

Abbey Meads 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

Requires improvement



Are services safe?

Requires improvement



Are services effective?

Good



Are services caring?

Good



Are services responsive to people's needs?

Good



Are services well-led?

Requires improvement



Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

Abbey Meads Medical Group is a large practice providing primary care services to patients resident in Swindon. The practice has one main practice and two branches, Penhill Practice and Crossroads Practice, nearby. The practice has a patient population of approximately 21,200 patients of which about 15% are over 65 years of age. Patients can attend any of the practices for primary care services. It is a teaching practice for medical students and GPs specialising in primary care.

We undertook a scheduled, announced inspection at the main practice and Penhill Practice on the 28 and 29 October 2014. Our inspection team was led by a Care Quality Commission (CQC) Lead Inspector and GP specialist advisor. Additional inspection team members were a practice manager specialist advisor and a CQC observer.

The overall rating for the practice is requires REQUIRES IMPROVEMENT

Our key findings were as follows:

- Staff were caring and treated patients with kindness and respect.
- Patients were able to get an urgent appointment when they needed one. However the waiting times for routine appointments or appointments with a specific GP was three to four weeks.
- Staff explained and involved patients in treatment decisions.
- The practice had the appropriate equipment, medicines and procedures to manage foreseeable patient emergencies.
- The practice met nationally recognised quality standards for improving patient care and maintaining quality.
- Patients were treated by suitably qualified staff.
- GPs and nurses followed national guidance in the care and treatment provided.
- The practice minimised patient risk through regular reviews of incidents and significant events. The practice responded to national patient safety alerts.
- The practice had developed an advance care planning tool to record patients' end of life choices.

Summary of findings

- The practice employed their own community mental health nurse to support patients with mental health needs.

However, there were also areas of practice where the provider needs to make improvements.

The provider **must:**

- Ensure administrative staff undertaking chaperone duties have a criminal records check via the Disclosure and Barring Service.
- Ensure the practice recruitment policy is followed when recruiting staff. For example, ensuring the appropriate number of references have been received
- Ensure there are systems to assess, monitor and address risks to standards of cleanliness and hygiene and the prevention of infection.

The provider **should:**

- Review GP and nurse staffing levels to ensure adequate numbers of suitably experienced and trained staff are available to maintain a consistent level of service, patient safety and continuity of care.
- Work towards a practice team culture which promotes co-operation and inclusiveness.
- Ensure there is a system to review and action plans from patient surveys, significant events and complaints to demonstrate recommendations have been addressed.
- Ensure there is a system to monitor that staff have read patient safety alerts.
- Develop a system to ensure equipment such as scissors and wound closures are in date.

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 improvements for safe. Staff understood their responsibilities to raise concerns, and report incidents and near misses. There were processes which recognised and supported patients who were at risk of abuse. The practice had the appropriate equipment, medicines and procedures to manage foreseeable patient emergencies. Medicines were stored, checked and records accurately maintained in line with legal and safety requirements. However, some of the facilities and furnishings at the branch practice were worn, did not aid cleaning and presented a cross infection risk. The practice had a system to assess the staff numbers to meet service requirements. However, the practice had staff vacancies, and recruitment difficulties. This resulted in additional appointments slotted into the nurses sessions increasing patient waiting time or reducing the time nurses had to prepare for each patient. We saw that the duty GP was very busy covering urgent appointments. Two patients and GP's commented on the lack of continuity of patient care provided by some GP locums. The practice had written guidance to support staff with the recruitment and selection process of new staff. However, staff records we looked at did not include all the necessary documentation to verify the identity and qualifications of staff. Although we were told administration staff did not undertake chaperone duties one staff member said they did when nursing staff were not available. The member of staff had not had training for the role or had security checks via the disclosure and barring service.

Requires improvement



Are services effective?

The practice is rated as good for effective. Data showed patient outcomes were at or above average for the locality. National Institute for Health and Care Excellence (NICE) guidance was referenced and used routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessment of capacity and the promotion of good health. Staff had received essential training such as basic life support appropriate to their roles. The practice could identify all appraisals and the personal development plans for all staff. Multidisciplinary working was evidenced.

Good



Are services caring?

The practice is rated as good for caring. Data showed patients rated the practice higher than others for several aspects of care. Patients said they were treated with care, dignity and respect and they were

Good



Summary of findings

involved in care and treatment decisions. Accessible information was provided to help patients understand the care available to them. We saw staff communicated with patients with kindness and respect ensuring confidentiality was maintained.

Are services responsive to people's needs?

The practice is rated as good for responsive. The practice provided a range of services for all patient groups. The practice delivered core services to meet the needs of the main patient population groups they treated. The practice employed a mental health nurse based at the main practice. This service offered listening and other psychological therapies and sign posting to other services. Patients with end of life care needs and their families were well supported. The practice had developed an advance care planning tool to enable patients to record their end of life care decisions and wishes. The practice had a minor illness clinic twice a week. The clinic was supported by a nurse prescriber who could write prescriptions for a range of conditions. Patients were able to get urgent appointments on the same day. However, there were waits of up to three weeks for routine appointments. The practice had extended the practice opening times and patients were able to access telephone consultations. The practice had arrangements in place to support patients with disabilities. There was a loop system for patients with hearing difficulties. We observed the layout of the building enabled patients with mobility needs to gain access without assistance. The practice had a comprehensive complaints system which patients had access to via the internet or the practice leaflet.

Good



Are services well-led?

The practice is rated as requires improvement for well-led. The practice had a clear vision and strategy to deliver this. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure. Staff told us they felt supported within their individual teams. However, staff did not always feel supported by management. They told us they did not always feel they could raise concerns or request support from all members of management, because they felt they were not always taken seriously or treated with respect. The practice had a number of policies and procedures to govern activity and regular governance meetings had taken place. There were systems in place to monitor and improve quality and identify risk. However, some risks such as staff recruitment procedures and infection prevention and control measures were not addressed and put patients at risk. The practice proactively sought feedback from patients. Patient survey results demonstrated the practice had responded to the comments however, we noted that actions (from the 2013/14 practice survey) to

Requires improvement



Summary of findings

resolve the concerns were limited. There was not a clear action plan to demonstrate how actions to resolve complaints would be addressed. Staff had regular performance reviews and attended staff meetings.

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 provider was rated as good for caring, effective and responsive overall and this included this population group. The provider was rated as requires improvement for safety and for well-led. The concerns which led to these ratings apply to everyone using the practice, including this population group. Nationally reported data showed the practice had good outcomes for conditions commonly found amongst older patients. The practice provided screening and specialist clinics to promote wellbeing, the early detection of symptoms and, the protection of patients at risk of complications of disease. The practice supported older patients by enabling access to services without patients having to attend the practice, such as home visits and online services. The practice had in place advance care planning resources to support older patients to achieve their end of life choices and decisions.

Requires improvement



People with long term conditions

The provider was rated as good for caring, effective and responsive overall and included this population group. The provider was rated as requires improvement for safety and for well-led. The concerns which led to these ratings apply to everyone using the practice, including this population group. When needed, longer appointments and home visits were available. The practice supported patients with long term conditions by offering advice and support through specialist clinics, screening and evidence based information. Patients had structured annual reviews to check their health and medicines requirements were met. The practice met nationally recognised quality standards for improving patient care and maintaining quality and was above the clinical commission group average for most indicators. Staff worked with other health care providers to reduce hospital admissions and enable patients to be treated at home. The practice had in place advance care planning resources to support patients with long term conditions to achieve their end of life choices and decisions.

Requires improvement



Families, children and young people

The provider was rated as good for caring, effective and responsive overall and this included this population group. The provider was rated as requires improvement for safety and for well-led. The concerns which led to these ratings apply to everyone using the practice, including this population group. Systems were in place for identifying and following-up children who were 'at risk'. For example, the GP met regularly with other agencies to review children and their

Requires improvement



Summary of findings

families 'at risk'. Immunisation rates were relatively high for all standard childhood immunisations. Patients told us and we saw evidence children and young people were treated in an age appropriate way and recognised as individuals. Appointments were available outside of school hours and the premises were suitable for children and babies. Patients had access to contraceptive and sexual health advice and treatment.

Working age people (including those recently retired and students)

The provider was rated as good for caring, effective and responsive overall and this included this population group. The provider was rated as requires improvement for safety and for well-led. The concerns which led to these ratings apply to everyone using the practice, including this population group. The needs of the working age population, those recently retired and students had been identified. There were extended practice opening hours at the main practice. The practice offered online services as well as a full range of health promotion and screening which reflected the needs for this age group.

Requires improvement



People whose circumstances may make them vulnerable

The provider was rated as good for caring, effective and responsive overall and this included this population group. The provider was rated as requires improvement for safety and for well-led. The concerns which led to these ratings apply to everyone using the practice, including this population group. The practice held a register of patients with learning disabilities. The practice had carried out annual health checks for patients with learning disabilities. The practice offered longer appointments for patients with learning disabilities requiring more time with their GP. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and who to contact within the practice.

Requires improvement



People experiencing poor mental health (including people with dementia)

The provider was rated as good for caring overall and this included this population group. The provider was rated as requires improvement for safety and for well-led. The concerns which led to these ratings apply to everyone using the practice, including this population group. The practice employed a mental health nurse based at the main practice. The service offered listening and other psychological therapies and sign posting to other services. The practice regularly monitored patients for the side effects of certain medicines used in the treatment of mental health conditions.

Requires improvement



Summary of findings

Patients with dementia were reviewed annually and patients with depression had a bio psychosocial (physical, social and psychological) assessment. The practice website included useful links to other information and support services. The practice had in place advanced care planning to support patients with dementia to achieve their end of life choices and decisions.

Summary of findings

What people who use the service say

During the inspection we spoke with six patients attending the main practice and three patients from the branch practice. We looked at 41 patient comment cards, feedback from a practice patient survey (2013), and data from the GP National Patient Survey 2013/2014.

Patients we spoke with were overall satisfied with the care and treatment received. They described staff as professional, friendly and caring. Patients gave examples of care from the GPs who were valued because they were patient, good listeners and knowledgeable. This was supported by feedback from the GP National Patient Survey 2013/2014 which indicated 93% of the practice respondents found the receptionists helpful and 87% described their experience of the practice as good or very good. Patients felt their privacy and dignity were respected by staff although 25% of patients in the GP National Patient Survey 2013/2014 were not satisfied with the level of privacy when speaking to receptionists at the practice. The practice had begun to address the issue. There was an electronic patient booking in system and a room behind reception where patients could speak with staff in privacy. On the day of the inspection we observed staff spoke discretely and used questions which required the patient to respond with yes/no responses.

All of the patient feedback told us patients were able to get an appointment on the day if there was an urgent

need for one. This was confirmed by results from the GP National Patient Survey which demonstrated 89% of respondents were able to get an appointment the last time they tried. However, seven patients commented there was sometimes a wait of up to three weeks to see a GP at their preferred practice. This feedback was confirmed by the practice patient survey 2013/2014. Feedback from the practice patient survey demonstrated some patients were not satisfied with the time taken for the practice to answer their telephone calls.

Patients from both practices we spoke with were not aware of the complaints process. They expressed confidence in the practice's management of concerns they might raise. There was information about how to make a complaint in the practice leaflet in the practice and on the practice website.

Patients told us they were included in their care decisions, able to ask questions of all staff and had treatment explained so they could make informed choices. This was supported by feedback from the GP National Patient Survey 2014 which indicated 84% and 86% respectively of patients said their GP and nurse were good at explaining tests and treatment.

Patients from both practices told us they were satisfied with the cleanliness of the premises and equipment.

Areas for improvement

Action the service **MUST** take to improve

- Ensure administrative staff undertaking chaperone duties have a criminal records check via the Disclosure and Barring Service.
- Ensure the practice recruitment policy is followed when recruiting staff. For example, ensuring the appropriate number of references have been received
- Ensure there are systems to assess, monitor and address risks to standards of cleanliness and hygiene and the prevention of infection.

Action the service **SHOULD** take to improve

- Review GP and nurse staffing levels to ensure adequate numbers of suitably experienced and trained staff are available to maintain a consistent level of service, patient safety and continuity of care.
- Work towards a practice team culture which promotes co-operation and inclusiveness.
- Ensure there is a system to review and action plans from patient surveys, significant events and complaints to demonstrate recommendations have been addressed.
- Ensure there is a system to monitor that staff have read patient safety alerts.

Summary of findings

- Develop a system to ensure equipment such as scissors and wound closures are in date.

Abbey Meads Medical Group

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a Care Quality Commission (CQC) lead inspector and GP specialist advisor. Additional inspection team members were a practice manager specialist advisor and a CQC observer.

Background to Abbey Meads Medical Group

Abbey Meads Medical Group is a large practice providing primary care services to patients resident in Swindon. The practice has one main location (Abbey Meads Medical Practice) and two branch locations, Penhill Practice and Crossroads Practice.

As part of the inspection we visited the main practice Elstree Way, Swindon SN25 4YZ and Penhill Practice 257, Penhill Drive, Swindon, SN2 5HN. Most patient services were located on the ground floor of both buildings.

The practice has a patient population approximately of 21,200 patients of which an estimated 15% are over 65 years of age. Patients can have an appointment at any of the three practices with any GP.

The practice has two male and two female GP partners. They employ five salaried GPs, three long term, part time locums, a practice manager, eight nursing staff, two phlebotomists, 28 reception and administrative staff. Most staff work part-time.

Each GP has a specialist lead role for the practice and nursing staff have specialist interests such as respiratory disease and diabetes.

Primary care services are provided by the Abbey Meads Medical Practice Monday, Tuesday and Wednesday 8.30am to 7.30pm, Thursday 7.30 am to 7.30pm and Friday 8.30am to 6.30pm. Penhill Practice is open Monday, Tuesday and Thursday 8.30am to 4pm and Wednesday and Friday 8.30am to 1pm. GPs are available for telephone consultations and home visits. The practice has opted out of the Out of Hour's primary care provision. This is provided by another Out of Hour's provider.

Why we carried out this inspection

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

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.

How we carried out this inspection

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?

Detailed findings

- Is it well-led?

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

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

Before our inspection, we reviewed a range of information we held about the service and asked other organisations, such as the Swindon Clinical Commissioning Group and the local Healthwatch to share what they knew.

We carried out an announced inspection at the main practice and one of the branch surgeries on the 28 and 29 October 2014. During the inspection we spoke with three GPs, the practice manager, four nursing staff and administration staff across both surgeries. We spoke with nine patients who used the service. We looked at patient surveys and comment cards. We observed how staff talked with patients.

We looked at practice documents such as policies, meeting minutes and quality assurance data as evidence to support what patients told us.

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

The practice used a range of information to identify risks and improve quality in relation to patient safety. For example, reported incidents, national patient safety alerts as well as comments and complaints received from patients. Staff we spoke with were aware of their responsibilities to raise concerns, and how to report incidents and near misses. For example, we saw records which demonstrated medicines and patient care issues were identified, reported and managed in a timely manner.

Adverse events and incident reports were reviewed at significant event meetings and we saw records of these.

We saw from records that national patient safety alerts were disseminated to practice staff via the practice intranet system. For example, the prescribing of a specific antidepressant. However, we were told there was no system to monitor the alerts had been read by staff.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. Significant event meetings were held every three months and we looked at records of the last three significant event meetings. A range of events were discussed including medicines concerns and clinical issues such as referral procedures. There was evidence learning had taken place as there had been changes to practice. For example, the use of national guidelines for using a specific vitamin injection. We saw from meeting minutes that meetings were well attended by all staff groups.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. Practice training records made available to us demonstrated staff had attended safeguarding training. Two of the GP partners had child protection training at level three in line with national guidance. Remaining staff had undertaken level two safeguarding training. GPs, nursing and administrative staff we spoke with explained how they recognised signs of abuse in older patients, vulnerable adults and children. They were also aware of their responsibilities regarding information sharing within the practice and the documentation of safeguarding. We saw records which

demonstrated GPs had contacted the appropriate external agencies when they had child protection concerns. Nursing staff gave examples of how they reported vulnerable adult concerns. The practice safeguarding policies for safeguarding vulnerable adults and children were comprehensive and included contact details of other agencies.

The practice had dedicated GPs with lead responsibilities for safeguarding vulnerable adults and children who had been trained to enable them to fulfil this role. All staff we spoke with were aware who these leads were and who to speak with in the practice if they had a safeguarding concern.

We were shown there was a system to highlight vulnerable patients on the practice's electronic records. This included information to raise staff awareness of relevant issues when patients attended appointments. For example, children subject to child protection plans. We saw from clinical meeting records patients 'at risk' were discussed with the relevant healthcare professionals involved in their support.

The practice had a chaperone policy. Signs to remind patients they could ask for a chaperone were visible on the waiting room noticeboard and in consulting rooms. Staff were aware of their roles and responsibilities regarding chaperoning. We were told by the practice manager administrative staff did not act as a chaperone in the absence of a nurse. However, we spoke to one member of administrative staff who had acted in that capacity. They were able to accurately describe their role which was in line with the practice policy. However, they had not had a criminal records check via the Disclosure and Barring Service (DBS) to undertake the role of chaperone.

Patients' records were kept on an electronic computer system. Staff explained the process which enabled communications about the patient, including scanned copies of communications from hospitals, to be checked and transferred to the patient record. Staff told us changes to patients' medicines by other healthcare providers were addressed by the GPs or practice nurse. We noted on significant event reviews when incidents regarding changes to patients' medicines were discovered the problem was addressed, for example, medicines changed or stopped.

Are services safe?

There was a system to review repeat medicines for patients with co-morbidities/multiple medicines. There was an alert on the electronic records to ensure patients received an annual medicines check.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a policy which ensured medicines were kept at the required temperatures. This was being followed by the practice staff, and the action to take in the event of a potential failure was described.

Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked at both surgeries including medicines for use in an emergency were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

We saw records that noted the actions taken in response to an audit of a medicine used for the treatment of arthritis. Following the review, recommendations included checking blood tests had been received and reviewed before issuing prescriptions and ensuring patients receiving their medicines from the hospital did not also have it prescribed by the practice.

There was a protocol for repeat prescribing which was in line with national guidance and was followed in the practices. The protocol complied with the legal framework and covered all required areas. For example, how staff who generated prescriptions were trained and how changes to patients' repeat medicines were managed.

We found the directions for the administration of vaccines by nurses were completed in line with legal requirements and national guidance. Nurses told us they were up to date with immunisation training.

Cleanliness and infection control

We saw cleaning schedules in place and cleaning records were kept. Patients at both practices we spoke with told us they always found the practices clean and they had no concerns about cleanliness or infection control. Most patient areas in both practices were visibly clean. However, one of the two patient toilets at the branch practice had stains on the toilet seat. The area around the toilet seat fittings was not clean. The sink taps and hand washing sink surrounds in the patient toilet at the branch practice were

lime scaled which would not have assisted cleaning. There was no receptacle for the disposal of feminine hygiene products. The practice manager said they were not aware of the situation and had not seen the toilet concerned. Some of the patient seating at the branch practice in the waiting area was torn which would not assist cleaning.

We observed one of the external waste bins did not have a lockable lid. This had been identified in a recent infection control audit. The practice manager told us they had experienced difficulties in getting the waste disposal contractors to address the issue and were following up the problem.

The practice had a lead for infection control. We saw evidence the lead had carried out an infection control audit of the Abbey Meads practice in 2014. There were some areas of improvement identified from the audit and actions completed. However, an action plan which identified when the improvements would be completed and who was responsible for ensuring the work was completed had not been produced. On the day of the inspection the practice did not provide us with an infection control audit of the branch practice. However, this was sent to us after the inspection.

There was an infection control policy and supporting procedures as guidance for staff. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use. Staff were able to describe how they would use these in order to comply with the practice's infection control policy for example, wearing gloves when handling specimens. There was also a policy for needle stick injury (when a needle or another sharp instrument cuts through the skin).

Hand hygiene technique signage was displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms.

We looked at a small sample of equipment used in wound care. From the sample we found scissors and wound closure materials were out of date (December 2011 and October 2013 respectively) and may have put patients at risk.

The practice had a legionella risk assessment undertaken by an outside agency. Action points from the assessment were addressed.

Are services safe?

Equipment

Staff we spoke with told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. We saw equipment maintenance logs and other records that confirmed equipment was regularly tested. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example weighing scales and blood pressure monitoring equipment.

Staffing and recruitment

We looked at four staff files. We could not see evidence references had been received for the successful applicants. This was not in line with the practice recruitment policy which set out the standards it followed when recruiting staff.

There was a rota system in place for the different staffing groups to plan for the required number of staff on duty. There was an arrangement in place for members of staff, including nursing and administrative staff to cover each other's annual leave.

The practice had a number of GP vacancies and locums were used on a regular basis to cover sessions. The registered manager said they were aware of the situation and were actively recruiting. We saw the practice had published a message on their website informing patients of the staffing difficulties. In addition the practice had their list closed by NHS England for some weeks to enable them to recruit and rationalise the patient list. We were told by the registered manager some locums were regularly used however, some staff expressed concerns about the arrangement of using locums not regularly employed by the practice. They felt it impacted on continuity of patient care and follow up of patients.

We saw from the nurses' appointments list patients were slotted into the nurses' sessions. The nurses told us patients were given the support and treatment they needed regardless of the allocated time given. This was supported by the patient comments. However, we were told slotting additional patients into the nurses schedule meant some patients had longer waiting times, there was reduced time to prepare for each patients treatment or sessions overran. We saw the duty GP was very busy with face to face and telephone consultations. We saw evidence there were occasions when the duty GP had additional

urgent appointments scheduled. The practice told us they had addressed the impact of the number of consultations made by the duty GP by ensuring the duty doctor only undertook one session rather than two. Seven patients commented that to get a non-urgent appointment with a GP meant attending a practice which was not near to where they lived.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor most risks to patients, staff and visitors to the practice. These included regular checks of the building, medicines management, staffing levels and dealing with emergencies and equipment. However, some risks infection prevention and control measures and stock control were not addressed and put the patients at risk. The practice kept a risk assessment file. Risks related to minor problems identified and dealt with on the premises. The practice did not proactively identify risks and the actions necessary to reduce and manage the risk.

Patients gave us examples of how their GP responded to deterioration in their condition. For example, contacting the hospital when they were concerned about changes in a patient's condition which required prompt attention. Nursing staff told us if they were concerned about a change in a patient's condition they would seek advice from the GP, or make an appointment for the patient to see the GP.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage foreseeable emergencies at both practices. We saw records showing all permanent GPs and nurses had received training in basic life support. However, we noted one locum's training record indicated their last training was in 2011 which was not in line with national guidance of an annual update. Emergency equipment was available at both practices including access to oxygen and two automated external defibrillator (used to attempt to restart a person's heart in an emergency). All staff asked knew the location of this equipment and records we saw confirmed these were checked regularly.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis and

Are services safe?

hypoglycaemia. Processes were also in place to check emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was rated and mitigating actions

recorded to reduce and manage the risk. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained the contact details of main services. We were shown by the practice manager fire drills and fire alarm checks were undertaken regularly with the last check undertaken in July 2014.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their treatment approaches. They were familiar with current best practice guidance accessing guidelines from the Scottish Intercollegiate Guidelines Network (SIGN) and the National Institute for Health and Care Excellence (NICE) such as antibiotic prescribing for respiratory (breathing) tract infections. We saw minutes of practice meetings where new guidelines were disseminated, the implications for the practice's performance and patients were discussed and required actions agreed.

We found from our discussions with the GPs and nurses that staff completed, in line with NICE guidelines, thorough assessments of patients' needs and these were reviewed when appropriate. For example, the use of recommended care pathways to manage patients' long term conditions such as asthma and diabetes.

The GPs told us they lead in specialist clinical areas such as diabetes, heart disease and asthma and the practice nurses supported this work which allowed the practice to focus on specific conditions. Nursing staff recognised their role responsibilities and boundaries. They told us they could approach some of the practice's GPs to ask for advice and support about patients' treatment. The practice used computerised tools which identified patients with complex needs who had multidisciplinary care plans. We saw the protocol the practice used to review patients recently discharged from hospital. This supported the GP to review the discharge notes, how changes to medicines were made and patient's records updated.

National data showed the practice was in line with regional referral rates to hospital and community care services for all conditions.

All GPs we spoke with used national standards for the referral of suspected cancer. GPs told us they reviewed each other's elective and urgent referrals to hospital. We saw a practice audit to demonstrate the appropriateness of GP referrals to hospital dermatology departments for suspicious skin lesions.

National quality data demonstrated the practice's performance for prescribing medicines for example, antibiotic prescribing and anti-inflammatory medicines was comparable to the national average.

We saw no evidence of discrimination when making care and treatment decisions. Interviews with GPs showed the culture in the practice was that patients were referred on need and age, sex and race was not taken into account in this decision-making.

Management, monitoring and improving outcomes for people

Staff from across the practice had key roles in the monitoring and improvement of outcomes for patients. These roles included data input, clinical review scheduling, child protection alerts and medicines management.

The practice showed us records which demonstrated seven audits had been undertaken from 2011-2014 by the GPs. For example, we saw from a clinical audit undertaken in 2012 30% patients who had removal of the spleen had been prescribed antibiotics and had up to date immunisations. The practice set up a patient register to monitor this group of patients. A re-audit in 2013 demonstrated all patients in this category had the appropriate treatment. Other audits included a GP audit of suspected skin cancer referrals in 2014 and other cancer referrals. Examples of nursing audits were of patient attendance and follow up at the minor illnesses clinic and review of patients with contraceptive implants.

We saw some of these audits were linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF is a national performance measurement tool). For example, we saw an audit regarding the prescribing of a specific anti-depressant (2011) and another regarding the medicine used for arthritis in 2013. This followed guidance from the Medicines and Healthcare Products Regulatory Agency (The MHRA is a government agency responsible for ensuring medicines and medical devices are safe) about the use of medicines. Following the audit the GPs carried out medication reviews for patients who were prescribed these medicines and altered their prescribing practice, in line with the guidelines. However, we noted there was not a system in place to monitor whether recommended actions had been followed through. For example, the addition of medicines alerts to be added to patients electronic records.

Are services effective?

(for example, treatment is effective)

The practice also used the information they collected for the QOF and their performance against national screening programmes to monitor outcomes for patients. For example, 98.5% of patients with diabetes had an annual medication review, and the practice met all the minimum standards for QOF in asthma, chronic obstructive pulmonary disease (lung disease) and palliative care.

The practice supported mothers, children and young people by working with other healthcare providers to provide maternity services. The practice worked collaboratively with other healthcare professionals to support children 'at risk' and their families. Records demonstrated the lead GP met with health visitors to review child protection plans and gained feedback from other agencies involved.

Immunisation clinics were led by qualified and trained nurses and baby health checks were undertaken by the GP.

The practice delivered enhanced services (locally developed services over and above the essential/ additional services normally provided to patients) to promote sexual health. This included sexually transmitted disease screening.

The practice nurse based at the main practice was a nurse prescriber. They were able to prescribe contraception and emergency contraception. Nurses undertook cervical smears. Patients who did not attend were contacted and offered another appointment.

Staff regularly checked patients receiving repeat prescriptions had been reviewed by the GP. They also checked all routine health checks were completed for long-term conditions such as diabetes and the latest prescribing guidance was being used. The IT system flagged up relevant patient medicines intolerances and allergies when the GP went to prescribe medicines.

Effective staffing

Practice staffing included GPs, nursing, managerial and administrative staff. We reviewed staff training records and saw nurses and GPs with the exception of a locum GP were up to date with attending mandatory courses such as annual basic life support. The GP partners had level three child protection training.

All GPs were up to date with their yearly continuing professional development requirements and all either have been revalidated or had a date for revalidation. (Every GP is

appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

Teams met regularly for example, the nurses had meetings to discuss clinical issues, updates and practice issues. These were supported by clinical meetings for all GPs and nurses. We saw from these records outside speakers were invited. Administration staff told us they also met as a team, however, there were no minutes to support the meetings for staff who were unable to attend. All staff undertook an annual appraisal which identified learning needs from which action plans were documented.

As the practice was a training practice, GPs who were in training were offered extended appointments and had access to a senior GP throughout the day for support.

Practice nurses had defined duties they were expected to perform and were able to demonstrate they were trained to fulfil these duties for example, administration of vaccines, cervical cytology and tests to measure blood clotting time. Those nurses with extended roles were also able to demonstrate they had appropriate training to fulfil these roles for example, in family planning and respiratory disease.

Working with colleagues and other services

The practice worked with other service providers to meet patients' needs and manage complex cases. Blood results, X ray results, letters from the local hospital including discharge summaries, and records from out of hours providers were received both electronically and by post. All staff we spoke with understood their roles and responsibilities in managing information from other healthcare providers and felt the system in place worked well.

The practice had a protocol outlining the process for staff to follow with regards to passing on, reading and actioning any issues arising from communications with other care providers. The GP who saw these documents and results was responsible for the action required.

The practice met with members of the multi-professional team every three months to discuss patients with palliative and end of life care needs. The practice delivered an enhanced service (a locally developed service over and above the essential/additional services normally provided

Are services effective?

(for example, treatment is effective)

to patients) to co-ordinate and manage the care of frail older people to avoid unplanned admissions to hospital. The GP lead for child protection met with health visitors to discuss children 'at risk' and their families to review child protection plans and safeguarding concerns.

Information sharing

The practice used a number of electronic systems to communicate with other providers. Electronic systems were also in place for making referrals. (The Choose and Book system enabled patients to choose which hospital they would be seen in and to book their own outpatient appointments in discussion with their chosen hospital).

We saw patient specific information from the Out of Hours provider was provided to the practice via email. The information was scanned into the patient's electronic record and the GP informed if action was required. Out of Hours (OOH) providers were informed by the practice of patients who had died and patients at end of life. Do not attempt pulmonary resuscitation orders were faxed to the OOH provider and the ambulance service.

Consent to care and treatment

Staff were aware of the Mental Capacity Act 2005 and their duties in fulfilling it. The nurses and GPs we spoke with about the subject were aware of their responsibilities in applying the principles to their practice. They gave examples of how patients should be supported to make their own decisions. For example, staff stressed the importance of knowing their patients, how they spent time explaining treatments and how they checked patients' understood what was said. They told us how they involved carers with the patient's permission. Nurses referred patients back to a GP when they refused treatment which nurses considered to be in the patient's best interest. Staff demonstrated a clear understanding of Gillick competencies. (These help GPs and nurses to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment).

Patients with learning disabilities and those with dementia were supported to make decisions through the use of care plans which they were involved in agreeing. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it).

There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures, a patient's verbal and written consent was documented in the electronic patient notes with a record of the relevant risks, benefits and complications of the procedure.

Health promotion and prevention

Nursing staff used their contact with patients to help maintain or improve mental and physical health and wellbeing. For example, offering smoking cessation advice to smokers. There was a comprehensive range of health promotion information in the practice and on the website which included mental health advice.

The practice offered NHS Health Checks to all its patients over the age of 75 years.

The practice had ways of identifying patients who needed additional support. For example, the practice kept a register of all patients with learning disabilities and these patients were offered an annual physical health check.

The practice's performance for cervical smear uptake was 87.1% (QOF 2014) which was just above the Swindon Clinical Commissioning Group (CCG) average. The practice performance for national mammography (in last three years prior to 2013) was higher than the Gloucestershire CCG average (77% and 74.9% respectively). The uptake for national bowel screening (over six months 2013) was lower than the Swindon CCG average (48.6% and 53.3% respectively).

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance for all immunisations was equivalent to the average for the CCG. There was a protocol for following up patients who did not attend clinics or appointments related to health promotion or prevention. For example, patients who did not attend for cervical smear were contacted by letter.

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice about patient satisfaction. This included information from the GP National Patient Survey, and a survey of 20 patients undertaken by the practice in 2014. The evidence from all these sources showed patients were satisfied with how they were treated and that this was with care, dignity and respect. For example, data from the GP National Patient Survey 2013/2014 showed 87% of respondents described their overall experience of the practice as good. The practice was above the clinical commissioning group (CCG) average for its satisfaction scores on consultations with GPs and nurses with 84% of practice respondents saying the nurses were good at treating them with care and concern and 87% saying the GP gave them enough time.

Patients completed CQC comment cards to provide us with feedback about the practice. We received 41 completed cards. All had positive comments with no negative comments about the service experienced. Patients described the service the practice offered as safe, caring and kind. They felt staff often went above and beyond what was required in order to help them. They said staff treated them with dignity and respect. We also spoke with nine patients during our inspection. They all told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

Staff and patients told us all consultations and treatments were carried out in the privacy of a consulting room. Disposable curtains were provided in consulting rooms and treatment rooms at both practices. We noted that consultation and treatment room doors were closed during consultations and conversations taking place in these rooms could not be overheard.

We observed staff were discreet when speaking with patients and understood the need to keep confidential information private. There was space available at both practices for patients to have confidential conversations with staff.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their

care and treatment and generally rated the practice well in these areas. For example, data from the GP National Patient Survey 2013/14 showed 87% of practice respondents said the nurse involved them in care decisions and 84% felt the GP was good at explaining treatment and results. Both these results were above the CCG average.

Patients we spoke with on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. Patient feedback on the comment cards we received was also positive and confirmed these views. We saw examples of resources designed to involve patients in their treatment and to understand their disease. For example, the practice used patient held records to involve patients in their disease management by logging their symptoms, experiences and treatment.

Nursing staff described examples of how patient choice was respected. For example, some patients were offered options of treatment for managing wounds to minimise disruption to their lifestyle and promote independence.

Staff told us translation services were available for patients who did not have English as a first language.

The practice worked actively with local palliative care services to support patients at the end of their life. Patients and relatives were involved in advance care planning and used a practice developed document to record patients' end of life care choices and wishes.

Patient/carer support to cope emotionally with care and treatment

The survey information we reviewed showed patients were positive about the emotional support provided. For example, 83% of respondents to the GP National Patients Survey said the last GP they spoke with treated them with care and concern when it had been needed. 86% of respondents said the last nurse they saw was good at listening to them. The patients we spoke with on the day of our inspection and the comment cards we received were also consistent with this survey information.

Notices in the patient waiting room, on the TV screen and patient website also signposted patients to a number of support groups and organisations. The practice's computer

Are services caring?

system alerted GPs if a patient was also a carer. We were shown the written information available to carers to ensure they understood the various avenues of support available to them.

The practice employed a mental health nurse based at the main practice. The nurse told us they saw patients requiring emotional support, support listening and other psychological therapies. In addition the nurse signposted

patients to other services. The practice regularly monitored patients for the side effects of certain medicines used in the treatment of mental health conditions. Patients with dementia were reviewed annually and patients with depression had a bio psychosocial (physical, social and psychological) assessment.

The practice website included useful links to other information and support services.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found overall the practice was responsive to patients' needs and had systems in place to maintain the level of service provided.

Longer appointments were available for patients who needed them and for those with long term conditions. This included appointments with a GP or nurse. Patients who were unable to attend the practice due to ill health could request a home visit or telephone consultation. Patients who worked could request a telephone consultation with a GP or nurse. The patient website enabled patients to order a repeat prescription.

The practice had an action plan to respond to suggestions from the Patient Participation Group (PPG) report in 2013/2014. However, the action plan did not identify responsibilities or dates for its completion. Not all concerns expressed by patients in the practice patient survey were responded to by clear actions. For example, the length of time patients waited for phone calls to be answered.

The practice had achieved and implemented the Gold Standards Framework for end of life care. They had a palliative care register and held regular multidisciplinary meetings to discuss patient and their families care and support needs.

The practice delivered an enhanced service (locally developed service over and above the essential/additional services normally provided to patients) to co-ordinate and manage the care of frail older people to avoid unplanned admission to hospital. The practice demonstrated their achievement of this service by regular meetings with other health care providers, the development of patient care plans and the identification of the most vulnerable patients.

The nurse practitioners offered a minor illness clinic twice a week. Patients were asked health related questions by the practice receptionist to determine whether it was appropriate to see the nurses. We saw patients saw the nurse for rashes, coughs and colds. The nurses did not see patients under one year old or over 75 years of age.

The practice employed a mental health nurse based at the main practice. The service offered listening and other psychological therapies and sign posting to other services.

The senior partner undertook minor surgical procedures. Patients were referred to the senior partner by other GPs in the practice and assessed by the GP to determine whether minor practice was appropriate or required referral to hospital. The practice's audit of fast track dermatology referrals found the GP made accurate diagnostic assessments of suspicious lesions.

Tackling inequity and promoting equality

The practice had access to online and telephone translation services for patients where English was not their first language.

The premises at both practices inspected were accessible to patients. The main practice building enabled patients with mobility needs to gain access without assistance. The practice waiting area was large enough to accommodate patients using wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. There were designated chairs in the waiting room with high backs and arms to enable patients to sit down and get up safely. Accessible toilet facilities including baby changing facilities were available in the reception area.

Most patient areas were on the ground floor. There was a patient lift for patients requiring access to the first floor. The practice had an induction loop system for patients with hearing difficulties.

The branch practice had accessible toilet facilities and a baby changing area in the main practice.

Access to the service

Primary care services were provided at the main practice Monday, Tuesday and Wednesday 8.30am to 7.30pm, Thursday 7.30am to 7.30pm and Friday 8.30am to 6.30pm. The Penhill branch practice, was open Monday, Tuesday and Thursday 8.30am to 4pm and Wednesday and Friday 8.30am to 1pm. GPs were available for telephone consultations and home visits. Patients were able to request a repeat prescription via the practice website, telephone or letter.

Information was available to patients about appointments on the practice website and practice leaflet. This included how to arrange urgent appointments and home visits and how to book appointments through the website. There were also arrangements in place to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed,

Are services responsive to people's needs?

(for example, to feedback?)

there was an answerphone message giving the telephone number which they should ring depending on the circumstances. Information about the out-of-hours service was provided to patients.

Patients stated they were generally satisfied with the appointments system. Information from the GP National Patient Survey 2014 demonstrated 89% of respondents said they were able to get an appointment the last time they tried and 78% said their experience of making an appointment was good. Patient feedback confirmed they could see a GP on the same day if their need was urgent. However, there could be up to a three week wait for routine appointments if patients wished to attend their local practice. The duty GP on the day saw patients with urgent appointments and made telephone calls. Each GP working also had one or two slots for urgent appointments or telephone consultations. Patients were able to book an appointment at any of the provider's three practices. GPs did not have their own patient lists but patients could see the GP of their choice if they were available.

Feedback from the practice patient survey (2013/2014) demonstrated some patients were not satisfied with the length of time taken by the practice to answer their telephone calls. They identified this was particularly

challenging when the practice first opened. The practice had introduced an on-line appointment booking system which they suggested could be an alternative to ringing the surgery.

Listening and learning from concerns and complaints

The practice had a system for handling formally recorded complaints and concerns. Its complaint policy was in line with recognised guidance and contractual obligations for GPs in England and there was a designated responsible person who handled all complaints in the practice.

The practice had received 15 complaints in 2014 which had been managed in line with the practice policy. There were no recurring themes in the complaints. However, we noted there was no evidence to demonstrate that learning points had been followed through to change practice. Feedback from patients told us they had no complaints about the practice. Patients we spoke with said they were confident any concerns would be managed appropriately.

There was information available to patients in the practice leaflet about who to contact in the practice if they wanted to make a complaint. The practice leaflet included information about other organisations to contact if the patient was not satisfied with the way the practice handled their complaint.

Are services well-led?

Requires improvement 

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

Our findings

Vision and strategy

The practice values reflected the importance of ensuring high quality primary care provision. Staff we spoke with gave examples of how team work and knowledge of their patients enabled a high standard of effective care and treatment. All staff we spoke with were committed to meeting the practice values. There was some evidence of divides within staff groups. Some staff raised concerns about communication with management. They did not always feel they could raise concerns or request support from all members of management, because they felt they were not always taken seriously or treated with respect. Some staff told us they did not feel they knew what the practice business issues were for example, how concerns about recruitment and staffing would be addressed. Staff felt the lack of collaboration and cooperation amongst management sometimes prevented them from delivering services which were fully reflective of the practice values.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff via the practice intranet. We looked at a range of these policies and procedures. Overall the policies and procedures we looked at had been reviewed and were up to date. The practice had systems to monitor most risks to patients, staff and visitors to the practice. These included regular checks of the building, medicines management, staffing levels and dealing with emergencies and equipment. However, some risks such as infection prevention and control measures were not addressed and put patients at risk.

The practice held a range of meetings. Significant event meeting minutes demonstrated risks and incidents were reviewed. There was evidence learning had taken place. We noted changes to practice had yet to be evaluated to monitor their effectiveness. We saw from meeting minutes these meetings were well attended by all staff groups and minutes from the meetings were shared with staff who did not attend via the staff intranet.

Teams met regularly for example, the nurses had meetings to discuss clinical issues, updates and practice performance issues such as Quality and Outcomes

Framework (QOF) targets. Administrative staff also met although there were no meeting minutes to inform staff unable to attend. We were told the GPs met every day at coffee time to discuss practice issues.

The practice had completed some clinical audits, for example, reviews of patients' medicines and reviews of fast track cancer referrals to dermatology clinics. Recommendations from some of the audits had yet to be re-audited to demonstrate the changes had been implemented and that improvements had been made.

There was not a system in place to ensure staff had received and read patient safety alert information.

Leadership, openness and transparency

There was a clear leadership structure which had named members of staff in lead roles. For example there was a nurse with lead responsibilities for infection control and a GP partner had lead responsibilities for safeguarding. Staff we spoke with were clear about their own roles and responsibilities and felt supported within their teams. However, staff did not always feel supported by management. They told us relationships between staff were generally positive but conflicts between some of the GP partners had led to a culture where communication about important issues did not always take place.

We saw from meeting minutes that individual team meetings were held regularly. Staff told us they raised issues at their team meetings and were able to take these to some of the GP partners for resolution if necessary. However, staff told us resolution of issues raised was sometimes difficult to achieve due to lack of cooperation amongst management.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example disciplinary procedures, induction policy, management of sickness) which were in place to support staff. These were up to date and reflected current HR procedures.

Practice seeks and acts on feedback from its patients, the public and staff

The practice had gathered feedback from patients through patient surveys, complaints and the patient participation group. The results and actions agreed from these surveys were available on the practice website. The practice had an active virtual patient participation group (PPG) which had a membership of 82 members. The PPG contained

Are services well-led?

Requires improvement 

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

representatives from patients of all age groups and reflected the main practice population profile. The PPG communicated with its members via email and through an on line forum. During 2013/2014 two web based patient surveys were conducted. The results demonstrated the practice had responded to some feedback from patients. For example, an increase in the number of health care assistants (HCA) employed. However, responses to other concerns such as the length of time taken to get through to the practice in the morning were not addressed. The PPG survey action plans did not have timescales to monitor actions were being achieved.

Staff told us they were able to give feedback and discussed any concerns or issues within their teams. Overall staff told us they felt involved and engaged in their own teams to improve outcomes for both staff and patients.

The practice had a whistleblowing policy which was available for all staff to read as guidance.

Management lead through learning and improvement

Evidence gathered throughout our inspection through staff interviews, records and policy reviews indicated management did not always lead through learning and improvement. For example action plans from significant event reviews were not reviewed, and communication across the whole staff group did not take place. Action plans from complaints, survey results were not completed to enable the practice to demonstrate change had taken place. Recommendations from the audits had yet to be re-audited to demonstrate the changes had been implemented and that improvements had been made.

Nursing staff told us they were able to remain updated with mandatory training requirements for example, immunisations and basic life support. We looked at staff files and saw that regular appraisal took place which included a personal development plan (PDP).

The practice was a GP training practice for medical students and GP registrars specialising in primary medical care.

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 Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	<p>Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed</p> <p>Regulation 19 HSCA 2008 (Regulated Activities) Regulations 2014 Fit and Proper Persons Employed.</p> <p>Patients who used the services and others were not protected because the registered person had not ensured that information was available in respect of a person employed for the purposes of carrying on a regulated activity, and such information as is appropriate.</p> <p>The provider had not ensured administrative staff undertaking chaperone duties had a criminal records check via the Disclosure and Barring Service (Regulation 19)</p> <p>This was a breach of regulation 21 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.</p>
Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	<p>Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment</p> <p>Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2014 Safe care and treatment</p> <p>Patients who used the services and others were not protected because the registered person did not have an effective system to assess, monitor and address infection (Regulation)12(2)(h).</p>

This section is primarily information for the provider

Requirement notices

This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.