Westbourne Medical Centre

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.

Summary of findings

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Summary of findings

Overall summary

Westbourne Medical Centre is situated in an urban location at Milburn Road, Westbourne, Bournemouth, BH4 9HJ.

During our inspection we spoke with six patients, one nurse practitioner, two healthcare technicians, three GPs and two practice nurses.

The practice served a population of which the majority considered themselves to be White British. There are a high proportion of patients aged 65 years or older.

The practice also offered a service for 15 care homes in their practice area and a care home for people with learning disabilities.

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Improvements are needed to ensure the practice is safe.

- There were systems in place for identifying and recording significant incidents, but these were not consistently followed by staff to ensure that patients' were protected from the potential of harm.
- The practice had arrangements in place for safeguarding vulnerable adults and children, but policies which under pinned these arrangements had not been fully reviewed and updated to ensure they were accurate and in line with best practice.
- Risk assessments in place to protect the patients' when they used the building did not adequately identify and or minimise the risk of cross infection.
- Suitable safe arrangements were in place for the management and handling of medicines at the practice.
- Staff were recruited in a safe manner, but appropriate checks were not consistently carried out in line with practice policy and procedures.
- There were suitable arrangements in place for dealing with emergencies.

Are services effective?

Improvements were needed to ensure the practice was effective.

- The practice had suitable arrangements in place to promote best practice which included monitoring and improving outcomes for patients.
- Staff were supported to undertake relevant qualifications and training, Staff members received an annual appraisal. Staff said they did not find the appraisal process effective, as improvements or learning needs the process identified were not acted upon.
- The practice promoted patients' health and provided a practice leaflet, website and other leaflets.
- They worked with other health providers to promote best practice and integrated care.

Are services caring?

Patients received appropriate care and treatment, but improvements were needed to ensure their privacy was respected and informed consent was obtained.

Summary of findings

- Patients told us they were treated with respect by staff and their privacy and dignity were maintained when they attended appointments. There were arrangements in place if a patient requested a chaperone.
- Patients were asked for their consent prior to any care or treatment being carried out.

Are services responsive to people's needs?

The practice was responsive to patients' needs, but improvements were needed.

- There were arrangements in place for patients to access the appointments system either on the telephone, in person or on line. Appointments were provided for urgent conditions and on a routine basis. When needed telephone consultations and home visits were organised.
- The practice had a complaints policy and patients were aware of how to raise concerns.

Are services well-led?

Improvements were needed to ensure the practice was well led.

- The practice had a clear vision of how it should operate and develop. There were links with other health professionals and providers to promote best practice.
- Staff meetings were held but these did not fully engage with all staff members.
- Governance arrangements in place did not fully protect patients from confidential information being disclosed inappropriately.
- Opportunities were made available for staff and patients to comment on the service provided, however these were not effective for staff members.
- Risks were identified, but there was no clear process to ensure these were minimised effectively.

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 guidance on protecting vulnerable adults was not up to date although the staff were aware of how to recognised signs and symptoms of abuse.
- Information was provided on keeping well and self-management of health and medical conditions.
- Reviews and clinics were offered for patients' who were older, these included annual health checks.
- When a patient was receiving end of life care the practice worked with the local community hospital which specialised in palliative care.

People with long-term conditions

- The guidance on protecting vulnerable adults was not up to date although the staff were aware of how to recognised signs and symptoms of abuse.
- Information was provided on keeping well and self-management of conditions.
- Reviews and clinics were offered for patients with a long term health or medical condition.

Mothers, babies, children and young people

- The guidance on protecting vulnerable adults was not up to date although the staff were aware of how to recognised signs and symptoms of abuse.
- The guidance on protecting vulnerable children was not up to date however staff were aware of how to recognise signs and symptoms of abuse.
- Antenatal and post natal care was offered by the practice for pregnant women.
- Child development checks and vaccinations clinics were offered by the practice.

The working-age population and those recently retired

- The guidance on protecting vulnerable adults was not up to date although the staff were aware of how to recognised signs and symptoms of abuse.

Summary of findings

- Extended opening hours were offered so patients who had to work were able to access care and treatment at a time suitable for them.
- Vaccinations for travel and illnesses such as Hepatitis B were offered by the practice.
- Patients aged 40 to 74 years old were able to have a health check if they wanted one.
- Information was provided on keeping well and self-management of health conditions.

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

- Patients were treated with respect and their dignity and privacy maintained.
- A translation service was available if needed.

People experiencing poor mental health

- The guidance on protecting vulnerable adults was not up to date although the staff were aware of how to recognised signs and symptoms of abuse.
- Patients were treated with respect and their dignity and privacy maintained.
- The practice worked with other agencies to provide care for patients' who were experiencing poor mental health.

Summary of findings

What people who use the service say

Overall we found improvements were needed to ensure the service was safe, effective, caring responsive and well led.

Patients we spoke with told us they were treated with respect and their privacy and dignity was maintained. Most patients said that they were able to arrange an appointment at a time convenient for them and were able to see their own GP.

One of the six patients we spoke with said that they had been waiting for over 25 minutes after their appointment time; the patient was not concerned about this, but they said they would appreciate being informed that appointments were running behind schedule.

One mother, who was attending the practice with her baby for a six week health check, told us they had received care throughout their pregnancy from the same midwife. They said they were very pleased with this.

The practice had a virtual Patient Participation Group (PPG) who coordinated a survey undertaken in November 2013. The survey was broadly positive about patient experience of the practice. Areas identified for improvement in 2014 included improving communication for patients' with no computer access; digital signage in the waiting room for patents' to receive messages and improvements on the health advice section in their newsletter. An action plan had been put into place to address these issues.

Areas for improvement

Action the service MUST take to improve

- The practice must ensure that patients' confidentiality within the surgery is respected at all times and ensure that processes around records management protect patients' confidentiality.
- The practice's infection control policy must reflect the guidance as detailed in the Health and Social Care Act 2008 - Code of Practice on the Prevention and Control of Infections.
- The appraisal system must be an opportunity for staff to consider their development and learning needs.

Action the service COULD take to improve

- Communication between staff members required improvements to ensure that all staff were aware of how the practice should operate.
- The practice had a complaints policy and patients were aware of how to raise concerns. However, analysis of complaints received could demonstrate that all are been acted upon.
- The practice had arrangements in place for staff whistleblowing and for safeguarding vulnerable adults and children, but policies which under pinned these arrangements could be fully reviewed and updated to ensure they are accurate and fit for use

Westbourne Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector and a GP and the team also had a practice manager.

Background to Westbourne Medical Centre

Westbourne Medical Centre is situated in an urban location at Milburn Road, Westbourne, Bournemouth, BH4 9HJ and covers an area of three square miles. The practice has approximately 16,000 patients registered for care and treatment.

The practice served a population of which the majority considered themselves to be white British. There are a high proportion of patients aged 65 years or older.

The practice offered appointments with GPs, nurse practitioners and practice nurses at the following times:

- Monday to Friday 8am to 11am and 3:00 pm to 5:30 pm.
- Emergency Duty Appointments 5:30 pm to 6:30 pm
- An evening surgery was available on Monday evenings from 6.30pm to 8.30pm.

The practice team consists of seven GPs, two salaried GPs, two nurse practitioners, four practice nurses, two healthcare technicians, reception and administration staff and a practice manager.

The practice also offered a service for 15 care homes in their practice area and a care home for people with learning disabilities. The practice used the 111 service for out of hour's provision.

Why we carried out this inspection

We inspected this service 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

Before visiting, we reviewed a range of information we hold about the service and asked other organisations to share what they knew about the service. Such as local Healthwatch, NHS England and the local Clinical Commissioning Group. We carried out an announced visit on 3 June 2014. During our visit we spoke with a range of staff including GPs, practice nurses and the practice manager and spoke with patients who used the practice.

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

- 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

Detailed findings

- 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

Are services safe?

Summary of findings

Improvements are needed to ensure the practice is safe.

- There were systems in place for identifying and recording significant incidents, but these were not consistently followed by staff to ensure that patients' were protected from the potential of harm.
- The practice had arrangements in place for safeguarding vulnerable adults and children, but policies which under pinned these arrangements had not been fully reviewed and updated to ensure they were accurate and in line with best practice.
- Risk assessments in place to protect the patients' when they used the building did not adequately identify and or minimise the risk of cross infection.
- Suitable safe arrangements were in place for the management and handling of medicines at the practice.
- Staff were recruited in a safe manner, but appropriate checks were not consistently carried out in line with practice policy and procedures.
- There were suitable arrangements in place for dealing with emergencies.

Our findings

Learning from Incidents

GPs we spoke with told us that significant events were recorded on their computer systems. Information from these events was shared at meetings and learning points were actioned. This was confirmed by minutes of practice meetings. We spoke with members of the nursing team and they were aware of how to report an incident and told us they usually attended meetings about this topic. However, staff described one incident where a medication error occurred which was not recorded and was only discussed verbally with a GP. The member of staff said that learning had occurred as a result of this particular incident even though this was not recorded. We reviewed the significant event log and found that overarching analysis had not been undertaken to ensure patient safety and learning.

Safeguarding

The practice had policies and procedures on safeguarding adults and children from harm or abuse. These had been reviewed in May 2014. We found that these policies did not reference the local authority guidance for the training of staff and were not updated to ensure all information was current and accurate. For example, the adult safeguarding policy had a reference to an Adult Services Inspectorate, which has not been in existence for over ten years.

The practice's adult safeguarding policy had detailed information on definitions on the types of abuse and how to recognise signs and symptoms. Staff we spoke with were able to describe signs and symptoms of abuse and how they would report such concerns to the lead GP. The practice did not provide training as recommended in the local authority's guidance, which followed the National Capability Framework for Safeguarding Adults. This sets out which staff should receive safeguarding awareness training, such as reception staff or more in depth training for clinicians and nurses. Clinical staff told us they had undertaken on line training in safeguarding, but this had not been provided for non-clinical staff.

The adult safeguarding policy stated that the GP should consider whether to protect a patient with the 'duty of confidentiality' before deciding whether to refer concerns to other agencies.

We saw that the children's safeguarding policy had links to relevant local authority processes and procedures to be

Are services safe?

followed if a member of staff suspected a child was at risk. However, the local policy referenced the Child Protection Register, this terminology has not been used nationally for over ten years. There were also lengthy extracts from legal frameworks and House of Lord's judgments. The policy did not set out clearly what signs and symptoms clinicians and non-clinicians should be looking for when dealing with families or children and young people. There were no details on how staff should respond to any concerns they might identify.

The practice had a whistleblowing policy in place, but only one member of staff we spoke with was aware of the policy and how they would report concerns. The policy stated that staff should write to the general manager, but no details were given of who this person was.

Whistleblowing policies did not allow for anonymous concerns to be raised, there was no reference to external agencies including the Care Quality Commission to whom concerns could be reported.

Monitoring Safety & Responding to Risk

The practice had risk assessments in place to ensure the health and safety was protected for patients, visitors and staff members. We looked at minutes of the practice staff meetings and found that reviews of risk assessments had been undertaken. These included sampling for Legionella (this is a bacteria found in water storage systems which can cause illness in people) and fire safety.

The practice manager and GPs dealt with safety alerts received from agencies such as the Medicines and Healthcare Products Regulatory Agency. They told us that when needed action was taken to ensure the safety of patients.

Medicines Management

We looked at the arrangements for managing medicines in the practice. We found the practice had suitable policies and procedures in place for the management of medicines. These included safe storage and handling of prescriptions. Arrangements were in place for repeat prescriptions with reviews being carried out routinely to ensure medicines were still required and effective for patients. Requests for repeat prescriptions were completed within two working days.

Nurse practitioners employed by the practice were able to prescribe medicines and had completed appropriate training to carry out this role. One nurse practitioner we spoke with told us that there were templates on the system to ensure that medicines were prescribed safely and in line with prescribing guidance.

Medicines were stored appropriately. We found that emergency medicines were available and were checked on a weekly basis or when needed to ensure they were within their expiry date and safe to use. The practice had three fridges which were used for the storage of vaccines and medicines which required cold storage. The temperatures of the fridges were checked on a daily basis to ensure they were working within safe limits.

One of the healthcare technicians was responsible for monitoring the stock of medicines. They told us they carried out regular checks of expiry dates and ensured the disposal of medicines which were out of date. This process was aided by use of a computer data base on which all medicines were recorded and when logged when they were used.

There was a community pharmacy situated in the same building as the practice. The pharmacy was owned by four of the practice GPs, but run as a separate entity. We spoke with the senior pharmacist who told us that they worked with the practice and assisted in medicines reviews in the practice. They also offered a medicines review service from the pharmacy. GPs we spoke with said that if there were issues with prescription, then the pharmacist would let them know.

Cleanliness & Infection Control

The practice did not have suitable arrangements and procedures in place to ensure patients were fully protected from the risks of infection. The practice had a nominated infection control lead who was a member of the administration team. The infection control policy did not reflect the guidance as detailed in the Health and Social Care Act 2008- Code of Practice on the prevention and Control of infection. The policy consisted of cleaning schedules and staff members responsible for these. There was limited information on how often checks of infection control should be carried out.

We saw that the practice was visibly clean and tidy. Seating in the waiting area was torn and had been taped over and could not be cleaned effectively. The practice manager told us that replacement seating had been ordered. Clinical rooms on one side of the building where nurse

Are services safe?

practitioners and GPs worked had carpeting that was deep cleaned on a three to six monthly basis. We saw that a curtain in one of the nurse practitioners room had not been changed since July 2013, even though best practice states this should occur at least every six months in patient areas to reduce the risk of cross infection between patients.

Consulting rooms used by practice nurses and healthcare technicians had been refurbished and had sealed flooring which could be cleaned effectively. All consulting rooms had couches which could be cleaned and paper rolls were in place for protection.

On the day of our visit patient swab samples were found in one of the medicine fridges, the samples were immediately removed and taken to the appropriate fridge to be stored prior to being collected.

We saw that hand wash sinks for both staff and patients had pictorial signage on safe hand washing techniques and there were supplies of liquid soap and paper towels. Hand cleansing gel was also available for use. We found that there were supplies of personal protective equipment for staff to use, such as gloves and aprons.

The practice carried out minor surgical procedures and a consulting room had been allocated specifically for this purpose.

Clinical waste was appropriately handled and disposed of, consulting rooms had sharps bins for disposal of used needles and clinical waste bins were in place.

Staffing & Recruitment

We spoke with one member of staff about how they were recruited. They told us that references had been taken up, but a criminal records check had not been undertaken following a risk assessment to determine whether a check was needed.

Policies did not contain current information to ensure that the process followed was safe and effective.

We were provided with a copy of the practice recruitment policy. This had been updated in November 2013 and reviewed in May 2014. The policy stated that all clinical staff would have a criminal records check. The policy had not been amended to reflect the change to the checks being made by the Disclosure and Barring Service (DBS), which took over this responsibility in 2012, or that the GP performers list should be checked.

The practice manager confirmed they checked that nurses were currently registered with the Nursing and Midwifery Council.

Dealing with Emergencies

The practice had comprehensive policies and procedures in place for dealing with emergency situations, such as, adverse weather, equipment failure and staff shortage. For example, if a fridge used to store vaccines was not working then they had arrangements with a GP practice nearby to store the vaccines. There was also information on who to contact to obtain advice on use of the vaccines if the fridge was not operational for a long period of time. In addition alternative sites to provide a service had been identified for potential use if the practice building became unavailable for any reason. Risks to providing services because of power and utility failure had been considered, as had interruption of access to both clinical and paper records. These arrangements enabled the practice to manage an interruption to service provision.

Equipment

The practice had suitable arrangements in place to ensure equipment was maintained and safe to use. We saw records which showed that portable appliance testing had been carried out regularly and there were no actions to take. Other checks which had been carried out to ensure that equipment was safe to use included weekly checks on medicines and the defibrillator for emergency use.

Are services effective?

(for example, treatment is effective)

Summary of findings

Improvements were needed to ensure the practice was effective.

- The practice had suitable arrangements in place to promote best practice which included monitoring and improving outcomes for patients.
- Staff were supported to undertake relevant qualifications and training, Staff members received an annual appraisal. Staff said they did not find the appraisal process effective, as improvements or learning needs the process identified were not acted upon.
- The practice promoted patients' health and provided a practice leaflet, website and other leaflets.
- They worked with other health providers to promote best practice and integrated care.

Our findings

Promoting Best Practice

The practice were aware of national guidelines for best practice including the National Institute for Health and Care Excellence (NICE) and the Quality and Outcomes Framework (QOF). (QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for how well they care for their patients. The results are published annually.) There were processes in place to monitor the practice's performance in relation to these. Areas which had been identified through this process as requiring improvement included prescribing of medicines used to reduce cholesterol levels in blood, to minimise the risk of strokes. We saw records which confirmed that areas of prescribing which needed to be reviewed had been identified and an action plan put into place.

Management, monitoring and improving outcomes for people

The practice had registered patients living across 15 care homes. Each care home had a GP who was responsible for supporting the care and treatment provided at each individual care home.

GPs we spoke with told us they held personal lists for patients and when they were away from the practice there was a buddying system in place to monitor results and follow up on any treatment needed. This meant the practice ensured there was some continuity of care wherever possible.

One GP told us about monitoring of admission to hospital Accident and Emergency (A&E) units. Patients who were considered to attend A&E often were reviewed by the practice to see whether more support could be provided by the practice to manage their condition.

Staffing

The practice team consisted of seven GPs, two salaried GPs, two nurse practitioners, four practice nurses, two healthcare technicians and reception and administration staff. The practice also had up to two GP trainees at a time.

Members of the nursing team told us there had recently been a high turnover of staff, but two qualified nurses were due to commence employment in the next three months.

Are services effective?

(for example, treatment is effective)

Staff were clear on their roles and responsibilities and could explain them to us. One GP trainee said they were well supported and received guidance and training to carry out their role. The nurse practitioner told us they worked as part of the duty team, as well as holding their own sessions. They said they received appropriate training and support and received regular training updates, in areas such as administering vaccines to children. The training schedule we looked at for all staff confirmed this.

The two healthcare technicians told us they were in the process of completing a national qualification in Health and Social Care. They told us that they were unable to complete the course as their tutor had left the practice, alternative arrangements had not been put into place to enable them to gain the qualification. Practice nurses we spoke with considered they received appropriate training to carry out their role, which covered areas such as customer care, chaperoning and fire safety. They said that the majority of the training was carried out on line.

All staff received an annual appraisal undertaken by one of the GPs. Some staff said they did not find this a useful exercise, as actions were not always taken where further support was requested. Members of the nursing team said that one nurse usually attended multi-disciplinary meetings and disseminated information to other members of the team.

Working with other services

Patients we spoke with said that they were referred to the local hospital when needed and they had not experienced any delays in this happening. GPs we spoke with said they worked with Intermediate Care Teams which included nurses, occupational therapists and social services to support patients' who lived in the community.

Patients were able to access a range of service easily. Health visitors and district nurses employed by the local trust were based in the practices building and were accessible if needed. Situated within the building was a private health clinic owned by five of the GPs who worked in the practice. The practice manager told us that a consulting room was used four times a week for sessions held by an NHS physiotherapist for patients registered with practice. Also, private counselling facilities were available.

Health Promotion & Prevention

We saw that health promotion leaflets were available in reception, but these were not prominently displayed for patients. This matter had been identified in a practice survey in January 2014, but had not been actioned. Leaflets covered carers groups and health checks.

The practice was situated in an area where there were support services for patients' such as alcohol addiction clinics. GPs told us they liaised with a drug and alcohol liaison service to coordinate care for those patients receiving medicines to assist them in stopping the misuse of alcohol. Staff also told us that they would signpost patients to services offered in a nearby area of Bournemouth where there was more support for patients' who misused illegal drugs, such as a needle exchanges and a self-referral service for stopping their drug misuse.

The practice website had links to self-management of conditions, such as women and men's health and allergy advice.

This meant that individual patients' needs were planned for so they received appropriate treatment and support.

Are services caring?

Summary of findings

Patients received appropriate care and treatment, but improvements were needed to ensure their privacy was respected and informed consent was obtained.

- Patients told us they were treated with respect by staff and their privacy and dignity were maintained when they attended appointments. There were arrangements in place if a patient requested a chaperone.
- Patients were asked for their consent prior to any care or treatment being carried out.

Our findings

Respect, Dignity, Compassion & Empathy

Patients we spoke with said that they were treated with respect by staff who worked at the practice. Patients considered that they received sufficient time to discuss their condition with GPs and nurses. Patients told us that they thought reception staff were friendly and helpful. One mother who was attending the practice for her baby's six week health check told us she was pleased that she had received her ante natal care from the same midwife.

The practice had a policy on chaperoning patients when needed. The policy clearly set out the roles and responsibilities of the chaperone. Staff we spoke with said they were aware of providing a chaperone if needed, but this had not been requested. One member of staff said they had received training on being a chaperone.

We saw there was a separate area away from the reception desk for patients to wait. This helped to promote confidentiality, however, we overheard a member of the reception staff telling a person on the telephone that a patient had recently died and naming them. This did not protect patient confidentiality as personal details were heard clearly. This was raised with the registered manager during the feedback session at the end of the inspection.

Involvement in decisions and consent

Patients told us that GPs and nurses asked for their consent and made sure they had sufficient information with which to make a decision. One of the GPs we spoke with said that when a local care home requested do not resuscitate decisions to be formalised they saw the patient to discuss this with them. The GP was able to describe the process they would carry out if a patient was unable to make an informed choice about their care or treatment. They told us about best interest decisions and involvement of relatives, other people who knew the patient or health professionals in the decision making process to ensure the patients views were suitably represented. They added that if needed they would write down information or use pictures to aid understanding. A trainee GP said that some of their consultations were recorded for training purposes and patients' were always asked for their consent before this happened.

Are services responsive to people's needs?

(for example, to feedback?)

Summary of findings

The practice was responsive to patients' needs, but improvements were needed.

- There were arrangements in place for patients to access the appointments system either on the telephone, in person or on line. Appointments were provided for urgent conditions and on a routine basis. When needed telephone consultations and home visits were organised.
- The practice had a complaints policy and patients were aware of how to raise concerns.

Our findings

Responding to and meeting people's needs

The practice had a virtual Patient Participation Group (PPG) who liaised via email, which represented the patient views on areas such as the appointment system and communication with the practice. The practice used a traffic light system to triage calls to the practice. This meant that if a patient's condition was urgent then they would be classified as red to be seen on the same day, an amber rating indicated that the patient needed to be seen within 48 hours and green was for a routine condition which could be seen within one to two weeks. Patients we spoke with said they sometimes had to wait to see a GP of their choice, but were seen on the same day if there was an emergency. Two patients said they used the practice website to book appointments.

GPs offered telephone appointments and emergency appointments at the end of their morning and afternoon surgeries. The nurse practitioner told us they worked as part of the duty team which consisted of a duty doctor and another GP and themselves. They said this team dealt with all the patients who needed to be seen on the same day.

Patients were able to access support if their first language was not English. One GP told us about the language telephone translation service which was available to use when patients' did not speak English as their first language. They said that some patients were refugees and the practice did not record their addresses because of their status.

One GP told us about the development of a crisis team for patients with dementia and how this has ensured early intervention in their care and treatment. The practice also liaised with local emergency care practitioners (ECP) to reduce hospital admissions. ECP are first responders to an emergency situation and were usually nurses or paramedics who have undergone further training.

The practice provided a service to a care home where patients' who had a learning disability lived. A GP told us these patients required input from psychiatrists and they were aware of other patients' with learning disabilities who lived in the community supported by care workers. They said that they worked with other health professionals to provide care and treatment.

Are services responsive to people's needs?

(for example, to feedback?)

When patients were receiving end of life care, arrangements were made for 'just in case' medicines to be available in patients' homes or care homes. This was put in place so that symptoms such as sickness and pain could be treated effectively without the need to see a GP. This meant patients who received end of life care had a choice of treatments available to them quickly.

Clinics were offered to monitor and manage long term health conditions and needs such as asthma, family planning, blood pressure checks and child health checks. Practice nurses offered vaccine clinics and women's health checks.

Access to the service

Patients we spoke with said they did not have any concerns about getting an appointment to be seen. However, comments from more than 60 patients on the NHS Choices website were looked at showed which showed that other patients were not always satisfied that they could get an appointment. For example, one patient wanted to see a GP, but could not get an appointment due to the GPs having personal lists, which meant they were only seen by that GP. This was responded to by the practice manager who said that a telephone consultation was offered and arrangements could have been made to see another GP.

Patients were aware of the out of hour's service and knew how to access it. GPs told us that information was sent to the out of hour's service when needed, for example when a patient was receiving end of life care. Any information on patients who had used the out of hour's service was incorporated in to the patients' records for continuity of care and treatment.

One of the six patients we spoke with said that they had been waiting for over 25 minutes after their appointment time, they were not concerned about the wait, but they said they would appreciate being informed that appointments were running behind schedule.

Patients' with limited mobility were able to access the premises easily. We saw the practice had a level entry and electric doors, patients' who had limited mobility or used a wheelchair were able to access the building. All consulting rooms were also on the ground floor.

Concerns & Complaints

There procedures in place for dealing with complaints. Patients told us that they were aware of how to make a complaint. We saw there was a suggestion box in the reception area. The practice leaflet also had information on how to raise any concerns and how the practice would respond.

Are services well-led?

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

Summary of findings

Improvements were needed to ensure the practice was well led.

- The practice had a clear vision of how it should operate and develop. There were links with other health professionals and providers to promote best practice.
- Staff meetings were held but these did not fully engage with all staff members.
- Governance arrangements in place did not fully protect patients from confidential information being disclosed inappropriately.
- Opportunities were made available for staff and patients to comment on the service provided, however these were not effective for staff members.
- Risks were identified, but there was no clear process to ensure these were minimised effectively.

Our findings

Leadership & Culture

The practice had a clear vision of how it should operate and develop, however not all staff were fully included in this process. All the GPs were spoken with were aware of the business plans of the practice and how partners wanted the practice to develop. However, this information was not effectively cascaded to other staff. Members of the nursing team we spoke to were not fully aware of the business plans of the practice and plans for development.

Communication between staff members required improvements to ensure that all staff were aware of how the practice should operate. The team of GPs and nurse practitioners and the practice manager considered there was effective communication between all staff members of the practice. However, other staff groups said that they did not routinely see the practice manager. They said that GPs were approachable on an individual basis, but not as a group. They considered that staff members operated in individual teams, rather than as a whole.

We saw that there were clinical meetings and meetings for reception staff, but there was no information on attendees for those that attended reception staff meetings. Members of the nursing team said that they did not routinely attend multi-disciplinary meetings and did not have educational meetings.

Governance Arrangements

Staff we spoke with were able to describe best practice when managing confidential and personal information, but were at that time unable to identify the practice Caldicott guardian. (This is the person responsible for ensuring that all information and data is handled and stored securely). All GP practices should have a named person as their Caldicott guardian to be responsible for handling and sharing of confidential information.

We saw a notice in the ladies toilet which advertised the pharmacy situated in the building. This stated that patients who had chosen to use this pharmacy would by default have given consent for their medical records to be accessed by the pharmacy staff. We spoke with a GP and the pharmacist who said that about 55% of patients used the pharmacy for their repeat prescriptions. When asked whether other patients' information that did not use the pharmacy was protected, we were told it was reliant on

Are services well-led?

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

professional judgment of the pharmacist. There were no processes in place which ensured that the practice shared information with the pharmacy in a manner which protected the rights of those patients who had not consented to their records being accessed by pharmacy staff.

Systems to monitor and improve quality & improvement

Two of the practice GP's carried out GP training and said that they received relevant training to carry out these roles. The GP trainee who we spoke with said that they were well supported and able to learn.

Systems used to identify risk did not ensure that changes to practice were put into place if needed. Meetings were regularly held about significant events, these were minuted. We found that overarching analysis had not been carried out to identify common themes and were lacking details of actions taken. There were no dates for review to ensure that any actions taken were effective.

GPs told us they were responsible for audits of clinical practice and used information from national audits, such as the Quality Outcomes Framework, to inform them of where areas of concern were. Records we looked at showed that actions were taken to improve outcomes for patients. For example the practice was working towards ensuring patients were on the correct medicines for their blood cholesterol levels.

We looked at the practice complaints log. Since April 2013 the practice had recorded 23 complaints. These had been investigated and the patient responded to. We noted that five were in relation to uncaring doctors and for each of these the complaints had been marked as no further action required.

Patient Experience & Involvement

The practice had systems in place which enabled patients to comment on the service provided. The practice had a virtual Patient Participation Group (PPG) who coordinated a survey undertaken in November 2013. The survey was broadly positive about patient experience of the practice. Areas identified for improvement in 2014 included improving communication for patients with no computer access, digital signage in the waiting room for patents to receive messages and improvements on the health advice section in their newsletter. An action plan had been put into place to address these issues. A suggestion box was available in the waiting area and this was accessed only by the practice manager.

The PPG group did not meet face to face, but corresponded via email. The PPG was not wholly representative of the ethnicity or diversity of the patients the practice served. We noted the practice leaflet requested that patients of a 'non British background' became involved in the group.

Staff engagement & Involvement

Systems for staff to give feedback on service provision required improvement. Members of nursing staff we spoke with said that they did not consider that their ideas and thoughts about developing the practice were listened to or acted upon by the practice management. They reported limited contact with the practice manager and GPs. They added they used to have a weekly management meeting, but this had stopped. The practice had not carried out a staff survey during the past twelve months to gather views on service provision.

Learning & Improvement

The practice had systems in place to monitor and assess patient outcomes to determine whether their treatment was effective and consistent. GPs told us they used information from the Quality Outcomes Framework to monitor how the practice was performing. They also monitored telephone calls to the reception team to ensure that staff were responding appropriate and professionally. Learning had resulted in some changes, for example, where possible there was avoidance of brand name medicines being prescribed. GPs specialised in different areas of care, such as arthritis and systems were in place to automatically recall patients for health checks.

Identification & Management of Risk

The practice had a private clinic and pharmacy situated in the same building. Both of which were owned and operated by partners in the GP practice. There were no clear lines of management systems in the practice for how the practice interacted with these services to ensure patient choice and confidentiality of information.

The nursing team did have protected learning time which allowed them to reflect on their practice and make improvements needed.

The practice did not have an overarching risk management plan however clinical risks were identified and acted upon.

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

- The guidance on protecting vulnerable adults was not up to date although the staff were aware of how to recognise signs and symptoms of abuse.
- Information was provided on keeping well and self-management of health and medical conditions.
- Reviews and clinics were offered for patients who were older, these included annual health checks.
- When a patient was receiving end of life care the practice worked with the local community hospital which specialised in palliative care.

Our findings

Safe

The practice had policies and procedures on safeguarding adults. We found that these policies did not fully reference the local authority's guidance. They had not been fully reviewed and updated to ensure all information was current and accurate. This meant that the correct guidance for staff to follow was not available.

Staff we spoke with was able to describe signs and symptoms of abuse and how they would report such concerns to the lead GP. They told us they had undertaken on line training in safeguarding, but this had not been reviewed to ensure it was effective and put into practice.

Caring

Patients we spoke with said that they were treated with respect by staff who worked at the practice.

Patients told us that GPs and nurses asked for their consent and made sure they had sufficient information with which to make a decision. One of the GPs we spoke with said that when a local care home requested do not resuscitate decisions to be formalised they saw the patient to discuss this with them. The GP was able to describe the process they would carry out if a patient was not able to make an informed choice. A trainee GP said that some of their consultations were recorded for training purposes and patients were always asked for their consent before this happened. This meant that consent was obtained at the point of a patient receiving treatment.

Effective

Patients received treatment based on recognised guidance to meet their needs. GPs and the nurse practitioner told us that they used templates on their computer system when diagnosing and treating patients. These templates included guidance on medicines to prescribe. The templates were based on recognised best practice standards, such as the National Institute for Health and Care Excellence.

Older people

GPs we spoke with said they were also responsible for carrying out clinical audits which were based on the Quality and Outcomes Framework which were completed yearly for the Clinical Commissioning Group (CCG). There were areas which had been identified through this process as requiring improvement such as the prescribing of medicines used to reduce cholesterol level in blood, to minimise the risk of strokes. One GP said they were due to undertake a review of antibiotics prescribed at the practice. We saw records which confirmed that areas of prescribing which needed to be reviewed had been identified and an action plan put into place.

The practice had 15 care homes registered with it. One GP told us that each care home had a GP who was responsible for the care and treatment provided at each individual care home.

Patients we spoke with said that they were referred to the local hospital when needed and they had not experienced any delays in this happening. GPs we spoke with said they worked with Intermediate Care Teams which included nurses, occupational therapists and social services to support patients who lived in the community.

We saw that health promotion leaflets were available in reception, but these were not prominently displayed for patients. This matter had been identified in a practice survey, but had not been actioned. Leaflets covered carers' groups and highlighted annual health checks for over 65 year olds.

One GP who was the lead for a local care home for people with dementia, said that they were aware of services arranged locally to enhance treatment provision, this included 'Singing for the Brain' sessions organised by the Alzheimer's Association. These are sessions where music and song is used to promote memory skills, by singing well known songs. They added that if a patient presented with early signs of dementia this was flagged up on the computer system so appropriate support could be given.

The practice website had links to self-management of conditions, such as women and men's health and allergy advice.

Responsive

One GP told us about the development of a crisis team for patients with dementia and how this has ensured early intervention in their care and treatment. The practice liaised with local emergency care practitioners (ECP) to reduce hospital admissions. ECP are 'first responders' to an emergency situation and were usually nurses or paramedics who have undergone further training.

When patients were receiving end of life care arrangements were made for 'just in case' medicines to be available in patients homes or care homes, so that symptoms such as sickness and pain could be treated effectively without the need to see a GP. This meant patients who received end of life care had a choice of treatments available to them quickly.

Well led

The GPs had a clear vision of how it should operate and develop, however not all staff were fully included in this process. The practice held meetings with other health professionals to promote best practice, but not all staff members attended these meetings, so learning was not effectively shared and put into place. There were systems in place to identify and manage risk to patients, but there was no clear process to ensure that actions taken were effective.

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

- The guidance on protecting vulnerable adults was not up to date although the staff were aware of how to recognise signs and symptoms of abuse.
- Information was provided on keeping well and self-management of conditions.
- Reviews and clinics were offered for patients' with a long term health or medical condition.

Our findings

Safe

The practice had policies and procedures on safeguarding adults. We found that these policies did not fully reference the local authority's guidance. They had not been fully reviewed and updated to ensure all information was current and accurate. This meant that the correct guidance for staff to follow was not available.

Staff we spoke with were able to describe signs and symptoms of abuse and how they would report such concerns to the lead GP. They told us they had undertaken on line training in safeguarding, but this had not been reviewed to ensure it was effective and put into practice.

Caring

Patients we spoke with said that they were treated with respect by staff who worked at the practice. Patients told us that GPs and nurses asked for their consent and made sure they had sufficient information with which to make a decision. A GP was able to describe the process they would carry out if a patient was able to make an informed choice. A trainee GP said that some of their consultations were recorded for training purposes and patients were always asked for their consent before this happened. This meant that consent was obtained at the point of a patient receiving treatment.

Effective

GPs and the nurse practitioner told us that they used templates on their computer system when diagnosing and treating patients. These templates included guidance on medicines to prescribe. The templates were based on recognised best practice standards, such as the National Institute for Health and Care Excellence.

Patients received treatment based on recognised guidance to meet their needs. GPs we spoke with said they were also responsible for carrying out clinical audits which were based on the Quality and Outcomes Framework which

People with long term conditions

were completed yearly for the Clinical Commissioning Group (CCG). Areas which had been identified as requiring improvement included prescribing of statins (medicines used to reduce cholesterol level in blood, to minimise the risk of strokes). We saw records which confirmed that areas of prescribing which needed to be reviewed had been identified and an action plan put into place.

The pharmacist told us they undertook a session each week which covered reviewing care and treatment of patients with asthma and breathing conditions. They confirmed they followed the practice template and highlighted any areas of concern to the relevant GP or nurse practitioner.

The practice website had links to self-management of conditions, such as women and men's health and allergy advice.

Responsive

When patients were receiving end of life care arrangements were made for 'just in case' medicines to be available in patients homes or care homes, so that symptoms such as sickness and pain could be treated effectively without the need to see a GP. This meant patients who received end of life care had a choice of treatments available to them quickly.

Clinics were offered to monitoring and management of conditions such as asthma, heart disease, diabetes and blood pressure checks.

Well led

The practice had a clear vision of how it should operate and develop, however not all staff were fully included in this process. The practice held meetings with other health professionals to promote best practice, but not all staff members attended these meetings, so learning was effectively shared and put into place. There were systems in place to identify and manage risk to patients, but there was no clear process to ensure that actions taken were effective.

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

- The guidance on protecting vulnerable adults was not up to date although the staff were aware of how to recognise signs and symptoms of abuse.
- The guidance on protecting vulnerable children was not up to date however staff were aware of how to recognise signs and symptoms of abuse.
- Not all staff were aware of how to obtain consent from patients' aged 16 years old or under.
- Antenatal and post natal care was offered by the practice for pregnant women.
- Child development checks and vaccinations clinics were offered by the practice.

Our findings

Safe

We saw that the children's safeguarding policy had links to relevant local authority processes and procedures to be followed if a member of staff suspected a child was at risk. However, the local policy referenced the Child Protection Register, this terminology has not been used nationally for over ten years. There were also lengthy extracts from legal frameworks and House of Lord's judgments. The policy did not set out clearly what signs and symptoms clinicians and non-clinicians should be looking for when dealing with families or children and young people. There were no details on how staff should respond to any concerns they might identify.

Staff we spoke with were able to describe signs and symptoms of abuse and how they would report such concerns to the lead GP. They told us they had undertaken on line training in safeguarding, but this had not been reviewed to ensure it was effective and put into practice.

Caring

Patients we spoke with said that they were treated with respect by staff who worked at the practice. One mother who was attending the surgery for her baby's six week health check told us she was pleased that she had received her ante natal care from the same midwife.

Patients told us that GPs and nurses asked for their consent and made sure they had sufficient information with which to make a decision. We spoke with staff members about consent arrangements for young patients under the age of 16 years olds. They were not all aware of Gillick Competence principles related to obtaining consent. Improvements are needed to ensure all staff were aware of these principles when providing care and treatment, to make sure appropriate care is given.

Effective

GPs and the nurse practitioner told us that they used templates on their computer system when diagnosing and

Mothers, babies, children and young people

treating patients. These templates included guidance on medicines to prescribe. The templates were based on recognised best practice standards, such as the National Institute for Health and Care Excellence.

Patients received treatment based on recognised guidance to meet their needs. GPs we spoke with said they were also responsible for carrying out clinical audits which were based on the Quality and Outcomes Framework which were completed yearly for the Clinical Commissioning Group (CCG). Areas which had been identified as requiring improvement had action plans put into place and these were monitored.

Health visitors and district nurses employed by the local trust were based in the practice's building and were accessible if needed. This meant that patients' were able to access a range of service easily.

The practice website had links to self-management of conditions, such as child health and women's health.

Responsive

Parents with young children were able to have them vaccinated against illnesses such as measles, mumps and rubella. This meant that young children could be protected against illness.

Child development checks were offered at six weeks of age, at the same time as post natal checks. Appointments could be made with health visitors to carry out development checks for children aged two to two and half years old, if a parent requested this. This meant that the health and welfare of children was monitored and treatment could be offered if needed.

Antenatal care was carried out at the practice and this was led by the GP and a midwife. Pregnant women could opt to have shared care with a hospital consultant. This meant a pregnant woman could choose where they wanted to receive treatment whilst pregnant.

The practice's website specified that family planning service were only available for patients over 16 years of age. This could potentially discourage and alienate young people from seeking appropriate care and treatment.

Well led

The practice had a clear vision of how it should operate and develop, however not all staff were fully included in this process. The practice held meetings with other health professionals to promote best practice, but not all staff members attended these meetings, so learning was not effectively shared and put into place. There were systems in place to identify and manage risk to patients, but there was no clear process to ensure that actions taken were effective.

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

- The guidance on protecting vulnerable adults was not up to date although the staff were aware of how to recognised signs and symptoms of abuse.
- Extended opening hours were offered so patients who had to work were able to access care and treatment at a time suitable for them.
- Vaccinations for travel and illnesses such as Hepatitis B were offered by the practice.
- Patients aged 40 to 74 years old were able to have a health check if they wanted one.
- Information was provided on keeping well and self-management of health conditions.

Our findings

Safe

The practice had policies and procedures on safeguarding adults. We found that these policies did not fully reference the local authority's guidance. They had not been fully reviewed and updated to ensure all information was current and accurate. This meant that the correct guidance for staff to follow was not available.

Staff we spoke with were able to describe signs and symptoms of abuse and how they would report such concerns to the lead GP. They told us they had undertaken on line training in safeguarding, but this had not been reviewed to ensure it was effective and put into practice.

Caring

Patients we spoke with said that they were treated with respect by staff who worked at the practice. Patients told us that GPs and nurses asked for their consent and made sure they had sufficient information with which to make a decision. The GP was able to describe the process they would carry out if a patient was able to make an informed choice. A trainee GP said that some of their consultations were recorded for training purposes and patients were always asked for their consent before this happened. This meant that consent was obtained at the point of a patient receiving treatment.

Effective

GPs and the nurse practitioner told us that they used templates on their computer system when diagnosing and treating patients. These templates included guidance on medicines to prescribe. The templates were based on recognised best practice standards, such as the National Institute for Health and Care Excellence.

Patients received treatment based on recognised guidance to meet their needs. GPs we spoke with said they were also responsible for carrying out clinical audits which were based on the Quality and Outcomes Framework which

Working age people (and those recently retired)

were completed yearly for the Clinical Commissioning Group (CCG). Areas which had been identified as requiring improvement had action plans put into place and these were monitored.

The practice website had links to self-management of conditions, such as women and men's health and allergy advice.

Responsive

Clinics were offered to monitoring and management of conditions such as asthma, adult immunisation for travel and family planning.

Telephone consultations were offered to patients and there was an evening surgery on Mondays from 6.30pm to 8.30pm by appointment only. The practice also offered an emergency duty appointment session Monday to Friday from 5.30pm to 6.30pm. This meant that those patients who were working were able to access the practice at a time convenient for them.

Well led

The practice had a clear vision of how it should operate and develop, however not all staff were fully included in this process. The practice held meetings with other health professionals to promote best practice, but not all staff members attended these meetings, so learning was effectively shared and put into place. There were systems in place to identify and manage risk to patients, but there was no clear process to ensure that actions taken were effective.

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

- Patients were treated with respect and their dignity and privacy maintained.
- A translation service was available if needed.

Our findings

Safe

The practice had policies and procedures on safeguarding adults. We found that these policies did not fully reference the local authority's guidance. They had not been fully reviewed and updated to ensure all information was current and accurate. This meant that the correct guidance for staff to follow was not available.

Staff we spoke with were able to describe signs and symptoms of abuse and how they would report such concerns to the lead GP. They told us they had undertaken on line training in safeguarding, but this had not been reviewed to ensure it was effective and put into practice.

Caring

Patients we spoke with said that they were treated with respect by staff who worked at the practice. Patients told us that GPs and nurses asked for their consent and made sure they had sufficient information with which to make a decision. This meant that consent was obtained at the point of a patient receiving treatment.

Effective

Patients received treatment based on recognised guidance to meet their needs. GPs and the nurse practitioner told us that they used templates on their computer system when diagnosing and treating patients. These templates included guidance on medicines to prescribe. The templates were based on recognised best practice standards, such as the National Institute for Health and Care Excellence.

Responsive

One GP told us about the language telephone translation service which was available to use when patients did not

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

speak English as their first language. They said that some patients were refugees and the practice did not record their addresses because of their status. This meant that patients were able to receive appropriate support.

The practice provided a service to a care home where patients who had a learning disability lived. A GP told us these patients required input from psychiatrists and they were aware of other patients with learning disabilities who lived in the community supported by care workers. They said that they worked with other health professionals to provide care and treatment.

Well led

The practice had a clear vision of how it should operate and develop, however not all staff were fully included in this process. The practice held meetings with other health professionals to promote best practice, but not all staff members attended these meetings, so learning was effectively shared and put into place. There were systems in place to identify and manage risk to patients, but there was no clear process to ensure that actions taken were effective.

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 guidance on protecting vulnerable adults was not up to date although the staff were aware of how to recognise signs and symptoms of abuse.
- Patients were treated with respect and their dignity and privacy maintained.
- The practice worked with other agencies to provide care for patients' who were experiencing poor mental health.

Our findings

Safe

The practice had policies and procedures on safeguarding adults and children. They had not been fully reviewed and updated to ensure all information was current and accurate. For example, the adult safeguarding policy had a reference to an Adult Services Inspectorate, which has not been in existence for over ten years. This meant that the correct guidance for staff to follow was not available.

Caring

Patients we spoke with said that they were treated with respect by staff who worked at the practice. Patients told us that GPs and nurses asked for their consent and made sure they had sufficient information with which to make a decision. This meant that consent was obtained at the point of a patient receiving treatment.

Effective

Patients received treatment based on recognised guidance to meet their needs. GPs and the nurse practitioner told us that they used templates on their computer system when diagnosing and treating patients. These templates included guidance on medicines to prescribe. The templates were based on recognised best practice standards, such as the National Institute for Health and Care Excellence.

Responsive

The practice was situated in an area where there were support services for patients such as alcohol addiction clinics. GPs told us they liaised with the Drug and Alcohol liaison services to coordinate care for those patients registered with their practice. For example, when a patient was receiving medicines to assist them in stopping misusing alcohol. Staff also told us that they would signpost patients to service offered in a nearby area of Bournemouth where there was more support for patients who misused illegal drugs, such as a needle exchanges and a self-referral service for stopping their drug misuse.

People experiencing poor mental health

Well led

The practice had a clear vision of how it should operate and develop, however not all staff were fully included in this process. The practice held meetings with other health professionals to promote best practice, but not all staff members attended these meetings, so learning was effectively shared and put into place. There were systems in place to identify and manage risk to patients, but there was no clear process to ensure that actions taken were effective.

This section is primarily information for the provider

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 12 HSCA (Regulated Activities) Regulations 2010 Cleanliness and infection control. The registered provider must ensure that service users, persons employed and other who may be at risk of exposure to a health care associated infection are protected against identifiable risks by the means of effective operation of systems. Regulation 12 (1) (a) (b) (c) (2) (a)

Regulated activity	Regulation
Diagnostic and screening procedures	Regulation 12 HSCA (Regulated Activities) Regulations 2010 Cleanliness and infection control. The registered provider must ensure that service users, persons employed and other who may be at risk of exposure to a health care associated infection are protected against identifiable risks by the means of effective operation of systems. Regulation 12 (1) (a) (b) (c) (2) (a)

Regulated activity	Regulation
Surgical procedures	Regulation 12 HSCA (Regulated Activities) Regulations 2010 Cleanliness and infection control. The registered provider must ensure that service users, persons employed and other who may be at risk of exposure to a health care associated infection are protected against identifiable risks by the means of effective operation of systems. Regulation 12 (1) (a) (b) (c) (2) (a)

Regulated activity	Regulation

This section is primarily information for the provider

Compliance actions

	Regulation 17 HSCA (Regulated Activities) Regulations 2010 Respecting and involving service users The registered person must make suitable arrangements to ensure care and treatment is provided to service users with due regard to their age, sex, religious persuasion, sexual orientation, racial origin, cultural and linguistic background and any disability they may have. Regulation 17 (2) (h)

Regulated activity	Regulation
Diagnostic and screening procedures	Regulation 17 HSCA (Regulated Activities) Regulations 2010 Respecting and involving service users The registered person must make suitable arrangements to ensure care and treatment is provided to service users with due regard to their age, sex, religious persuasion, sexual orientation, racial origin, cultural and linguistic background and any disability they may have. Regulation 17 (2) (h)

Regulated activity	Regulation
Surgical procedures	Regulation 17 HSCA (Regulated Activities) Regulations 2010 Respecting and involving service users The registered person must make suitable arrangements to ensure care and treatment is provided to service users with due regard to their age, sex, religious persuasion, sexual orientation, racial origin, cultural and linguistic background and any disability they may have. Regulation 17 (2) (h)

Regulated activity	Regulation
	Regulation 18 HSCA (Regulated Activities) Regulations 2010 Consent to care and treatment. The registered person must have suitable arrangements in place for obtaining and acting in accordance with the consent of service users.

This section is primarily information for the provider

Compliance actions

Regulation 18 (1) (a) (b)(2)

Regulated activity	Regulation
Diagnostic and screening procedures	Regulation 18 HSCA (Regulated Activities) Regulations 2010 Consent to care and treatment. The registered person must have suitable arrangements in place for obtaining and acting in accordance with the consent of service users. Regulation 18 (1) (a) (b)(2)

Regulated activity	Regulation
Surgical procedures	Regulation 18 HSCA (Regulated Activities) Regulations 2010 Consent to care and treatment. The registered person must have suitable arrangements in place for obtaining and acting in accordance with the consent of service users. Regulation 18 (1) (a) (b)(2)

Regulated activity	Regulation
	Regulation 23 HSCA (Regulated Activities) Regulations 2010 Supporting workers The registered person must have suitable arrangements in place to ensure that staff employed are appropriately trained and supervised to perform their duties. Regulation 23 (1) (a) (b)

Regulated activity	Regulation
Diagnostic and screening procedures	Regulation 23 HSCA (Regulated Activities) Regulations 2010 Supporting workers The registered person must have suitable arrangements in place to ensure that staff employed are appropriately trained and supervised to perform their duties.

This section is primarily information for the provider

Compliance actions

Regulation 23 (1) (a) (b)

Regulated activity	Regulation
Surgical procedures	Regulation 23 HSCA (Regulated Activities) Regulations 2010 Supporting workers The registered person must have suitable arrangements in place to ensure that staff employed are appropriately trained and supervised to perform their duties. Regulation 23 (1) (a) (b)

Regulated activity	Regulation
Family planning services	Regulation 23 HSCA (Regulated Activities) Regulations 2010 Supporting workers The registered person must have suitable arrangements in place to ensure that staff employed are appropriately trained and supervised to perform their duties. Regulation 23 (1) (a) (b)

Regulated activity	Regulation
Maternity and midwifery services	Regulation 23 HSCA (Regulated Activities) Regulations 2010 Supporting workers The registered person must have suitable arrangements in place to ensure that staff employed are appropriately trained and supervised to perform their duties. Regulation 23 (1) (a) (b)