Morland House Surgery

Quality Report

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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this service	Good
Are services safe?	Requires improvement
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We inspected Morland House Surgery on 25 February 2015. This was a comprehensive inspection. The practice had been inspected in July 2014 when we were testing our new approach to inspection. We returned to check that the practice had acted to address issues which breached regulations relating to management of medicines reported at the previous inspection and to enable us to apply a judgement of ratings for the practice.

The practice is rated as good overall. Patients received care and treatment from a team of staff who place patient satisfaction at the core of their work. Patients we spoke with and other sources of patient feedback confirmed that the GPs and staff were caring and responded promptly to patient needs. A range of visiting care professionals attended the practice to provide convenient access to services. The practice had taken action on the issues relating to medicines management reported previously. Significant improvement had been achieved. However, the practice must improve on other aspects of how medicines are managed.

Our key findings were as follows:

- The practice was clean and tidy and there were systems in place to reduce the risk and spread of infection.
- Patients found access to the service met their needs. Sufficient appointments were available to meet demand and there was a flexible approach to provision of appointments that were convenient for patients.
- Staff treated patients in a friendly and professional manner. This was reflected in the results of both local and national patient surveys.
- GPs treated patients in accordance with national and local guidelines. Staff are trained and knowledgeable.

Summary of findings

- The practice worked with other services to ensure patients with complex needs are cared for appropriately. Health visitors told us there are good working arrangements with the GPs.

We saw several areas of outstanding practice including:

- The practice provides a wide range of additional services on site to give local access to patients and reduce the need to visit hospital or other care providers.

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

Importantly, the provider must:

- Introduce a tracking system for blank prescriptions which records when they are issued to individual GPs.
- Ensure the system for prescribing high risk medicines is operated consistently.

In addition the provider should:

- Ensure cleaning of high level surfaces is carried out effectively in consulting rooms.
- Carry out a risk assessment to determine whether all relevant medicines are held in the emergency medicines stock.
- Increase the number of audit cycles to monitor clinical quality and systems to identify where action could be taken.
- Consider carrying out DBS checks for reception staff who undertake chaperone duties.

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?

Requires improvement

The practice is rated as requires improvement for providing safe services. Staff understood their responsibilities to raise concerns, and to report incidents and such incidents were reviewed and action taken to prevent reoccurrence. Most risks to patients were assessed and systems were in place to address these risks. The practice had addressed issues relating to management of medicines found at the previous inspection in July 2014. However, the practice must improve further aspects of managing medicines to ensure high risk medicines are not dispensed before patients have received relevant monitoring of their condition and blank prescriptions are tracked when issued to GPs.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from National Institute for Health and Care Excellence and used it routinely. Patient's needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. There was evidence of appraisals and personal development plans for all staff. Staff worked with multidisciplinary teams.

Are services caring?

Good

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

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. The practice provided a range of additional services on site. It acted on suggestions for improvements and changed the way it delivered services in response to feedback from the patient participation group (PPG). A wide range of appointment opportunities were

Summary of findings

available and patients reported good access to appointments that met their needs. The needs of working patients had been identified and early morning and Saturday morning appointments were available every week.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear strategy to deliver good quality and timely services to patients. Staff were clear about their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular meetings that supported effective management. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group (PPG) was active. Staff had received inductions, 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

Good

The practice is rated as good for the care of older people. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older patients in its population and had a range of enhanced services, for example, in dementia and end of life care. It was responsive to the needs of older patients, and offered home visits and services on site such as a visiting nurse specialising in care of the elderly.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. Nursing staff had lead roles in chronic disease management. Longer appointments and home visits were available when needed. All these patients had structured annual reviews to check that their health and medication needs were being met. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care. Patients with diabetes who commenced insulin therapy received a daily call from the diabetes nurse to support them in taking their new medicine.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk. Immunisation rates were relatively high for all standard childhood immunisations. Patients and staff told us that when a parent requested an appointment for a child who was ill the appointment was made for the same day. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with midwives and health visitors.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflected the

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needs of this age group. Early morning appointments were available one day each week and on Saturday mornings to assist patients who found it difficult to attend the surgery during the working day. Physiotherapy was available on site to offer choice to patients needing this service.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including carers and those with a learning disability. It had carried out annual health checks for patients with a learning disability and 73% of these patients had received their health check in the last year. It offered longer appointments for patients with a learning disability.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable patients. It had told vulnerable patients about how to access various support groups and voluntary organisations. Staff knew how to recognise signs of abuse in vulnerable adults. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). The practice had achieved 97% of the quality targets for caring for patients experiencing poor mental health. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. Counselling services were available on site. A memory clinic was held at the practice and professionals from the local drug and alcohol team visited the practice to support patients with substance misuse issues.

Summary of findings

What people who use the service say

The results from the most recent national patient survey showed patients to be positive about the services they received from the practice. This was reflected by 96% of the 106 patients who responded saying they would recommend the practice. The national survey results also showed that 100% of the 106 respondents said the GP was good at listening to them and 99% said the GP gave them enough time. Patients who completed both local and national surveys and those we spoke with during the inspection all rated the surgery highly for ease of obtaining appointments. The survey results placed the practice in the top three within the CCG for patient satisfaction.

The 12 patients we spoke with during the inspection and the five patients who completed CQC comment cards prior to our visit were also positive about the care and treatment they received from the practice. Patients told us they were treated with dignity and respect and felt involved in planning their care and treatment needs. They also told us that GPs were caring and gave good explanations of their treatment.

Areas for improvement

Action the service MUST take to improve

- Introduce a tracking system for blank prescriptions which records when they are issued to individual GPs.
- Ensure the system for prescribing high risk medicines is operated consistently.

Action the service SHOULD take to improve

- Ensure cleaning of high level surfaces is carried out effectively in consulting rooms.
- Carry out a risk assessment to determine whether all relevant medicines are held in the emergency medicines stock.
- Increase the number of audit cycles to monitor clinical quality and systems to identify where action could be taken.
- Consider carrying out DBS checks for reception staff who undertake chaperone duties.

Outstanding practice

The practice provides a wide range of additional services on site to give local access to patients and reduce the need to visit hospital or other care providers

Morland House Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector**.** The team included a GP, a Practice Nurse Advisor and a CQC pharmacy advisor. We were also accompanied by a second pharmacist advisor in an observer role.

Background to Morland House Surgery

Morland House Surgery is located in a converted house which has been expanded over a number of years to provide services to approximately 10,400 patients. The practice is in a semi-rural location and a number of health professionals and other services visit the practice to offer local access. There are two GP partners and eight employed GPs. Seven of the GPs are female and three male. The practice holds a Personal Medical Service (PMS) contract to deliver care and treatment. (PMS contracts are negotiated with the local area team of NHS England)

The practice was inspected during the testing of our new inspection methodology. During the previous inspection we found the practice had breached regulation 13 relating to management of medicines. We returned to check that the practice had taken action to address the breach and carry out a further comprehensive inspection to apply the judgement of ratings detailed in this report. We found the practice had addressed the matters found during the previous inspection.

Information available to the CQC showed the practice performed well in delivering the targets contained in the Quality and Outcomes Framework (QOF). The QOF is a voluntary incentive scheme for GP practices in the UK, rewarding them for how well they care for patients. The practice takes part in enhanced services for example, extended surgery hours are offered one morning a week and every Saturday.

All services are provided from Morland House Surgery, London Road, Wheatley, Oxfordshire, OX33 1YJ.

The practice has opted out of providing out of hours services to their patients. Out of hours provision is available from NHS 111 and from the local out of hours service provided by Oxfordshire NHS Foundation Trust. The out of hours arrangements are displayed at the practice, in the practice information leaflet and on the website.

Why we carried out this inspection

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

We carried out a comprehensive inspection of this service on 25 February 2015 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 practice is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, and to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This provider had been inspected before and the previous inspection found that the practice was not meeting all the essential standards of quality and safety. Therefore, the current inspection also took place in order to follow up on the areas highlighted in the last inspection. 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

Before visiting the practice we reviewed a range of information we hold. We also received information from local organisations such as NHS England, Healthwatch and the Oxfordshire Clinical Commissioning Group (CCG). We carried out an announced inspection visit on 25 February 2015. During our inspection we spoke with a range of staff, including GPs, a practice nurse, the practice manager, a health care assistant (HCA) and reception and administration staff. We also spoke with health visitors who worked closely with the practice GPs and nurses.

We observed how patients were being cared for and spoke with 12 patients and reviewed personal care or treatment records. We reviewed five comment cards completed by patients, who shared their views and experiences of the service, in the two weeks prior to our visit.

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

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

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

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

The percentage of the practice population who were over 65 was above the Oxfordshire average. There were fewer younger children registered with the practice than the local average. The practice was not located in an area of income deprivation and a small traveller community lived nearby.

Requires improvement

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. For example, one review of a significant event resulted in a change in the system the practice used to seek advice on patient treatment from hospital consultants to ensure the advice was sought promptly.

We reviewed incident reports and minutes of meetings from the last year where these were discussed. This showed the practice had managed these consistently and could evidence a safe track record.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events. We saw the reports of these events and discussed the process for recording incidents with the practice manager and GPs. All serious events were discussed at weekly GP meetings. This provided senior staff with the opportunity to discuss the incident and to record any learning points. Minutes of the meetings at which significant events were discussed were held in a folder in the staff room. Staff we spoke with were aware of the location of this file and were able to review the learning from all significant events. We saw an example where a specific incident had been investigated and suggestions had been sought about how to prevent the incident reoccurring. Systems within the practice had been changed to minimise future risks.

Reliable safety systems and processes including safeguarding

One of the GP partners took the lead in safeguarding and we saw they had undertaken the appropriate level three training in the subject. The other GPs we spoke with and the practice manager told us that all GPs were trained to the appropriate level three in child safeguarding. We were unable to access records that evidenced this. Staff we spoke with were clear about their responsibilities to report any concerns they may have. Contact details for the local authority safeguarding team were readily available to practice staff to avoid delays in the reporting of any concerns. GPs and nursing staff had an electronic link to the local safeguarding team should they need to raise any concerns.

The GP who led on safeguarding met regularly with the health visiting team and one of the district nurses attended the GPs' weekly meetings, this gave them the opportunity to discuss any safeguarding concerns. At the previous inspection we reviewed the minutes of a special meeting which had been held to discuss a specific concern. The GPs we spoke with were able to provide us with examples of contact made with social services when they had identified concerns about patients in their care.

We looked at the training record for practice nurses and the administration and reception staff. These showed that all staff had received relevant role specific training on safeguarding. We asked members of nursing and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Staff we spoke with knew which GP to report any concerns they had regarding safety of patients.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments; for example children subject to child protection plans.

There was a chaperone policy, which was visible on the waiting room noticeboard and in consulting rooms. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). All nursing staff, including health care assistants, had been trained to be a chaperone. Reception staff would act as a chaperone if nursing staff were not available. Receptionists had also undertaken training and understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination. The practice had undertaken a risk assessment of administration staff who undertook chaperone duties. However, DBS checks had not been completed for the reception staff who carried out chaperone duties.

Requires improvement

Are services safe?

Medicines management

We checked medicines kept in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring that medicines requiring cold storage were kept at the required temperatures, which described the action to take in the event of a potential failure. The practice staff followed the policy. In the event of a power cut staff would not be able to check the temperature readings for this fridge.

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

The nurses administered vaccines using directions that had been produced in line with legal requirements and national guidance. There was evidence that nurses had received appropriate training to administer vaccines. A member of the nursing staff was qualified to initiate insulin for diabetic patients and received updates in this specific clinical area of expertise for which they prescribed.

There was a system in place for the management of high risk medicines, which included regular monitoring in line with national guidance. The practice produced a weekly list of patients receiving these medicines. The record of any patient who had not received the required monitoring was passed to the GPs for review. One patient had been recently issued their medicine when they had not received their blood test to check that further prescribing was appropriate. However, we found examples of other GPs ensuring tests had been completed before they approved further prescriptions. Patients were at risk because the practice did not operate consistent approach to prescribing high risk medicines.

The dispensary worked to a set of standard operating procedures (SoP's) that covered a variety of practices undertaken in the dispensary. For example, signing of prescriptions. We saw that the SoP's had been reviewed in the last year and were up-to-date and signed by dispensary staff. We heard that the dispensary had introduced an electronic stock control system in 2014 and that this had caused ordering problems. The system had been turned off and ordering had returned to a manual system.

Blank prescription forms that were identifiable to GPs at the practice were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times. However, blank prescriptions used for computer generated prescriptions were not. These prescriptions were signed for when they were delivered to the practice and were kept within the dispensary until required by the GPs. The serial numbers of the prescriptions allocated to GPs were not logged. GPs locked their consulting rooms when not in use making blank prescriptions held in printers difficult to access by others.

The practice held stocks of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse) and had in place standard procedures that set out how they were managed. These were being followed by the practice staff. For example, controlled drugs were stored in a controlled drugs cupboard and access to them was restricted and the keys held securely. We saw that when controlled drugs were ordered from one wholesaler the practice did not supply a signed requisition which is a legal requirement. The practice had contacted the wholesaler who had told them it was not required. There were arrangements in place for the destruction of controlled drugs. We saw that the practice had introduced a double check system for the issue of controlled drugs from the dispensary. Staff were aware of how to raise concerns around controlled drugs with the controlled drugs accountable officer in their area.

Dispensing staff at the practice were aware prescriptions should be signed before being dispensed. Safe systems of dispensing were in operation with a system of second checking in place either by the electronic system or by another member of staff.

The practice had a system in place to assess the quality of the dispensing process and had signed up to the Dispensing Services Quality Scheme, which rewards practices for providing high quality services to patients of their dispensary.

Records showed that all members of staff involved in the dispensing process had received appropriate training and their competence was checked annually.

The practice had established a service for patients to pick up their dispensed prescriptions at one rural location and

had systems in place to monitor how these medicines were collected. They also had arrangements in place to ensure that patients collecting medicines from these locations were given all the relevant information they required.

Cleanliness and infection control

A lead nurse was responsible for infection control procedures at the practice. There were appropriate policies and procedures in place to reduce the risk and spread of infection. Infection control procedures were checked every six months. We saw the results of the last three checks in August 2013 and February 2014.

Hand washing reminders were available above all sinks both in clinical and patient areas. There was a supply of liquid soap and hand towels in all areas. Personal protective equipment (PPE) such as gloves and aprons were available for staff and they were aware of when PPE should be used. There was segregation of waste. Clinical waste was disposed of appropriately and after being removed from the practice was kept in locked waste bins to await collection.

Patients we spoke with commented positively on the standard of cleanliness at the practice. The premises were visibly clean and well maintained. Work surfaces could be cleaned easily and were clutter free. However, we found some curtain rails in consulting rooms were dirty. There was a cleaning schedule for staff outlining the cleaning tasks that should be completed on a daily, weekly and quarterly basis. There was a communication log in place which contained messages for and from the cleaning staff. This showed the practice carried out monitoring of cleaning and reported any areas which required attention by the cleaners. The log recorded the cleaners had taken action when issues were identified.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. 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 measuring devices. Records we reviewed showed that essential equipment within the building had been serviced and maintained in accordance with manufacturer's guidance. For example the fire alarm system and gas boiler.

Staffing and recruitment

Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks through the Disclosure and Barring Service (DBS). The majority of staff had been working at the practice for a number of years. The practice manager and GPs we spoke with told us that they felt the stable work force provided a safe environment for their patients. The records we reviewed were those of staff recruited in the last year. The practice had a recruitment policy that set out the standards it followed when recruiting all grades and staff roles. However, the practice had not undertaken criminal records checks on administration staff who carried out chaperone duties. The practice commenced an immediate review of who could undertake chaperone duties.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. There was also an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual leave. Newly appointed staff had this expectation written in their contracts.

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. The practice used a calculation of patients to GP sessions to decide on staffing levels to meet patients' needs.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy. The health and safety policy was supported by a range of risk assessments. For example,

equipment safety and manual handling. Health and safety information was available to staff. There was a fire risk assessment in place as well as checks of fire safety equipment and fire safety training for staff.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). Staff knew the location of this equipment and records confirmed that it was checked regularly. The notes of the practice's significant event meetings showed that staff had discussed a medical emergency concerning a patient and that the practice had learned from this appropriately.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. The practice did not routinely hold medicines to counteract the effects of an overdose of prescribed opium substitutes in their emergency medicines stock. The practice should risk assess whether these medicines should be held. Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. 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 relevant contact details for staff to refer to. For example, contact details of a heating company to contact if the heating system failed. The practice had updated their plan since our last visit and we saw that contingency arrangements to provide services in the event of the practice becoming unsafe to use were included.

Good

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 approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. Updates in guidance from the National Institute for Health and Care Excellence (NICE) were discussed at the weekly clinical meetings. During our previous visit we attended one of these meetings and evidenced that updated guidelines were discussed. Minutes of meetings confirmed new guidance was discussed.

The GPs told us they led in specialist clinical areas such as diabetes, heart disease and asthma and two of the practice nurses supported this work, which allowed the practice to focus on specific conditions. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support. We heard that the practice nurse with specialist responsibility for supporting patients with diabetes added additional checks into their programme of supporting patients who had recently commenced taking insulin. Where patients encountered difficulty in adapting to this treatment the nurse would carry out a home visit if the patient could not attend the practice.

We reviewed the practice prescribing performance and saw that they achieved all local targets for management of medicines in 2013/14. Data showed us that the practice was on target for a similar performance in 2014/15. This was in line with or better than other practices in the clinical commissioning group (CCG). The practice used computerised tools to identify patients with complex needs and these patients were identified on the practice records. For example those with multiple long term conditions. There was a system in place to follow up patients recently discharged from hospital. Some patients we spoke with had experienced hospital admission and they told us the GPs were aware of their needs when they attended the practice following discharge from hospital.

National data showed that the practice was in line with referral rates to secondary and other community care services for all conditions. All GPs we spoke with used national standards for the referral of patients with suspected cancers referred and seen within two weeks. The practice had conducted an audit of referrals to the dermatology department to ensure all referrals were appropriate.

We saw no evidence of discrimination when making care and treatment decisions which were made on clinical need.

Management, monitoring and improving outcomes for people

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, and managing child protection alerts and medicines management.

The practice showed us 17 clinical audits that had been undertaken in the last two years. Three of these were completed audits where the practice was able to demonstrate the changes resulting since the initial audit. Following each clinical audit, changes to treatment or care were made where needed and the audit repeated to ensure outcomes for patients had improved. For example, the practice carried out an audit to ensure patients with diabetes who had recently given birth received a specific blood test. The aim of the audit was to ensure that all patients received the blood test. The first audit found nine patients (75%) had not received the blood test. The information was shared with GPs to remind them to call this group of patients in to receive their blood test. A second clinical audit was completed one year later which demonstrated that only two patients (13%) had not received their blood test.

We saw that clinical audits were often linked to medicines management information, national screening programmes, safety alerts or as a result of information from the quality and outcomes framework (QOF). (QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures. For example, the practice undertook annual audits of the quality of cervical cytology smears taken.

The practice also used the information collected for the QOF to monitor outcomes for patients. For example, 99% of patients with diabetes had received a flu immunisation in

Good

Are services effective?

(for example, treatment is effective)

2013/14 and the practice met all the minimum standards for QOF in diabetes, asthma and chronic obstructive pulmonary disease (lung disease). This practice was not an outlier for any QOF clinical targets.

There was a protocol for repeat prescribing which was in line with national guidance. In line with this, staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also checked that all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines.

The practice had achieved and implemented the gold standards framework for end of life care. It had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss the care and support needs of patients and their families.

A GP at the practice undertook minor surgical procedures in line with their registration and NICE guidance. The GP was appropriately trained and kept up to date and conducted regular audit to ascertain that minor surgical procedures had been carried out appropriately.

Effective staffing

Practice staffing included GPs, practice nurses, managerial and administrative staff. We reviewed the practice training record records and saw that all staff were up to date with attending mandatory courses such as basic life support. We noted a good skill mix among the doctors with GPs holding additional diplomas in sexual and reproductive medicine and obstetrics. 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).

All staff undertook annual appraisals that identified learning needs from which action plans were documented. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses, for example three members of staff were signed up to take NVQ's in customer care. The practice supported doctors at the foundation stage of their training before they decided to become GPs. These doctors were offered extended appointments and had access to a senior GP throughout the day for support. We received positive feedback from the trainee we spoke with.

Practice nurses were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties. For example, on administration of vaccines and cervical cytology. Those with extended roles for example, seeing patients with long-term conditions such as asthma, COPD and diabetes had appropriate training to fulfil these roles.

Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and manage the care and treatment of patients with complex medical conditions. Blood results, X ray results, letters from the local hospital including discharge summaries, out of hours providers and the 111 service were received electronically. Urgent communication was received by fax. Communication with hospitals and services in other areas was sent by post or fax. Designated members of the administration staff held responsibility for ensuring communication from hospitals was passed to the GPs on the day they were received. GPs reviewed these communications each day. The practice had a system in place for the duty GP to review the results for GPs who were on holiday or absent from the practice. The GP seeing these documents and results was responsible for the action required.

The practice held weekly clinical meetings to which other health care professionals were invited to attend when appropriate. The care and treatment of patients with complex needs was discussed at this meeting. This included those identified as requiring end of life care (as part of a national programme called the gold standards framework). The meetings were attended by district nurses and palliative care nurses and decisions about care planning were documented and circulated to all who attended. Copies of the minutes were held in a central folder which all staff at the practice were aware of and could access.

Meetings were also held with the health visitors to discuss children at risk. We spoke with two members of the health visiting team and they told us that liaison with practice staff worked well and that communication was effective. The health visitors and district nurses who worked with the

practice were located in a building next door to the practice and we heard how this benefitted patient care by enabling face to face communication between these professionals and the practice staff.

Information sharing

The practice used electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. Electronic systems were also in place for making referrals, and the practice made the majority of referrals last year through the Choose and Book system. (Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital). We found that this system was also used for some urgent two week wait referrals.

The practice has also signed up to the electronic Summary Care Record and planned to have this fully operational by 2015. (Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours).

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

Consent to care and treatment

GPs we spoke with were aware of the need to gain informed consent from patients and there was a practice protocol setting out the requirements to obtain consent. Although not all staff had undergone formal training in the Mental Capacity Act (MCA) 2005 they were aware of the principles of the Act and the need to ensure best interests decisions were made appropriately for people who lacked the capacity to consent. All the patients we spoke with told us the GP explained their treatment and all commented that there was enough time to discuss their needs. Patients with a learning disability were supported to make decisions through the use of care plans, which they were involved in agreeing.

GPs and nurses explained how they gave patients the information they required about their treatment to ensure they were able to make informed choices. Written consent was taken for travel vaccinations as part of a risk assessment and ensured that patients were aware of the risks and benefits of their treatment.

All clinical staff demonstrated a clear understanding of Gillick competencies. (These are used to help assess whether a young person between the age of 13 and 16 had the maturity to make their own decisions and to understand the implications of those decisions).

Health promotion and prevention

All new patients to the practice were offered a health assessment to ensure the practice was aware of their health needs.

The practice had numerous ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice kept a register of all patients with a learning disability and had completed an annual health check for 11 of the 15 patients on this register. The practice had also identified the smoking status of 97% of patients with long term medical conditions and had offered smoking cessation advice to 94% of these patients. Similar mechanisms of identifying 'at risk' groups were used for patients who were obese. Referral to exercise classes and dietary advice was offered to this group of patients. The practice actively promoted the benefits of flu immunisation and data showed that 83% of patients aged over 75 had received their flu immunisation in the last year. This compared favourably with the national average.

The practice had a range of health promotion leaflets in their waiting rooms. Noticeboards were used to signpost patients to relevant support organisations such as an advocacy service or carer support. A noticeboard carrying information specific to sexual health was provided for younger patients. The patient website carried a link to an online clinical information service which patients could access to obtain information relating to specific health conditions and maintaining good health.

The practice carried out child immunisations with a GP carrying out the first immunisation for each child. This gave parents the opportunity to discuss any health concerns and to ensure the parent was aware of what the vaccination was for. The practice achieved approximately 92% of all childhood immunisations This exceeded the national target of 90%. An audit had been undertaken on adolescent

Good

Are services effective?

(for example, treatment is effective)

booster vaccinations which raised awareness with staff for the need to encourage or plan for these to be carried out; this improved the outcome for patients as it ensured they continued to be protected.

Practice nurses had specialist training and skills, for example in the treatment of asthma, diabetes and travel vaccinations. This enabled them to advise patients about the management of their own health in these specialist areas. GPs were able to refer patients for dietary advice from a visiting dietician and to a local exercise service. The practice met the national target for carrying out cervical smears and nurses audited their performance in achieving successful tests of this nature.

The practice had identified the smoking status of over 85% of patients over the age of 15. This was slightly above the local average. Advice on smoking cessation had been offered to 97% of the patients who smoked and this was significantly better than the local average.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey carried out in 2014, the practice survey from 2013/14 of 247 patients and four recent comments from patients taking part in the 'friends and family' survey. The evidence from all these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, the practice compared their survey data with that of similar sized practices elsewhere in the country. This showed them scoring eight points more than the national average in respect shown for patients and paying attention to confidentiality and privacy. The national survey results showed that 100% of the 106 respondents said the GP was good at listening to them and 99% said the GP gave them enough time. The satisfaction results we reviewed placed the practice in the top three in the CCG.

Patients completed CQC comment cards to tell us what they thought about the practice. We received five completed cards and all were positive about the service experienced. Patients said they felt the practice staff were efficient, helpful and caring. The 12 patients we spoke with said staff treated them with dignity and respect.

We saw that all consultations and treatments were carried out in the privacy of a consulting or treatment room. Conversations held in these rooms could not be overheard by others. Disposable curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments.

Staff told us how they respected patients' confidentiality and privacy. The majority of telephone calls were answered by staff working in the administration office away from the reception desk. This ensured that confidential information could not be overheard. Patients we spoke with and the results of the national patient survey showed us that the majority of patients did not have any concerns relating to their confidentiality being maintained.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example, data from the national patient survey showed 98% of practice respondents said the GP, and 92% said the practice nurses, involved them in care decisions. The survey results also showed that 98% of patients said the GP was good at explaining treatment and results. Both these results were above the CCG average.

The 12 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 aligned with these views. The patients we spoke with told us they never felt rushed during their consultations. GPs and nurses told us how they gave patients the information they required about their treatment to ensure they were able to make informed choices. Some patients we spoke with had long term medical conditions. They told us they understood the importance of managing their conditions and that the practice reminded them when they needed a review of their condition. GPs told us they took additional time to explain treatment choices to patients from the local traveller community. It was recognised that a number of these patients found difficulty understanding written material and therefore all information regarding treatment needed to be explained verbally.

Staff told us that translation services were available for patients who did not have English as a first language but this service had rarely been required.

Patient/carer support to cope emotionally with care and treatment

Bereaved families were given contact details for local services which were available to support them. GPs told us that they involved families and carers in end of life care. They ensured that the out of hours service was aware of any information regarding their patients' end of life needs.

Good

Are services caring?

One GP had a specialist interest in palliative care. We were told at our previous inspection that the practice supported patients as far as possible if their wish was to die in their own home.

Notices in the patient waiting room gave information to patients on how to access a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

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

The practice engaged with the clinical commissioning group (CCG). For example there were regular meetings with the CCG medicines management pharmacist to review practice performance in meeting local prescribing targets. We reviewed records that showed the practice was performing well in meeting these targets.

A range of clinics and services were offered to patients, which included family planning, antenatal and children's immunisation. The practice ran regular nurse specialist clinics for long-term conditions. These included diabetes and respiratory disease clinics. Longer appointments were available for patients if required, such as those with long term conditions. GPs placed all new patients who were diagnosed with a long term condition on a practice register. This enabled them to be included in recall programmes to ensure they received regular reviews of their conditions.

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the last survey conducted in conjunction with the patient participation group (PPG). For example, early morning appointments were available one morning each week.

There was recognition that some patients found it difficult to attend hospitals and other clinics located away from the practice. In response the practice made facilities available for a wide range of visiting professionals to offer services on site. These included; physiotherapy, the memory clinic, a nurse specialising in care of the elderly, dietician, counselling and the drugs and alcohol specialist team.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example patients from a local travelling community were sometimes seen without appointment because the practice had identified that patients from this community found more difficulty in attending for a booked appointment. Some patients relied on a local voluntary driver service to bring them to and from their appointments. The appointment times for these patients were made to fit in with the availability of the volunteer drivers.

The practice provided equality and diversity training through e-learning. The staff training record showed that over 80% of staff had completed this training in the last three months. The premises and services had been adapted to meet the needs of patient with disabilities. Consulting rooms were located on the ground and first floor with lift access to the first floor. Treatment rooms were on the ground floor with either level access or access via gentle slopes. The practice had wide corridors on the ground floor that provided sufficient space for both wheelchair and mobility scooter access. This made movement around the practice easier and helped to maintain patients' independence.

We saw that the waiting areas were large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities.

The practice had very few patients registered whose first language was not English. One of the GPs spoke Polish and we were told that this had proven helpful for some patients. Staff told us they had not needed to access translation services but these could be obtained via the CCG.

Access to the service

The practice was open every weekday from 8.30am to 6.30pm. Early morning opening took place every Thursday. Appointments were available from 8:30am to 6pm on four weekdays and from 7.30am on a Thursday. The practice did not close during the lunch period. A range of appointments were available including book in advance, some bookable for the next day and on the day urgent appointments. Telephone consultations were available for patients who did not require a face to face consultation or found it difficult to attend the practice. A variety of means to book appointments were available. They could be booked by phone, in person or online.

Comprehensive information was available to patients about appointments on the patient website and in the practice leaflet. This included how to arrange urgent

Good

Are services responsive to people's needs?

(for example, to feedback?)

appointments and home visits and how to book appointments through the website. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients.

Longer appointments were also available for patients who needed them and those with long-term conditions. This also included appointments with the patient's preferred GP. Home visits were made to those patients who could not attend the practice and to patients who lived in local care homes.

Patients were satisfied with the appointments system. They confirmed that they could see a doctor on the same day if they needed to. They also said they could see another doctor if there was a wait to see the doctor of their choice. Comments received from patients showed that patients in urgent need of treatment had often been able to make appointments on the same day of contacting the practice. Some of the patients we spoke with told us of their positive experiences in obtaining an appointment on the day they called the practice when they felt it was urgent. We heard of some examples where e-mails was used to exchange information between GPs and patients. This system was in a trial stage and was not widely available at the time of our inspection.

Survey information we reviewed confirmed patients appreciated the access they had to appointments and to the practice in general. One hundred per cent of respondents said they found it easy to get through to the surgery by phone, 96% said they were able to get an appointment or speak to someone last time they tried and a similar 96% said the last appointment they had was convenient. These results were better than the CCG average.

The practice's extended opening hours on one morning each week and every Saturday morning were particularly useful to patients with work commitments. We found that the Saturday morning clinic contained book in advance, book on the day and drop in appointments. This enabled patients with urgent need to see a GP at the weekend the opportunity to do so. The GPs told us they did not restrict the numbers of patients they consulted on a Saturday morning and that additional appointments were added for patients who arrived without a booking to ensure all patients who needed urgent consultations were seen. This on the day service was designed to reduce the need for patients to attend the hospital A&E department. The dispensary was also open on Saturday mornings enabling patients to collect their medicines.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. There was a designated responsible person who handled all complaints in the practice. The practice manager was responsible for co-ordinating investigations and responses to complaints and the GPs supported this process.

We saw that information was available to help patients understand the complaints system. There were posters in the waiting room and the complaints procedure was available in both the patient leaflet and on the patient website. Some of the patients we spoke with were aware of the process to follow if they wished to make a complaint and others told us they were sure they could ask staff how to lodge a complaint if the need arose. None of the patients we spoke with had ever needed to make a complaint about the practice.

We looked at the record of complaints that had been received by the practice. All the complaints had been responded to in a courteous manner by the practice manager. The practice manager kept a tracking sheet for each complaint to ensure it was dealt with in line with the practice complaints policy. Reception staff told us that if a patient approached them with a concern or complaint they would direct the patient to speak with the practice manager or would forward to the practice manager any written complaint. Practice staff told us that whenever possible the practice manager tried to address concerns to satisfy the patient as soon as possible. All complaints were reviewed at practice quarterly meetings and discussed with the appropriate staff. The quarterly review of complaints had not revealed any themes or trends in complaints. However, lessons learned from individual complaints had been acted on.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. There was a strong commitment from all staff we spoke with to deliver timely services to patients and we found patients were satisfied with access to GPs and nurses for appointments. The practice recognised the needs of a semi-rural population by providing a range of additional services on site. The results from patient surveys indicated that patients appreciated all aspects of service the practice provided. The national patient survey conducted in 2014 showed that 100% of respondents rated their overall experience of the practice as good or very good and 96% would recommend it to others. This was higher than other practices in the CCG. Results from recently undertaken friends and family surveys showed a similarly high recommendation rating from patients.

The commitment to deliver prompt access to a GP was evidenced by the number of GP clinics available each week and from the arrangements the practice operated to ensure demand for appointments was met during GPs leave and other absence from the practice. We heard that the practice was involved in discussions with neighbouring practices to explore opportunities to work together and provide further enhanced access to services.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff in a policies file and via the desktop on any computer within the practice. We looked at eight of these policies and procedures. All eight policies and procedures we looked at had been reviewed annually and were up to date.

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

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed it was performing in line with national standards. QOF data was regularly discussed at team meetings and action was taken to maintain or improve outcomes.

The practice had a programme of clinical audits which it used to monitor and identify where improvements to quality could be made. However, the practice could enhance the number of completed clinical audit cycles undertaken. A total of 17 audits had been undertaken in the last two years and three of these were completed audit cycles. We saw that the standard operating procedures for the dispensary had been audited and updated in the last year. There was evidence that the practice was involved in comparing performance with other practices in the CCG. For example it was active in the CCG management of medicines programme and showed good performance in achieving medicines management targets.

The practice included governance issues on the agenda of clinical team meetings. There was an information governance policy and staff we spoke with were clear on their responsibilities to maintain confidentiality of patient data. The practice had completed the national quality assurance process for ensuring it managed patient data safely and held it securely.

Leadership, openness and transparency

We saw from minutes that team meetings were held regularly at varying intervals. For example, the clinical team met once a week. There was an open invitation to other care professionals, for example the health visitors, to attend this meeting for specific issues relating to their sphere of responsibility. Staff told us that there was an open culture within the practice. Some staff told us they felt confident they could attend the weekly clinical meeting if they requested to discuss matters they wanted to report directly to the GPs. All staff said they were happy to raise issues at team meetings.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies. For example the disciplinary procedures and management of sickness which were in place to support staff. We saw a copy of the staff handbook that was available to all staff in both a folder and electronically. This included sections on bullying and harassment and appraisals. Staff we spoke with knew where to find these policies if required.

Are services well-led?

Good

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

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

The practice had gathered feedback from patients through patient surveys, their patient participation group and from complaints received. The practice had an active patient participation group (PPG) which had evolved over time from a small group of patients who met at the practice to a much wider group who were able to contribute their views both in person and via electronic communication. The PPG had carried out annual surveys. We saw the analysis of the last patient survey which had been completed by 247 patients. A number of respondents had requested longer opening hours and the practice had introduced early morning clinics in addition to the Saturday clinic that was available. The results and actions agreed from the survey were available on the practice website.

The practice had gathered feedback from staff through team meetings and the staff annual appraisals. Minutes of staff meetings showed that everybody was given the opportunity to make comments or suggestions. There was evidence that relevant staff were involved in reviewing incidents in order to learn from them and minimise future risks. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us that they had been offered the opportunity to take training in customer care and that they would be given time to undertake this training. Staff told us they felt involved and engaged in the practice and were able to contribute to improving outcomes for patients. A central folder containing minutes of the various staff meetings was available and staff we spoke with told us they knew where to source this.

The practice had a whistleblowing policy which was available to all staff in their handbook. Some staff we spoke with were not familiar with the terminology of whistleblowing. However they told us they would not hesitate to report any instances where a colleague might be placing patient safety and care at risk to senior management or one of the GPs. Staff were unaware that they could contact the CQC if they felt unable to report the matter to anyone within the practice.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their professional development through training and supervision. We saw the practice recorded regular appraisals for staff and were told of the development opportunities staff were able to access. For example, one member of staff was signed up to start a National Vocational Qualification (NVQ) in supervision and management. Training was also included as part of some staff meetings. The GPs and nurses at the practice had taken part in training to ensure they had the right skills to appropriately treat and support patients with certain long term conditions. The practice had one nurse specifically trained to provide care and support to patients with diabetes.

The practice had completed reviews of significant events and other incidents. These were shared with staff by a briefing from their line manager or by referring to the minutes in the communication folder which all staff were aware of and accessed. Significant events that had been reviewed were summarised and the learning points from the review were identified in the summary.

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 Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The registered person did not protect service users against the risks associated with the unsafe use and management of medicines, by means of the making of appropriate arrangements for the obtaining, recording, handling, using, safe keeping, dispensing, safe administration, and disposal of medicines used for the regulated activity. Regulation 12 (g). This was a breach of Regulation 13 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.