsible for their care.
- Staff worked in partnership with other health care professionals to ensure that older patients received the care and treatment they needed so that, where possible, emergency admissions into hospital could be avoided. The practice held weekly 'integrated' team meetings, which were attended by GPs, social workers, community nurses and care home nursing staff. These meetings were used to review the needs of patients with the most complex needs, and to formulate emergency health care plans.

People with long term conditions

The practice is rated as good for the care of people with long-term conditions.

Good



- The QOF data, for 2014/15, showed the practice had performed above, or broadly in line with, local CCG and national averages, in relation to providing care and treatment for majority of the clinical conditions commonly associated with this population group.
- Patients with long-term conditions were invited to attend an annual chronic disease review, the length of which reflected the complexity of their long-term conditions. Opportunistic screening was undertaken as part of these reviews. Patients at risk of an emergency hospital admission were identified as a priority, and their needs were reviewed at the weekly 'integrated' team meetings held at the practice.
- The weekly contact staff had with care home and community nursing staff, helped improve the care provided to housebound patients with long-term conditions.

Summary of findings

- Clinical staff were good at working with other professionals to deliver a multi-disciplinary package of care to patients with complex needs.

Families, children and young people

The practice is rated as good for the care of families, children and young people.

- There were appropriate systems in place to protect children who were at risk and living in disadvantaged circumstances. For example, regular meetings were held with local community health staff to discuss the needs of vulnerable children and families. All clinical staff had completed appropriate safeguarding training. Appointments were available outside of school hours and the practice's premises were suitable for children and babies.
- The practice offered contraceptive and sexual health advice, and information was available, about how patients could access specialist sexual health services.
- The practice offered a full range of immunisations for children. Publicly available information showed the practice's performance was overall, broadly in line with the local CCG averages.
- The practice had a comprehensive screening programme. The QOF data showed the uptake of cervical screening for females aged between 25 and 64, attending within the target period, was just below the national average, (75.5% compared to 81.8%).

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 practice was proactive in offering online services, as well as a full range of health promotion and screening that reflected the needs of this group of patients.
- The QOF data showed the practice had performed either above, or broadly in line with, most of the local CCG and England averages, in providing recommended care and treatment to this group of patients.
- Although the practice did not provide access to extended hours appointments, their patients were able to access out-of-hours care via a locality extended hours service.

Good



Summary of findings

People whose circumstances may make them vulnerable

The practice is rated as good for the care of people whose circumstances may make them vulnerable.

Good



- There were suitable arrangements for meeting the needs of vulnerable patients. The practice maintained a register of patients with learning disabilities, which was used to ensure they received an annual healthcare review. Extended appointments were offered to enable this to happen.
- Systems were in place to protect vulnerable children from harm. Staff understood their responsibilities regarding information sharing and the documentation of safeguarding concerns. They regularly worked with multi-disciplinary teams to help protect vulnerable patients.
- Appropriate arrangements had been made to meet the needs of patients who were also carers.
- Staff worked with the local homeless persons' charity and substance mis-use service, to help support their more vulnerable patients, and they provided a 'safe place' for those who might need one.

People experiencing poor mental health (including people with dementia)

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia).

Good



- The QOF data, for 2014/15, showed the practice had performed below the local CCG and national averages, in relation to providing care and treatment to this group of patients.
- The practice's clinical IT system clearly identified patients with dementia and mental health needs, to ensure staff were aware of their specific needs. These patients were invited to attend an annual health review. Those who were not actively being treated by local mental health services, were also invited to attend a follow-up appointment with one of the GPs or the nurse practitioner, to help ensure their needs were being appropriately met.
- Patients experiencing poor mental health had access to information about how to contact various support groups and voluntary organisations. When appropriate, the practice provided community mental health staff with a room, free of charge, where they could carry out crisis assessments or see their patients for routine appointments.
- Clinical staff actively carried out opportunistic dementia screening, to help ensure their patients were receiving the care and support they needed to stay healthy and safe.

Summary of findings

- Staff had taken action to improve the dementia friendliness of the building. This included the purchase of dementia friendly signage and equipment such as suitable toilet seats.
- Staff had completed Dementia Friends training, which helps to raise awareness of dementia related issues and provides information about the support available to patients.

Summary of findings

What people who use the service say

We spoke with four patients from the practice's patient participation group. Feedback was positive about the way staff treated them and they said they valued the care and treatment they received from staff. These patients told us:

- Staff were caring, helpful and professional.
- They could usually get an appointment when they needed one, and they were given enough time during their consultations.
- Privacy and dignity was respected.
- They could usually see a GP of their choice.
- They felt listened to and treatment choices were explained to them.
- Where appropriate, they had been given information about how to live a healthy lifestyle.
- The practice was always clean.
- They would feel comfortable raising concerns with the practice.

As part of our inspection we asked practice staff to invite patients to complete Care Quality Commission (CQC) comment cards. We received 43 completed comment cards. All the respondents were positive about the standard of care provided. Words used to describe the service included: absolutely fantastic; nice and pleasant; helpful and professional; very good; good in all respects; very friendly practice; caring and polite; excellent; attentive and willing to listen. There were only seven negative comments, and these related to difficulties patients felt they had experienced when trying to obtain an appointment.

Data from the NHS National GP Patient Survey of the practice, published in July 2016, showed patient

satisfaction levels with the quality of GP and nurse consultations, were very good and mostly above the local clinical commissioning group (CCG) and national averages. Patient satisfaction levels in relation to telephone access and appointment availability were broadly in line with local CCG and national averages. For example, of the patients who responded to the survey:

- 99% had confidence and trust in the last GP they saw, compared with the local CCG average of 96% and the national average of 95%.
- 99% had confidence and trust in the last nurse they saw or spoke to, compared to the local CCG average of 98%, and the national average of 97%.
- 90% found receptionists at the practice helpful, compared with the local CCG average of 79% and the national average of 73%.
- 94% said the last appointment they got was convenient. This was the same as the local CCG average, but above the national average of 92%.
- 79% were able to get an appointment to see or speak to someone the last time they tried, compared with the local CCG average of 82% and the national average of 85%.
- 70% found it easy to get through to the surgery by telephone, compared with the local CCG average of 79% and the national average of 73%.
- 74% said they usually waited 15 minutes or less after their appointment time, compared to the local CCG average of 69% and the national average of 65%.

(261 surveys were sent out. There were 110 responses which was a response rate of 42%. This equated to 1.4% of the practice population.)

Summary of findings

Areas for improvement

Action the service **MUST** take to improve

- Persons employed by the provider in the provision of a regulated activity must receive appropriate training as is necessary to enable them to carry out the duties they are employed to perform.

Action the service **SHOULD** take to improve

- Carry out a recorded risk assessment in relation to any decision made not to obtain a Disclosure and Barring Service check for staff appointed to a particular post.

- Prepare a development plan which clearly sets out how the GP provider intends to enact their vision and strategy.
- Carry out an annual comprehensive infection control audit.
- Hold regular clinical meetings, and ensure they are minuted.
- Develop a planned, structured approach to carrying out clinical audits.

The New City Medical Group

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 GP specialist advisor.

Background to The New City Medical Group

New City Medical Group provides care and treatment to 5256 patients of all ages, based on a General Medical Services (GMS) contract. The practice is part of the NHS Sunderland clinical commissioning group (CCG) and provides care and treatment to patients living in the Hendon area of Sunderland. We visited the following location as part of the inspection: New City Medical Centre, Tatham Street, Hendon, Sunderland, SR1 2QB.

The practice serves an area where deprivation is higher than the local CCG and England averages. In general, people living in more deprived areas tend to have a greater need for health services. The percentage of people with a long-standing health condition is also higher than the England average, as is the percentage of people with caring responsibilities. Life expectancy for both men and women is lower than the England average. National data showed that 5.6% of the population are from an Asian ethnic minority background, and 2.3% are from other non-white ethnic groups.

The practice occupies a purpose built, two-storey building that provides patients with access to ground and first floor treatment and consultation rooms. Lift access is provided to the first floor. The provider is a single female GP. The practice employs a salaried GP (male), two sessional GPs (one male and one female), and a long-term locum GP

(female). The organisation is in the process of recruiting a second salaried GP. Other staff included a practice nurse (female), a healthcare assistant (female), a practice manager and assistant manager, and a team of administrative and reception staff.

The practice is open Monday to Friday between 8:30am and 6pm. GP appointment times are Monday to Friday between 9am and 11:30am, and between 2:30pm and 5:30pm. The practice is closed at weekends.

When the practice is closed patients can access out-of-hours care via Vocare, known locally as Northern Doctors Urgent Care, and the NHS 111 service.

Why we carried out this inspection

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

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

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 13 September 2016. During our visit we:

Detailed findings

- Spoke with a range of staff including the GP provider, a salaried GP, the practice manager, the practice nurse and some administrative staff. We also spoke with four members of the practice's patient participation group.
- Observed how patients were being cared for.
- Reviewed an anonymised sample of the personal care or treatment records of patients.
- Reviewed comment cards where patients shared their views and experiences of the service.

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

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

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

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

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

Are services safe?

Our findings

Safe track record and learning

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

- There was a system for recording, investigating and learning from incidents, and this was known by the staff we spoke with. Where relevant, patient safety incidents had been reported to the local clinical commissioning group (CCG) via the Safeguard Incident and Risk Management System (SIRMS). (This system enables GPs to flag up any issues via their surgery computer, to a central monitoring system, so that the local CCG can identify any trends and areas for improvement.)
- Staff had identified and reported on nine significant events during the previous 12 months. The sample of records we looked at, and evidence obtained from interviews with staff, showed the practice had managed such events consistently and appropriately. Following the completion of a recent SEA, the team had reviewed relevant policies and procedures, provided staff with additional training, and shared information openly with relevant professionals, the patient concerned and those people acting on their behalf.
- The practice's approach to the handling and reporting of significant events ensured the provider complied with their responsibilities under the Duty of Candour regulation. (The Duty of Candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment.)
- The practice had a system for responding to safety alerts. All safety alerts, including those covering medicines, were usually forwarded to clinicians by a designated member of staff, so that appropriate action could be taken in response. Suitable records had been kept. However, in response to a recent safety alert relating to the prioritisation of the clinical needs of patients requesting a GP home visit, the practice's assessment of their performance against the guidance had been carried out without any input from the practice manager or the GP provider. This was discussed with the GP provider and practice manager who indicated they would review their governance system for handling safety alerts.

Overview of safety systems and processes

Overall, there were appropriate systems and processes in place to keep patients and staff safe. These included:

- Maintaining appropriate standards of cleanliness and hygiene. Cleaning staff followed an agreed cleaning schedule, which the practice monitored monthly to ensure it was being adhered to. Cleaning schedules were also in place for specific items of equipment. A designated member of staff carried out the role of infection control lead. There were infection control protocols in place and these could be easily accessed by staff. Sharps bin receptacles were available in the consultation rooms and those we looked at had been signed and dated by the assembler. Clinical waste was appropriately handled. However, there were no arrangements for carrying out regular comprehensive infection control audits.
- Carrying out of a range of employment checks to make sure staff were safe to work with vulnerable patients. We looked at a sample of four staff recruitment files. Some of the information we asked to look at was not readily available on the day of the inspection. However, this was submitted shortly after our visit and provided evidence of compliance with the regulations. Appropriate indemnity cover was in place for clinical staff. The provider had obtained information about staff's previous employment and, where relevant, copies of their qualifications, as well as written references. Disclosure and Barring Service (DBS) checks had also been carried out on clinical staff and proof of identity had been obtained. (DBS checks identify whether a person has a criminal record, or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable.) The provider had decided not to carry out DBS checks on some of the administrative staff; however, they had not completed a recorded risk assessment which identified the reasons why they had considered it unnecessary.
- Policies and procedures for safeguarding children and vulnerable adults. The GP provider acted as the children and vulnerable adults safeguarding lead, providing advice and guidance to their colleagues. Staff demonstrated they understood their safeguarding responsibilities and the clinical team worked in collaboration with key local health and social care

Are services safe?

colleagues, to protect vulnerable children and adults. Multi-disciplinary meetings were held to monitor vulnerable patients and share information about risks. However, the GP provider told us they had limited contact with health visitors, due to the local arrangements for their management. This has the potential to affect the quality of the whole service provided to the under five age group. The GP provider had raised this concern with the local CCG. Children at risk, and vulnerable adults, were clearly identified on the practice's clinical IT system, to ensure clinical staff took this into account during consultations. All clinical staff had received safeguarding training relevant to their role, with the GPs and practice nurse having completed level three child protection training.

- The provision of chaperone arrangements to protect patients from harm. All the staff who acted as chaperones were trained for the role and had undergone a Disclosure and Barring Service (DBS) check. The chaperone service was advertised in the patient waiting areas.
- Appropriate arrangements for managing medicines, including emergency drugs and vaccines. Suitable arrangements had been made to store and monitor vaccines. These included carrying out daily temperature checks of the vaccine refrigerators and keeping appropriate records. Patient Group Directions (PGD) had been adopted by the practice, to enable nurses to administer medicines in line with legislation. These were up-to-date and had been signed. (PGDs are written instructions for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment.) There was a good system for monitoring repeat prescriptions and carrying out medicines reviews. Appropriate systems were in place to manage high risk medicines. Stocks of prescription forms were checked and logged on being received into the practice, and these were securely stored.

Monitoring risks to patients

Most risks to patients' safety were effectively managed.

- Checks of the practice's fire systems and equipment had been carried out, and fire drills had been held. However, although the practice had arranged for a comprehensive fire risk assessment to be carried out in 2013, the

practice manager was unable to confirm that the actions detailed in the resulting action plan, had been addressed. Regular checks of the temperature of the hot and cold water systems had been carried out. However, the practice had not arranged for a legionella risk assessment to be completed by a competent person. (Legionella is a bacterium that can grow in contaminated water and can be potentially fatal.) Following the inspection, the practice manager took immediate action to address both of these concerns, and they provided evidence of the action taken to address the shortfalls we had identified.

- The practice had arranged for all clinical equipment to be serviced and calibrated, to ensure it was safe and in good working order. For example, all electrical equipment had been checked, and the lift had been serviced, to make sure they were safe to use. Various health and safety risk assessments had been completed, to help keep the building safe and free from hazards. The practice manager told us they carried out a more general risk assessment from time to time, and that the most recent one had resulted in the purchase of bariatric seating in the reception area. A health and safety information poster was on display in the administrative area, to help raise staff awareness.
- There were suitable arrangements for planning and monitoring the number and mix of staff required to meet patients' needs. The practice did not have a full complement of GP staff, at the time of our visit. Although they had been successful in recruiting and retaining a core group of long-term, salaried GPs, they had not been able to appoint another salaried GP to cover a further ten clinical sessions. The GP provider told us this was currently being covered, wherever possible, by regular GP locums. The practice had a full complement of nursing staff. Administrative staff had allocated roles, but were also able to carry out all reception and office duties. Rotas were in place which helped to make sure sufficient numbers of staff were always on duty to meet patients' needs, and staff covered each other's holiday leave.

Arrangements to deal with emergencies and major incidents

The practice had made satisfactory arrangements to deal with emergencies and major incidents.

Are services safe?

- There was an instant messaging system on the computers in all the consultation and treatment rooms, which alerted staff to any emergency.
- Most staff had completed basic life support training, to help them respond appropriately in the event of an emergency.
- Emergency medicines were available in the practice. These were kept in a secure area and staff knew of their location. The room in which they were kept was clearly identified. All of the emergency medicines we checked were within their expiry dates. However, GP staff did not routinely carry a range of medicines for use in acute situations, when carrying out home visits. The GP provider told us they had made a conscious decision for staff not to carry emergency medicines. The reasons for this were: the relatively low number of home visits carried out; medicines were easily available from local pharmacies; the practice's close proximity to the local Accident and Emergency Department.
- Staff also had access to a defibrillator and a supply of oxygen for use in an emergency. Regular checks had been carried out, to make sure they were in good working order.
- The practice had a business continuity plan in place for major incidents, such as power failure or building damage. This was accessible to all staff via the practice's intranet system. A copy of the plan was also kept off site by a key individual.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Staff carried out assessments and treatment in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines. The practice had systems in place to keep all clinical staff up-to-date with new guidance. This included participating in a local network which provided staff with access to current national and local guidelines, and information about updates.

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality and Outcomes Framework (QOF), and their performance against national screening programmes, to monitor and improve outcomes for patients. The QOF data, for 2014/15, showed the practice had obtained 89.8% of the total points available to them for providing recommended care and treatment. This was below the local clinical commission group (CCG) average of 95.7% and the England average of 94.8%. (QOF is intended to improve the quality of general practice and reward good practice).

- Overall, the practice had obtained 95.7% of the total points available to them for the diabetes clinical indicator. This was 2.2% above the local CCG average and 6.5% above the England average. For five of the ten clinical indicators, the practice's performance was either better than, or broadly in line with, the England averages. For example, the percentage of patients with diabetes, in whom the last blood pressure reading, in the period from 1 April 2014 to 31 March 2015, was 140/80 mmHg or less, was higher when compared to the England average (72.5% compared to 71.2%). However, the data also showed the practice had performed less well in relation to some of the indicators. For example, the percentage of patients with diabetes, with a record of a foot examination and risk classification, in the same period of time, was below the England average (73.9% compared to 81.2%).
- Overall, the practice had obtained 69.5% of the total points available to them for the mental health clinical indicator. This was 22.3% below the local CCG average and 23.3% below the England average. (The QOF data

showed the practice had a higher prevalence of patients with mental health than the local CCG and England average.) For two of the six sub-clinical indicators, the practice's performance was either better than, or broadly in line with, the England averages. For example, the percentage of patients receiving lithium therapy, with a record of blood creatine and thyroid-stimulating hormone levels, during the preceding four months, was higher when compared to the England average (100% compared to 96.6%). However, for the other four indicators, the practice's performance was below the local CCG and England averages. For example, the percentage of patients with the specified mental health conditions, who had had a comprehensive, agreed care plan documented in their medical record, during the period from 1 April 2014 to 31 March 2015, was lower when compared with the England average (69.2% compared to 77.2%). Evidence from the inspection showed staff were aware that their performance was below the local CCG and England averages, and that they were working hard to address this. This included undertaking work to make sure that their register of mental health patients was accurate.

The practice's exception reporting rate, at 10.1%, was 0.7% below the local CCG average and 0.9% above the England average. (The QOF scheme includes the concept of 'exception reporting' to ensure that practices are not penalised where, for example, patients do not attend for review, or where a medication cannot be prescribed due to a contraindication or side-effect.) We found the practice had strong patient recall and follow-up processes in place which were implemented by staff. Exception reporting rates for the diabetes and mental health related indicators were either below, or broadly in line with, local CCG and national averages.

Publicly available information identified a large variation in the average daily quantities of hypnotics prescribed by clinical staff at the practice. Staff were clear about the reasons for this, and had put plans in place to address this. For example, patients prescribed hypnotics had active reduction plans in place. A system had been introduced to help ensure that hypnotics were identified by prescribers as 'acute' medicines, thereby requiring doctors to authorise the prescription each time. The practice recognised that they needed further support in this area, and were pursuing this with the local CCG.

Are services effective?

(for example, treatment is effective)

Publicly available information also showed that the number of emergency hospital admissions, for 19 ambulatory care sensitive conditions per 1,000 population, covering the period from 1 April 2014 to 31 March 2015, was higher than the national average (26.2 compared to 14.6), but broadly in line with the local CCG average. We found the practice had effective systems and processes in place to review and monitor emergency hospital admissions. On the basis of the data we looked at, the admissions that had taken place looked to be appropriate.

There was evidence of quality improvement activity and this included carrying out clinical audits. However, the practice did not have a planned, structured approach to carrying out audit activity.

- We looked at the two clinical audits that had been carried out during the previous 24 months. Although brief, these were relevant, showed learning points and evidence of changes to practice. The audits were clearly linked to areas where staff had reviewed updated NICE guidelines, and European Union (EU) guidance, and identified potential risks to their patients. For example, clinical staff had carried out an audit in response to EU guidance that the concomitant use of Proton Pump Inhibitors (medicines which reduce the amount of acid made in the stomach) in conjunction with Cloidogrel (used to inhibit blood clots in coronary artery disease), should be avoided, to prevent potentially harmful side effects. Following completion of the full cycle audit, the findings indicated that the number of patients on this combination of medicines had been reduced, and an alert had been placed on the electronic patient record system, to warn prescribers of the harmful interaction between the two medicines.
- The practice had carried out medicine audits, with the support of local CCG pharmacy staff, to help ensure prescribing decisions were in line with local guidelines. The practice had also participated in the National Diabetes Audit and carried out joint work with the local diabetic nurse, to help improve the care and treatment they provided their patients. This included inviting patients to attend Insulin Therapy Review and Diabetes Education appointments.

Effective staffing

Staff were not always supported to participate in relevant training. We found that some staff had not completed all of the training the provider considered to be mandatory. Specifically, we found that:

- Six out of eight non-clinical staff had not completed adult safeguarding training.
- Eight out of twelve staff had not completed training in information governance.
- Eight out of twelve staff had not completed training in health and safety.
- Ten out of twelve staff had not completed training in infection control. The infection control lead had not completed more advanced training, to help them carry out this key role.
- Eleven out of twelve staff had not completed training in fire safety.
- Two out of twelve staff had not completed Cardio Pulmonary Resuscitation (CPR) training. In addition, records showed the CPR training for two clinical staff had not been updated for over 23 months. (Advice from the Resuscitation Council (UK) states that clinical and non-clinical staff should have annual updates.)

The practice manager acknowledged that sufficient protected learning time had not always been allocated, to help ensure staff had the time they needed to complete their mandatory training.

Staff told us they had received an appropriate induction. However, there was no record of this in two of the staff files we looked at. Evidence confirming that these staff had completed an induction was forwarded to us shortly after the inspection.

The practice was able to demonstrate how they ensured clinical staff undertook role specific training in relation to meeting patients' clinical needs. For example:

- One of the salaried GPs had attended a two-day minor surgery course.
- The healthcare assistant had attended relevant day release training, to help support them develop in their extended role within the practice.
- Clinical staff had attended domestic violence and Mental Capacity Act training.

Are services effective?

(for example, treatment is effective)

- Staff carrying out the role of chaperone had received training to help them do this.
- The practice nurse had completed additional post qualification training to help them meet the needs of patients with long-term conditions, such as diabetes. They had completed training in prescribing, administering immunisations and carrying out cervical screening, and they were also in the process of completing a diploma in sexual health.

Overall, an effective appraisal system was in place.

- The majority of staff had received an annual appraisal of their performance during the previous 12 months. However, the practice manager had not undergone an appraisal during 2015/16. They told us they were well supported in carrying out their roles and responsibilities. The GP provider submitted information immediately following the inspection which confirmed that the practice manager had undergone an appraisal.
- The practice nurse confirmed one of the GPs carried out their appraisal, and that suitable arrangements were in place to provide them with support in relation to the prescribing aspect of their role. They told us they had access to clinical supervision, via CCG locality meetings.
- Appropriate arrangements were in place to ensure the GPs received support to undergo revalidation with the General Medical Council.

Coordinating patient care and information sharing

The practice's patient clinical record and intranet systems helped to make sure staff had the information they needed to plan and deliver care and treatment.

- The information included patients' medical records and test results. Staff shared NHS patient information leaflets, and other forms of guidance, with patients to help them manage their long-term conditions.
- All relevant information was shared with other services, such as hospitals, in a timely way. Important information about the needs of vulnerable patients was shared with the out-of-hours and emergency services.
- Staff worked well together, and with other health and social care professionals, to meet the range and complexity of patients' needs and to assess and plan on-going care and treatment.

- Clinical staff used 'special notes' to record important information about vulnerable patients with complex needs, so this could be shared with out-of-hours emergency professionals in a timely manner.

Consent to care and treatment

Patients' consent to care and treatment was sought in line with legislation and guidance.

- Staff understood the relevant consent and decision-making requirements of the legislation and guidance, including the Mental Capacity Act (MCA, 2005).
- When staff provided care and treatment to young people, or adult patients whose mental capacity to consent was unclear, they carried out appropriate assessments of their capacity and recorded the outcome.
- Relevant staff had completed training in the use of the MCA. For example, in the MCA and the use of the 'Deciding Right' documentation, to help them respond appropriately to the needs of patients with capacity issues. (Deciding Right is a North-East initiative which helps professionals to make care decisions in advance.)

Supporting patients to live healthier lives

Staff were committed to supporting patients to live healthier lives through a targeted and proactive approach to health promotion.

- Patients had access to appropriate health assessments and checks. These included health checks for new patients and NHS health checks for people aged between 40 and 74 years.
- There were suitable arrangements for making sure a clinician followed up any abnormalities or risks identified during these checks.

The practice had a comprehensive screening programme. They had performed above, or broadly in line with, national averages in relation to breast and cervical screening. However, their bowel cancer screening rate was lower than the national average. (The inspection team were aware that that this is a regional issue and not confined to this practice.) Data showed:

- The uptake of breast screening for females aged between 50 and 70, during the last 36 months, was above the national average, 75.3% compared to 72.2%.

Are services effective?

(for example, treatment is effective)

- The uptake of bowel cancer screening in patients aged between 60 and 69, during the last 30 months, was below the national average, 51.4% compared to 57.9%.
- The uptake of cervical screening for females aged between 25 and 64, attending during the target period, was lower, at 75.5%, than the national average of 81.8%. The practice had protocols for the management of cervical screening, and for informing women of the results of these tests. These protocols were in line with national guidance. The GP provider told us the high levels of economic and social deprivation within the practice area had an impact on the numbers of women attending cervical screening appointments. Staff told us that when the national screening programme notified them that a patient had failed to attend their screening appointment, the practice sent out a further letter of invitation to encourage non-attenders to contact the practice.
- The practice offered a full range of immunisations for children. Publicly available information showed the practice's performance was below the local CCG averages. For example, childhood immunisation rates for the vaccinations given to children under two years old ranged from 88.9% to 97.2% (the local CCG averages ranged from 93.7% to 98.6%). For five year olds, the rates ranged from 85.7% to 94.3% (the local CCG averages ranged from 94.7% to 98.9%).

Are services caring?

Our findings

Respect, dignity, compassion and empathy

Staff were highly motivated to offer care that was kind and which promoted patients' dignity. Throughout the inspection staff were courteous and helpful to patients who attended the practice or contacted it by telephone. We saw that patients were treated with dignity and respect. Privacy screens were provided in consulting rooms so that patients' privacy and dignity could be maintained during examinations and treatments. Consultation and treatment room doors were closed during consultations, so that conversations could not be overheard. Reception staff said that a private area would be found if patients needed to discuss a confidential matter.

Feedback from patients was positive about the way staff treated them. We spoke with four patients from the practice's patient participation group. They told us they were given enough time during their consultations and that their privacy and dignity was respected. They said they felt listened to, and that treatment choices were explained to them. They told us they would feel comfortable raising concerns with the practice.

As part of our inspection we asked practice staff to invite patients to complete Care Quality Commission (CQC) comment cards. We received 43 completed comment cards. All the respondents were positive about the standard of care provided. Words used to describe the service included: absolutely fantastic; nice and pleasant; helpful and professional; very good; good in all respects; very friendly practice; caring and polite; excellent; attentive and willing to listen. There were only seven negative comments, and these related to difficulties patients felt they had experienced when trying to obtain an appointment.

Data from the NHS National GP Patient Survey of the practice, published in July 2016, showed patient satisfaction levels with the quality of GP and nurse consultations, were mostly above the local clinical commissioning group (CCG) and national averages. For example, of the patients who responded to the survey:

- 91% said the last GP they saw or spoke to was good at listening to them, compared to the local CCG and the national averages of 89%.

- 89% said the last GP they saw or spoke to was good at giving them enough time, compared to the local CCG and the national averages of 87%.
- 99% had confidence and trust in the last GP they saw, compared with the local CCG average of 96% and the national average of 95%.
- 91% said the last nurse they saw or spoke to was good at listening to them. This was the same as the local CCG average, but above the national average of 89%.
- 95% said the last nurse they saw or spoke to was good at giving them enough time, compared to the local CCG average of 94% and the national average of 92%.
- 99% had confidence and trust in the last nurse they saw or spoke to, compared to the local CCG average of 98% and the national average of 97%.
- 90% found receptionists at the practice helpful, compared with the local CCG average of 79% and the national average of 73%.

Staff had gathered feedback from patients through their Friends and Family Test survey. During 2015, the practice had received a total of 332 responses. Out of these, 298 patients had indicated that they were likely to recommend the practice to friends and family, (14 had responded with a 'don't know' reply.)

Care planning and involvement in decisions about care and treatment

Patients we spoke with, and those who commented on this in their CQC comment cards, told us clinical staff involved them in decisions about their care and treatment. Results from the NHS GP Patient Survey of the practice showed patient satisfaction levels regarding involvement in decision-making were above the local CCG and national averages. Of the patients who responded to the survey:

- 92% said the last GP they saw was good at explaining tests and treatments, compared to the local CCG and the national averages of 86%.
- 87% said the last GP they saw was good at involving them in decisions about their care, compared to the local CCG and the national averages of 82%.
- 93% said the last nurse they saw was good at explaining tests and treatments, compared with the local CCG average of 92% and the national average of 90%.

Are services caring?

- 90% said the last nurse they saw was good at involving them in decisions about their care, compared to the local CCG average of 88% and the national average of 85%.

Patient and carer support to cope emotionally with care and treatment

Staff were good at helping patients and their carers to cope emotionally with their care and treatment.

- They understood patients' social needs, supported them to manage their own health and care, and helped them maintain their independence.
- Notices in the patient waiting room told patients how to access a range of support groups and organisations.
- Where patients had experienced bereavement, staff would contact them to offer condolences and support.

The practice was committed to supporting patients who were also carers.

- The practice's healthcare assistant acted as the carers' lead and provided patients with advice, support and information.
- The practice manager and a member of the administrative team had completed a course in how to support carers, to help raise awareness of the needs of this group of patients.
- Staff maintained a register of these patients, to help make sure they received suitable support, such as an annual carers' health check and appropriate vaccinations. There were 145 patients on this register, which equated to 2.76% of the practice's population.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

Services were planned and delivered to take into account the needs of different patient groups and to provide flexibility, choice and continuity of care. The GP provider had a good knowledge of the demands that the key physical long-term conditions placed on the practice and used this to help them plan the range of services needed to meet their patients' needs. Examples of the practice being responsive included:

- Providing all patients over 75 years of age with a named GP who was responsible for their care, and access to a regular health review and check-up, either with a GP or the nurse. The practice held weekly 'integrated team' meetings, which were attended by GPs, social workers, care home nurses and local community nursing staff. These meetings were used to review the needs of patients with the most complex needs, and to formulate emergency health care plans. Staff kept a palliative care register which included not only patients with incurable cancer, but those with other end stage chronic illnesses. This helped to ensure the practice was able to monitor and meet the needs of such patients.
 - The provision of nurse-led long-term conditions (LTCs) reviews. Patients were invited to attend an annual chronic disease review, the length of which reflected the complexity of their long-term conditions. The healthcare assistant carried out the initial appointment where basic tests were carried out, as well as any appropriate opportunistic screening for atrial fibrillation, dementia and smoking cessation. Patients then received a second appointment during which the nurse practitioner reviewed their healthcare needs, and set up a care plan where appropriate.
 - A full programme of childhood immunisations was offered by the practice nursing team during weekly clinics. Patients attending for a post-natal check received a 30 minute appointment, to help ensure their needs could be fully assessed and met. A designated member of the administrative team was responsible for making sure the practice's information about children at risk of harm was up-to-date. Regular meetings took place involving the community midwife, to help identify potential safeguarding issues and manage risk.
- Appointments were available outside of school hours and ill children were provided with access to same day care, and the premises were suitable for children and babies. The practice offered family planning and sexual health advice during clinic appointments, and staff promoted the use of the local sexual health clinic.
- Inviting mental health patients to attend an annual health review. Those who were not actively being treated by local mental health services, were also invited to attend a follow-up appointment with one of the GPs or the nurse practitioner, to help ensure their needs were being appropriately met. Other ways of supporting these patients to stay safe, included the authorising of weekly prescriptions for those with a recent history of overdose, and face-to-face reviews, held at two to four weekly intervals, to assess patients' responses to the medicines they were taking. Patients experiencing poor mental health had access to information about how to access various support groups and voluntary organisations. When appropriate, the practice provided community mental health staff with a room, free of charge, where they could carry out crisis assessments or see their patients for routine appointments.
 - Actively carrying out opportunistic dementia screening, to help ensure patients were receiving the care and support they needed to stay healthy and safe. Where appropriate, the healthcare assistant carried out a relevant blood test and completed a standardised screening tool to assess levels of cognitive impairment. A GP appointment was made for patients with a score indicating cognitive impairment and, where necessary, they were referred to the local memory protection service. Staff had taken action to improve the dementia friendliness of the building. This included the purchase of dementia friendly signage and equipment such as suitable toilet seats.
 - Offering a range of health promotion clinics, including smoking cessation appointments, new patient checks and holiday vaccinations, to help patients stay healthy. Although the practice did not provide access to extended hours appointments, their patients were able to access out-of-hours care via the local extended hours

Are services responsive to people's needs?

(for example, to feedback?)

service. (This service is provided by clinicians from a group of ten local practices.) Patients were able to use on-line services to access appointments and request prescriptions.

- Making reasonable adjustments to help patients with disabilities, and those whose first language was not English, to access the service. Staff maintained a register of patients with learning disabilities and they had had this validated by the local social services department. All patients with learning disabilities were invited to attend the practice for an annual review lasting one hour. disabled toilets which had appropriate aids and adaptations, on both floors. Staff worked with the local homeless persons' charity and substance mis-use service to help support their more vulnerable patients, and the practice provided a 'safe place' for those who might need this.

Access to the service

The practice was open Monday to Friday between 8:30am and 6pm. GP appointment times were Monday to Friday between 9am and 11:30am, and between 2:30pm and 5:30pm. The practice was closed at weekends.

All consultations were by appointment only and could be booked by telephone, in person or on-line. Patients were able to access book-on-the day appointments, as well as routine, pre-bookable appointments up to eight days in advance. Routine chronic disease appointments with the nurse practitioner and the healthcare assistant were bookable up to four weeks ahead. The GP providing duty doctor cover ensured that any requests for home visits were reviewed and allocated, to enable the practice to make an appropriate and prompt response. The practice's appointment system provided the duty doctor with a number of daily urgent appointment slots, which could be used for patients presenting with urgent same day needs.

The majority of patients who provided feedback on clinical commissioning group (CQC) comment cards, raised no concerns about telephone access to the practice or appointment availability. Results from the NHS GP Patient Survey of the practice, published in July 2016, showed that patient satisfaction levels with the convenience of

appointments, appointment waiting times and appointment availability, were either above, or broadly in line with, the local CCG and national averages. Patient satisfaction with telephone access was below the local CCG average. Of the patients who responded to the survey:

- 94% said the last appointment they got was convenient. This was the same as the local CCG average, and above the national average of 92%.
- 79% were able to get an appointment to see or speak to someone the last time they tried, compared with the local CCG average of 82% and the national average of 85%.
- 70% found it easy to get through to the surgery by telephone, compared with the local CCG average of 79% and the national average of 73%.
- 74% said they usually waited 15 minutes or less after their appointment time, compared to the local CCG average of 69% and the national average of 65%.

Listening and learning from concerns and complaints

The practice had a system in place for managing complaints.

- This included having designated staff who were responsible for handling any complaints and a complaints policy which provided staff with guidance about how to handle them.
- Information about how to complain was available on the practice's website and was also on display in the patient waiting areas. Comment boxes provided patients with the opportunity to make suggestions or raise concerns anonymously.
- The practice had received four complaints during the previous 12 months. Records showed they had taken each complaint seriously and tried to address the concerns raised.
- An annual review of complaints received was carried out, as part of the arrangements for submitting information about how these were managed to their local commissioners.

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 clinical team were committed to their patients and to providing them with the best possible care and treatment. All of the staff we spoke to were proud to work for the practice and had a clear understanding of their roles and responsibilities. The practice had prepared a statement of purpose for their Care Quality Commission registration, and there was an agreed mission statement and patient charter in place. The GP provider had a clear vision of how they wanted the practice to develop. It was clear they had carefully considered the challenges they faced. Evidence made available during the inspection, demonstrated they were taking steps to address these challenges and make improvements to the service. However, the practice manager told us that a documented development plan, setting out the actions they would take to deliver their vision and strategy, had not been completed.

Governance arrangements

Overall, governance arrangements within the practice worked well. However, we identified that the practice could strengthen some aspects of their governance arrangements, particularly in relation to ensuring that staff complete the mandatory training considered necessary by the GP provider.

- There was a clear staffing structure, which helped ensure staff were aware of their roles and responsibilities.
- Staff were supported to learn lessons when things went wrong, and there was an effective system which ensured the identification, promotion and sharing of good practice.
- Regular planned multi-disciplinary team meetings were held to share information and manage patient risk. In addition, the GPs met informally each day to provide peer support, discuss cases, give advice and allocate work. However, these meetings were not minuted. Also, there were no regular meetings of the whole clinical staff team. Holding such meetings will help promote effective teamwork and ensure good organisational accountability.
- Most organisational risks had been satisfactorily managed.

- Staff had access to a range of policies and procedures. Those we looked at were up-to-date and had been recently reviewed.
- Patients had opportunities to give feedback on how services were delivered and what could be improved.

Leadership, openness and transparency

Effective clinical leadership was in place, and this was underpinned by an ethos and values which placed patients at the centre of their work. Clinical staff had clear designated lead roles, to help maintain high clinical standards. Staff worked well together as a team, and also in collaboration with other professionals, to help ensure patients' needs were met. There were good levels of staff satisfaction, with many having worked at the practice for a considerable number of years. This helped to provide consistency and continuity of care and treatment.

The provider had complied with the requirements of the Duty of Candour regulation. (The Duty of Candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).

- The GP provider and practice manager encouraged a culture of openness and honesty. Staff we spoke with told us they felt well supported by the leadership at the practice. Clinical staff met daily to share information about patients' needs, and to support each other.
- There were effective systems which helped to ensure that when things went wrong, patients received an apology and action was taken to prevent the same thing from happening again.

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

The practice encouraged and valued feedback from patients and staff. The practice had recently carried out an in-house patient survey, and produced an action plan to address the issues raised. They had an active patient participation group (PPG), consisting of five core members, as well as a virtual PPG. The PPG provided a patient's perspective on issues, concerns and areas for future service developments.

Are services well-led?

Good 

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

- An information leaflet about the PPG was available in the patient waiting areas. This had also been uploaded onto the practice's website. Forms encouraging patients to express an interest in the PPG were also available in the waiting areas.
- PPG meetings had been held during 2016. Agenda items for the most recent meeting in September 2016 included: exploring the possibility of setting up an outreach service that would provide gardening activities for patients with dementia; the provision of a counselling service; disabled access to the practice; making better use of local community based organisations to support the more vulnerable patients.
- On the day of the inspection, a local Healthwatch representative attended a PPG meeting to provide members with information about how to develop their group. The Healthwatch representative told us the practice was very open to working with them. The PPG members told us the practice welcomed their views and that, wherever possible, took action in relation to any issues they raised.

It was evident that the GP provider and practice manager valued and encouraged feedback from their staff. Arrangements had been made which ensured that staff had received an annual appraisal.

Continuous improvement

Staff demonstrated a commitment to continuous improvement. In particular, they:

- Carried out quality improvement activity, to help improve patient outcomes.
- Learnt from any significant events that had occurred, to help prevent them from happening again.
- Attended local clinical commissioning group 'Time-in, Time-out' events, to help them keep up to date with best practice and current guidelines.
- Had undertaken role-specific training, to help them meet patients' needs.

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 18 HSCA (RA) Regulations 2014 Staffing
Family planning services	The registered person failed to ensure all staff received appropriate training, to enable them to carry out the duties for which they had been employed.
Maternity and midwifery services	Regulation 18(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
Surgical procedures	
Treatment of disease, disorder or injury	