

# Springfield House

## 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?

Inadequate



Are services effective?

Requires improvement



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

We carried out an announced comprehensive inspection at Springfield House Medical Centre on 18 March 2015. Overall the practice is rated as requires improvement.

Specifically, we found the practice to be good for providing caring and responsive services. We found the practice to require improvement for providing effective and well-led services. We found the practice inadequate in relation to providing safe services. It also required improvement for providing services for all the population groups that we assess.

Our key findings were as follows:

- Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs

- Patients were at risk of harm because systems and processes were not in place to keep them safe. For example appropriate recruitment checks on staff had not been undertaken prior to their employment.
- Patients' needs were assessed and care was planned and delivered following best practice guidance.
- Staff were clear about reporting incidents, near misses and concerns, however there was insufficient evidence of learning and communication with staff and issues had not been notified to relevant authorities.
- Patients were positive about their interactions with staff and said they were treated with compassion and dignity.
- The practice had no clear leadership structure, staff lacked understanding of the aims and vision and there were limited formal governance arrangements.
- Information about services and how to complain was available and easy to understand.

# Summary of findings

- The practice had a number of policies and procedures to govern activity, but these were several years old and had not been reviewed. The practice did not hold regular governance meetings and issues were discussed at ad hoc meetings.

The provider must:

- Ensure recruitment arrangements include all necessary pre-employment checks for all staff.
- Ensure an effective infection control regime is in place.
- Ensure there are formal governance arrangements in place including systems for assessing and monitoring risks.
- Ensure safeguarding adults training is provided.

- Ensure safe and effective medications management is in place.
- Ensure equipment is calibrated, tested and within manufacturers recommended usage date.

The areas where the provider should make improvements are:

- Clarify the leadership structure and ensure there is leadership capacity to deliver all improvements
- Ensure serious adverse incidents notifications are made to CQC and CCG.

**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 inadequate for providing safe services and improvements must be made. Staff were clear about reporting incidents, near misses and concerns. Although the practice reviewed when things went wrong, lessons learned were not clearly communicated. Patients were at risk of harm because systems and processes were not in place in a way to keep them safe. For example safeguarding measures were not effective, recruitment procedures were inadequate, and medicine management was ineffective.

Inadequate



### Are services effective?

The practice is rated as requires improvement 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. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health, although the need for additional training on the Mental Capacity Act and its implications was identified. Staff had received most training appropriate to their roles. We saw no evidence that audit was driving improvement in performance to enhance patient outcomes. There was evidence of appraisals and personal development plans for all staff. Staff worked with multidisciplinary teams.

Requires improvement



### Are services caring?

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.

Good



### Are services responsive to people's needs?

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients said they usually found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day. The practice had good

Good



# Summary of findings

facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised.

## Are services well-led?

The practice is rated as requires improvement for being well-led. It had a statement of purpose but not all staff was aware of this and their responsibilities in relation to it or understood the practice vision. There was a leadership structure and most staff felt supported by the management team. The practice had a number of policies and procedures to govern activity, but some of these were overdue a review. Meetings were not well documented and lacked structure and consistency. The practice proactively sought feedback from patients; there was no patient participation group (PPG). All staff had received inductions and had received regular performance reviews. There was no apparent strategy relating to clinical audits and there was a lack of management responsibility for some areas, for example medicines management and safety alerts.

**Requires improvement**



# Summary of findings

## The six population groups and what we found

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

### Older people

The practice is rated as requires improvement 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 people 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 people, and offered home visits and rapid access appointments for those with enhanced needs. Improvements around safe care must be introduced for all population groups.

Requires improvement



### People with long term conditions

The practice is rated as requires improvement for the care of people with long-term conditions. Clinical staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. All these patients had a named GP and a structured annual review 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. Improvements around safe care must be introduced for all population groups.

Requires improvement



### Families, children and young people

The practice is rated as requires improvement 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 high for all standard childhood immunisations. Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this. 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, health visitors and outreach clinics. All children under five years of age were guaranteed a same day appointment. Improvements around safe care must be introduced for all population groups.

Requires improvement



# Summary of findings

## **Working age people (including those recently retired and students)**

The practice is rated as requires improvement 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 reflects the needs for this age group. Improvements around safe care must be introduced for all population groups.

**Requires improvement**



## **People whose circumstances may make them vulnerable**

The practice is rated as requires improvement for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including homeless people, asylum seekers and those with a learning disability. It had carried out annual health checks for people with a learning disability. It offered longer appointments for people with a learning disability.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. 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 and children, although some training had not been provided. Some staff were not fully aware of their responsibilities regarding information sharing; documentation of safeguarding concerns although knew how to contact relevant agencies in normal working hours and out of hours. Improvements around safe care must be introduced for all population groups.

**Requires improvement**



## **People experiencing poor mental health (including people with dementia)**

The practice is rated as requires improvement for the care of people experiencing poor mental health (including people with dementia). The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. It carried out advance care planning for patients with dementia.

The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations. It had a system in place to follow up patients who had attended accident and emergency (A&E) where they may have been experiencing poor mental health. Staff had received training on how

**Requires improvement**



# Summary of findings

to care for people with mental health needs and dementia and patients were referred to specialists when appropriate. Improvements around safe care must be introduced for all population groups.

# Summary of findings

## What people who use the service say

We received 31 completed CQC patient comment cards and spoke with ten patients at the time of our inspection visit. We spoke with mothers and fathers with young children, working age people, older people and people with long term conditions.

Patients we spoke with and who completed CQC comment cards were positive about the care and treatment provided by the clinical staff and the assistance provided by other members of the practice team. They told us that they were treated with respect and that their dignity was maintained.

We also looked at the results of the 2014 GP patient survey. This is an independent survey run by Ipsos MORI on behalf of NHS England. The survey showed that the practice was average or higher than average amongst practices in the area:

87% of respondents found the receptionists at the practice helpful

92% of respondents said the last appointment they got was convenient

84% of respondents said the last GP they saw or spoke to was good at listening to them

85% of respondents described their overall experience of this surgery as good

## Areas for improvement

### Action the service **MUST** take to improve

- Ensure recruitment arrangements include all necessary pre- employment checks for all staff.
- Ensure an effective infection control regime is in place.
- Ensure there are formal governance arrangements in place including systems for assessing and monitoring risks.
- Ensure safeguarding adults training is provided.
- Ensure safe and effective medications management is in place.

- Ensure equipment is calibrated, tested and within manufacturers recommended usage date.

### Action the service **SHOULD** take to improve

- Clarify the leadership structure and ensure there is leadership capacity to deliver all improvements
- Ensure serious adverse incidents notifications are made to CQC and CCG.

# Springfield House

## Detailed findings

### Our inspection team

#### Our inspection team was led by:

Our inspection team consisted of a CQC Lead Inspector and two specialist advisors (a GP and a practice manager).

### Background to Springfield House

Springfield House Medical Centre is situated to the North West of Oldham town centre. At the time of this inspection we were informed 7568 patients were registered with the practice.

The practice consisted of five GPs (four partners and one salaried GP, two female and three male). These GPs are providing general medical services to registered patients at the practice under a general medical services (GMS) contract. The GPs are supported in providing clinical services by two practice nurses (female) and one health care assistant (HCA) (female). Clinical staff are supported by the practice manager and her team who are responsible for the general administration, reception and organisation of systems within the practice.

The practice is part of the Oldham cluster, which is a group of GP practices who support each other for business continuity and best practice learning.

The practice opted out of providing out of hours services and this is provided by Gotodoc.

### Why we carried out this inspection

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

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

Please note that when referring to information throughout this report, for example any reference to the Quality and Outcomes Framework (QOF) 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?
- 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

# Detailed findings

- 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 visiting, we reviewed a range of information we hold about the practice and asked other organisations to share

what they knew. We carried out an announced visit on 18th March 2015. During our visit we spoke with two GPs, one nurse, one HCA, the practice manager, the office manager and reception staff.

We saw how staff interacted with patients and managed patient information when patients telephoned or called in at the service. We saw how patients accessed the service and the accessibility of the facilities for patients with a disability. We reviewed a variety of documents used by the practice to run the service.

# Are services safe?

## Our findings

### Safe track record

Before visiting the practice we reviewed a range of information we hold about the practice and asked other organisations such as NHS England and the Clinical Commissioning Group (CCG) to share what they knew. No concerns were raised about the safe track record of the practice. The Practice Manager told us they completed incident reports and carried out significant event analysis as part of their on-going professional development. We looked at a number of these reports and saw that they were a summary of information about incidents; they did not contain enough detail for us to track the incident and review all the information available. Some of these significant adverse incidents had not been referred to the CCG or the Care Quality Commission (CQC). The Practice Manager and GPs recognised that they wished to improve the manner in which significant events were documented and managed. We found from speaking to staff that significant events had been identified and the appropriate agencies involved in investigations, however when we looked at minutes of team meetings we could find no record of significant events having been discussed, appropriate learning identified or shared. We were shown some ad hoc emails where significant events had been discussed, however there was no effective structure or system in place. We noted that a recent incident and on-going multi-agency investigation involving a potential serious assault had not yet been raised as a significant event. We noted that the practice had played an active part in assisting with the investigation and had fulfilled all its responsibilities, other than providing notifications to the CQC and CCG. The Practice Manager and the GPs that we spoke to confirmed that improvements around the recording and review of these events were required.

The practice did not have an effective system for managing safety alerts from external agencies. For example those from the medicines and healthcare products regulatory agency (MHRA). These were received electronically by the Practice Manager and sent to the clinical staff for their information. Nobody at the practice had responsibility for managing these alerts and ensuring that all had been allocated appropriately, reviewed, progressed and finalised. As a result there was no method to ensure that they had been investigated and action taken to ensure no patients were at risk. We asked one of the GPs about two

such recent alerts (Domperidone and Pregabalin). The GP was aware of the former and told us that an audit of patients potentially affected had been completed; they were unable to show us the audit. The latter they were less familiar with and were unable to locate the alert or any information relating to what had happened as a result of the alert.

### Learning and improvement from safety incidents

The practice did not have effective systems in place to monitor patient safety. The Practice Manager told us that significant events and changes to practice were discussed with practice staff; however there was no evidence of this having been documented. GPs and the management team at the practice told us that they wished to improve their formal documentation processes as they recognised this was one of their weaknesses. We were told that because staff had been at the practice for many years, they knew their responsibilities and carried out their work and learned effectively without this being formally recorded. The Practice Manager told us that regular informal clinical meetings were held and that meetings for administration staff took place less frequently. We looked at the minutes of these meetings and saw that meetings were held regularly, the last clinical meeting having been held 9th March 2015 and practice meeting 16th February 2015.

### Reliable safety systems and processes including safeguarding

Safeguarding policies and procedures for children and vulnerable adults had been implemented at the practice. One of the GPs took the lead role for safeguarding. Their role included providing support to their practice colleagues for safeguarding matters and speaking with external safeguarding agencies, such as the local social services, CCG safeguarding teams and other health and social care professionals as required. We were made aware of an on-going serious case review which the practice was contributing to. We also found that they had failed to respond to this as a notifiable significant adverse incident to the CCG and CQC which they had a responsibility to do. When we spoke to the lead GP about dealing with contraception issues for patients under 16, they lacked an ability to recognise the wider potential safeguarding issues.

Staff we spoke with were able to describe how they could keep patients safe by recognising signs of potential abuse and reporting it promptly, they were aware of who the practice safeguarding lead was. Staff were able to provide

## Are services safe?

us with the appropriate Local Authority contact number for raising safeguarding concerns should they need to. We noted that the practice did not have a whistleblowing policy for staff to refer to if they wished to raise concerns without informing the practice management team. Staff had been trained in safeguarding children, but not in safeguarding adults. The lead GP told us that this was because it was not provided by the CCG. Several staff members including the safeguarding lead had received training in safeguarding children to Level 3. Practice nurses and receptionists were available to chaperone patients who requested this service and information about this service was available in the waiting area and in the practice information sheet. Staff had not been formally trained in how to chaperone, but told us that they had gathered the knowledge to do so over time. When we spoke to nurses and receptionists they told us that they were confident in performing a role as a chaperone, and told us that the GPs would always explain in full to the patient what they were doing and why. We noted that receptionists had not undertaken Disclosure and Barring Service (DBS) checks and no risk assessments had been completed as to the reason why non might be required. We also noted that one of the practice nurses did not have a DBS check completed. The Practice Manager told us that this would be rectified as soon as possible.

### Medicines management

There was no one identified at the practice as being responsible for medicines management. There was no effective overall system in place for the management, secure storage and prescription of medicines within the practice. Prescribing of medicines was monitored closely and prescribing for long term conditions was reviewed regularly by the GPs as they were identified by the practice internal systems. A system was in place to prevent patients re ordering repeat prescriptions before an appropriate period of time had elapsed. Patients who had any history of drug abuse or who were suspected of such were flagged on the clinical system and prescribing was closely monitored. Prescription security was well managed by the practice. We were told and documentation confirmed that a pharmacist advisor from the CCG attended approximately every two months. They provided advice and listed medicines which required attention; we saw no evidence of these visits leading to a strategic approach to medicines management within the practice.

We looked at the processes and procedures for storing medicines. This included vaccines that were required to be stored within a particular temperature range. We saw that there were two purpose built fridges in the main part of the practice; we noted that they had locks on them but the keys were in the locks and the doors to the rooms where they were located were not routinely locked. Both these fridges had devices for monitoring maximum and minimum temperatures. The fridges were not hard wired and one of the fridges had its power source located where it might be inadvertently switched off. We saw that systems were in place to check temperatures of the fridges and staff managed the stock contained within them by visual inspection. We looked at a domestic fridge located in the basement, we were told that this was used to temporarily store vaccines if there was a delivery and access to the main fridges was not possible. We saw that this fridge had not been checked for temperature variation since 2014. We saw liquid Nitrogen was stored in the basement, there was no evidence of the container having been checked and we were told it had not been used for several years. We discussed this with the GPs and Practice Manager and they told us they would have it disposed of by an appropriate company.

In a cupboard in one of the treatment rooms we found a shopping bag containing a large number of opened and unopened medicines, some of which were controlled drugs, including morphine sulphate tablets, buprenorphine patches and tramadol tablets. Many of these medicines appeared to have been prescribed to patients and some were partly used, most of these medicines had passed their expiry date, we also found an empty box of Diazepam. We spoke to the GPs and the Practice Manager about these medicines and they could provide no explanation as to their presence. The practice had no facilities for the storage of controlled drugs, which must be kept securely and strictly accounted for. One of the GPs was unsure if the practice held controlled drugs or not. Treatment rooms were not routinely locked. Once patients had been allowed access by reception staff from the waiting room, via a secure door leading to the to the clinical areas, there was no control of their movement and they were not supervised, this meant they could potentially access medicines and equipment.

## Are services safe?

There was no cold chain policy in place to ensure that the drugs requiring storage at particular temperatures were dealt with appropriately. However, staff we spoke to were clear on how to deal with temperature sensitive drugs.

There was no policy or agreed approach to what emergency drugs GPs would take on home visits, the GPs we spoke to did not take any, they said that access to ambulances in such an urban area was very good and to date had encountered no problems with this approach.

### Cleanliness and infection control

We found the practice to be clean at the time of our inspection and patients we spoke to confirmed that this was always the case. There was a cleaning schedule for the cleaning staff to follow and appropriate cleaning equipment was available, but this was not checked or audited. One of the practice nurses was the nominated lead for infection control. She told us that she had received no formal training on the subject since 2010 when in a previous employment. She told us that she had been in post at this practice since July 2011 and had inherited the role; she was unaware if any of the other staff had received any training in the subject. The practice had not undertaken any infection control audits in recent years. We were told that one had been undertaken by the local authority, although this was not available for inspection. An infection control policy was available; this had not been reviewed for several years. The Practice Manager told us that a number of the policies at the practice were in need of review.

We saw that practice staff were provided with equipment (for example disposable gloves and aprons) to protect them from exposure to potential infections whilst examining or providing treatment to patients. These items were seen to be readily accessible to staff in the relevant consulting/treatment rooms. We talked to staff about handling samples provided by patients, they had a sound knowledge of how to deal with these. There was no documented protocol in place.

We looked at the treatment rooms used for consultations and minor procedures. We found these rooms to be clean and fit for purpose. Hand washing facilities were available and storage and use of medical instruments complied with national guidance. Appropriate signs were displayed to promote effective hand washing techniques.

Appropriate arrangements were in place to dispose of used medical equipment and clinical waste safely. Clinical waste and used medical equipment was stored safely and securely before being removed by a registered company for safe disposal. We examined records that detailed when such waste had been removed. Sharps boxes were provided for use; however these were not fixed to walls and were not all positioned out of the reach of small children.

### Equipment

The Practice Manager told us that due to a misunderstanding with contractors, annual checks of fire extinguishers, portable appliance testing (PAT) and calibration of equipment such as fridges and other electrical devices was not up to date. Documentation evidenced that equipment in use had been inspected to ensure it remained effective. Some electrical items had been PAT tested in March 2011 and some more recently; no PAT tests had taken place within the last 12 months. Equipment requiring calibration, such as scales and sphygmomanometers (for measuring blood pressure) had been checked on 12/3/14, but were now overdue for calibration.

Staff we spoke with told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. Most equipment was single use only and appropriate measures were in place for cleaning equipment that was not. We looked at medical equipment that was used at the practice in readiness for use and found that most was within the manufacturers' recommended use by date. We found some equipment and in treatment rooms had passed its expiry date, for example needles and flow meters. There was no documented method of recording equipment stored at the practice, stock levels, expiry dates and what was to be ordered. No single person had responsibility for overseeing equipment. Equipment stored in the basement lacked any stock control and some was found to have passed its expiry date.

### Staffing and recruitment

The provider had a recruitment policy which had been reviewed in December 2014. The policy did not outline the mandatory checks required to be undertaken by an employer before a new member of staff can start work. This was reflected in the staff files that we looked at which were missing information, for example proof of identity, employment references and DBS checks.

## Are services safe?

The GPs had checks undertaken regularly by the NHS England as part of their appraisal and revalidation process. Revalidation is whereby licensed doctors are required to demonstrate on a regular basis that they are up to date and fit to practice. There was suitable liability insurance in place.

Staff told us there were enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. Procedures were in place to manage expected absences, such as annual leave, and unexpected absences through staff sickness. Any sickness was closely monitored. Support was given to staff where possible when they required it with issues related to sickness. The staff worked well as a team and as such supported each other in times of absence and unexpected increased need and demand.

### **Monitoring safety and responding to risk**

Systems in place to identify and report risks within the practice were poor, although there was an open and consultative ethos, allowing staff to raise concerns if they had any. There were no structured regular assessments and checks of clinical practice, medications, equipment and the environment.

There was an incident and accident book and staff knew where this was located. Staff reported that they would always speak to the Practice Manager if an accident occurred and ensure that it was recorded. The practice had a detailed Health and Safety policy although this had not been reviewed for some years.

### **Arrangements to deal with emergencies and major incidents**

Basic life support training was completed annually for all staff, although we were not shown formal written evidence of this.. We spoke with staff who told us they had received annual training and it was clear they knew what to do in the event of an emergency such as sudden illness or fire. Fire safety training had been undertaken and fire alarm tests were completed regularly.

We saw emergency equipment and emergency drugs were available and staff knew where these could be located. Each treatment room had an emergency drugs box marked “anaphylaxis drugs”, these boxes contained syringes and ampoules of medicines for emergency use. We saw no evidence of hypoglycaemia emergency medications. We saw that emergency drugs and equipment, such as oxygen were checked approximately every six months by the practice nurses to ensure it worked and was within the manufacturer’s recommended usage date. However we found the expiry date of some emergency equipment had passed, including an oxygen delivery tube, expired 11/2006 and a paediatric resuscitator expired 04/2011.

A written contingency plan was in place to manage any event that resulted in the practice being unable to safely provide the usual services. Staff we spoke with were aware of the policy relating to emergency procedures. The practice formed part of the “Oldham cluster” which was a group of GP practices who agreed to support each other for business purposes and met to discuss current issues and plan to mitigate against foreseeable risks.

# Are services effective?

(for example, treatment is effective)

## Our findings

### Effective needs assessment

Patients we spoke with said they received care appropriate to their needs. They told us they were involved in decisions about their care as much as possible and were helped to come to decisions about the treatment they required. New patient health checks were carried out by the practice nurses and health care assistants (HCAs).

The practice had an effective system for reviewing patients with specific conditions. Conditions for review included asthma, heart disease, kidney disease, chronic obstructive pulmonary disease (COPD), hypertension, mental health, stroke and thyroid. Patients with multiple conditions were allocated longer appointments and more regular reviews in order to review their more complex needs. The practice maintained a system where patients were sent recall letters to remind them about reviews; if these were not answered then staff would telephone patients to remind them.

Care Plans were in place for patients who were identified as needing them, these included patients over 75 and those with specific conditions such as COPD, asthma and heart failure. We reviewed a sample of these care plans and saw they were detailed and had been used by other health professionals to make informed decisions. Clinical staff we spoke with were very open about asking for and providing colleagues with advice and support. GPs told us this supported all clinical staff to continually review and discuss new best practice guidelines.

We saw an unplanned admission scheme was underway at the practice, 120 patients were under the scheme, each with an active care plan which was reviewed every three months. Appointments for these patients were guaranteed same day and access to a wider community pathway was provided. Each GP referral for these patients was assessed by an appropriate clinician, for example District Nurse, podiatrist or social worker, with the aim to keep patients at home and with appropriate care.

Multi-disciplinary meetings were held regularly to discuss individual patient cases making sure that all treatment options were covered. The clinicians aimed to follow best practice such as the National Institute for Health and Care Excellence (NICE) guidelines when making clinical decisions. Clinical staff discussed NICE guidelines at staff meetings and local forums where appropriate.

The Quality and Outcomes Framework (QOF) is a system for the performance management and payment of GPs in the NHS. It was intended to improve the quality of general practice and the QOF rewards GPs for implementing "good practice" in their surgeries. This practice had achieved high scores for QOF over recent years which demonstrated they provided good effective care to patients. QOF information indicated the practice's overall performance to be 96.7%, over 3% above the CCG average.

### Management, monitoring and improving outcomes for people

Information about the outcomes of patients care and treatment was collected and recorded electronically in individual patient records. This included information about their assessment, diagnosis, treatment and referral to other services. If information was deemed to be particularly significant, it was flagged to appear on the patient's home screen so it was immediately visible to the viewer. This included information such as whether a person was a carer or a vulnerable person.

The practice completed clinical audit cycles. Clinical audits are quality improvement processes that seek to improve patient care and outcomes through the systematic review of patient care and the implementation of change. Clinical audits were instigated from within the practice or as part of the practice's engagement with local CCG audits. We found most of the audits were driven individually by the GPs themselves and there was no overall audit strategy. We were shown audits of minor surgery, smear tests and immunisations.

We saw no evidence of documented peer review of clinical decisions within the practice and we discussed this with the Practice Manager and two of the GPs. They confirmed that peer review of decisions was completed on a regular basis in clinical meetings and by ad hoc discussions; they recognised the need to document reviews and told us that this would be introduced.

The GPs, nurses and HCAs had developed areas of expertise and took the lead in a range of clinical and non-clinical areas such as joint injections, palliative care, and safeguarding patients. They provided advice and support to colleagues in respect of their individual area.

# Are services effective?

## (for example, treatment is effective)

Feedback from patients we spoke with, or who provided written comments, was complimentary and positive about the quality of the care and treatment provided by the staff team at the practice.

### Effective staffing

All the staff we spoke to at the practice were very complimentary about the fact that they had access to good training. Staff undertook some mandatory training to ensure they were competent in the role they were employed to undertake. In addition to this they were encouraged to develop within that role and progress to other roles within the practice. We spoke to one member of staff who had been a receptionist and due to their own ambition and support from the practice, completed a national vocational qualification (NVQ) and had become a qualified HCA. The Practice Manager had no system in place to manage staff training, training certificates were not routinely held by management and no training plan was in place to maintain an overview of training requirements for staff.

Most reception staff were long serving and they knew the regular patients well. There was an induction process for any new staff. Staff told us that they were an effective team and would cover for each other at short notice.

All GPs were up to date with their yearly continuing professional development requirements and all either had 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). GPs had developed their own areas of expertise and one of them attended annual training relating to performing minor surgery to ensure their skill level remained at the appropriate level.

All patients we spoke with were complimentary about the staff and we observed that staff appeared competent, comfortable and knowledgeable about the role they undertook. We saw one of the receptionists deal effectively with two people who wished to be seen as temporary residents but who lacked the requisite documentation. The staff member showed patience and resolved the situation by altering appointment times to facilitate the patient's requirements.

### Working with colleagues and other services

All the practice staff worked closely together to provide an effective service for its patients. They also worked collaboratively with community services and professionals from other disciplines to ensure all round care for patients. Minutes of meetings evidenced that district and palliative nurses attended team meetings to discuss the palliative patients registered with the practice. This evidenced good information sharing and integrated care for those patients at the end of their lives.

We saw that a clinical information system was used and was updated by the practice in a timely manner so that information about patients was as current as possible. This ensured that the practice and other services such as out of hours care providers were in receipt of the most current information about patients. The practice had dedicated members of staff for updating information on systems and scanning documents onto the patient record.

The practice worked with a pharmacy expert from the CCG who visited on an ad hoc basis and performed audits of some areas of prescription management which the GPs actioned and sent results to the practice manager. The GPs were unable to provide any documented evidence of these audits and any resulting action. The GPs said they were never certain when these visits would take place and said they wished to improve on the management and overall strategy relating to clinical audits.

### Information sharing

GPs met regularly with the practice nurses and the Practice Manager. We were told but were unable to confirm from documentation that information about risks and significant events was shared openly and honestly at these meetings. The GPs and Practice Manager attended CCG meetings and disseminated what they had learned in practice meetings. Regular meetings involving all team members kept staff up to date with current information around enhanced services, requirements in the community and local families or children at risk.

Patients and individual cases were discussed by the practice clinicians and also with other health and social care professionals who were invited to attend meetings. The GPs and the Practice Manager attended local area meetings. Feedback from these meetings was shared with practice staff where appropriate.

# Are services effective?

(for example, treatment is effective)

There was an informative practice website with information for patients including signposting, what clinics were available and prescription information. There was no patient participation group established at the practice and the Practice Manager told us that although they had experienced difficulty previously in gaining enough interest to maintain one, this was one of the priorities for the coming months.

The practice demonstrated good information sharing, for example developing care plans for elderly patients in consultation with the local care homes and family members. All requests for advice from care homes were dealt with within four hours.

## Consent to care and treatment

Patients we spoke with told us that they were spoken to appropriately by staff and were involved in making decisions about their care and treatment. They also said that they were provided with enough information to make a choice and gave informed consent to treatment. The practice computer system identified those patients who were registered as carers so that clinicians were aware that consent to treatment may be an issue for consideration.

GPs and clinicians had not received formal training in the Mental Capacity Act however we saw evidence from GPs that patients were supported in their best interests, with the involvement of other clinicians, families and/or carers where necessary. We talked to one of the GPs about making a best interest decision for a patient; they knew which appropriate people should be consulted and the importance of an auditable document trail. We saw that GPs provided documented advance decision making for patients, for example DNACPRs (do not attempt cardio pulmonary resuscitation). The GPs told us that they regularly encountered and were confident in dealing with issues around capacity and consent when seeing patients

at local care homes. We spoke to the GPs and Practice Manager about the lack of formal training in the Mental Capacity Act and its implications; we were told that training for staff would be included in future planning.

The 2014 national GP patient survey indicated 84% of people at the practice said the last GP they saw or spoke to was good at explaining tests and treatments, 72% said the last GP they saw or spoke to was good at involving them in decision making and 95% had confidence and trust in the last GP they saw or spoke to. These percentages were on par or above the average for the area. 400 surveys were sent out with 113 being returned representing a 28% response rate.

## Health promotion and prevention

All new patients were offered a consultation and health check with the practice nurse or the HCA. This included discussions about their environment, family life, carer status, mental health and physical wellbeing as well as checks on blood pressure, smoking, diet and alcohol and drug dependency if appropriate. Where there were issues identified that required more detailed consultation, then patients were referred to one of the GPs.

The practice website and surgery waiting areas provided a wide variety of up to date information on a range of topics and health promotion literature was readily available to support people considering any change in their lifestyle. The practice also reached out to the local community to promote better health by engaging in various help and support groups. The practice utilised opportunistic health promotion during patient consultations and an in house smoking cessation service was offered. A protocol was in place whereby if a child did not attend for appointments for vaccinations, then the health visitor would automatically be informed.

# Are services caring?

## Our findings

### Respect, dignity, compassion and empathy

We spoke to ten patients in person and received feedback from 31 via completed CQC comments cards. Information we received from patients reflected that practice staff were professional, friendly and treated them with dignity and respect. Patients spoke highly of the practice, the reception staff and the GPs.

Patients informed us that their privacy and dignity was always respected and maintained particularly during physical or intimate examinations. All patient appointments were conducted in the privacy of an individual consultation or treatment room. There were privacy curtains or separate examination areas for use in the consulting rooms during physical and intimate examinations and a chaperone service was offered. Staff had not received formal training on how to be an effective chaperone; however they were confident they were providing an effective service and patients we spoke to said they felt safe. We noted that information displayed on the computer display at the reception desk was visible whilst standing at the counter, this meant that patients confidential information may have been viewed by unauthorised people.

Staff we spoke with were clear on their responsibilities to treat people according to their wishes and diversity. We saw that staff had received training in safeguarding children and information governance, training on how to safeguard adults had yet to be provided. We witnessed staff displaying patience and flexibility when dealing with patients in the reception area.

We looked at the results of the 2014 GP patient survey. This is an independent survey run on behalf of NHS England. The survey results reflected that 79% of respondents said the last GP they saw or spoke to at the practice was good at treating them with care and concern. 96% of respondents said the last nurse they saw or spoke to was good at listening to them. These percentages were similar or higher than those for most other practices in the area.

### Care planning and involvement in decisions about care and treatment

Patients said that staff were very good at listening to them and clinical staff provided lots of information to assist them

in deciding what was best for their health. Patients told us that clinical staff were very patient and took time in ensuring that they understood treatments and medications before they left the consultation.

A wide range of information about various medical conditions was accessible to patients from the practice clinicians, the practice website and prominently displayed in the waiting areas.

The practice maintained care plans for patients who required regular or specialist treatment. The practice had a system in place for identifying people who would benefit from a care plan. We looked at some of these plans and saw that they were well written and considered appropriate measures for on-going effective health management for patients. Clinical staff demonstrated knowledge of appropriate referrals to other healthcare professionals.

The 2014 GP patient survey reported that 72% of respondents said the last GP they saw or spoke to at the practice was good at involving them in making decisions about their care. 96% of respondents said the last nurse they saw or spoke to at the practice was good at explaining tests and treatments. These percentages were similar or higher than most other practices in the area.

### Patient/carer support to cope emotionally with care and treatment

The patients we spoke with on the day of our inspection and the comment cards we received showed us that patients found staff supportive and compassionate. We were told by patients that staff understood patient's personal circumstances and so were better able to respond to their emotional needs.

Notices in the patient waiting room and the practice website signposted people to a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer or a vulnerable person. We were shown the written information available for carers to ensure they understood the various avenues of support available to them. We noted that patients with learning disabilities were offered an annual 30 minute consultation, which was conducted with their carer present. Any patients who lacked capacity to make their own decision were supported by the use of best interest meetings.

One of the GPs took the lead for palliative care. The practice maintained a palliative care register and held

## Are services caring?

regular multidisciplinary meetings with community healthcare staff to discuss the care plans and support needs of patients and their families. We saw evidence of these meetings when we looked at practice

documentation. Patient care plans and supportive information informed out of hours services of any particular needs of patients who were coming towards the end of their lives.

# Are services responsive to people's needs?

(for example, to feedback?)

## Our findings

### Responding to and meeting people's needs

The practice team had planned and implemented a service that was responsive to the needs of the local patient population. The practice actively engaged with commissioners of services, local authorities, other providers, patients and those close to them to support the provision of coordinated and integrated pathways of care that met patients' needs. The practice had explored and was involved in a variety of ways to continually improve the way they responded to people's needs. These included regular commissioning group meetings, practice manager meetings, primary health care team meetings and meetings with community matrons and district nurses.

Patients were able to access appointments with a named doctor where possible. Patients told us that reception staff were very flexible in trying to ensure they saw their preferred GP, many preferred to wait for a later appointment in order to see that GP. Where this was not possible continuity of care was ensured by effective verbal and electronic communication between the clinical team members. Longer appointments could be made for patients such as those with long term conditions or who were carers. Clinical staff also conducted home visits to patients whose illness or disability meant they could not attend an appointment at the practice.

GPs we spoke to were able to demonstrate that they considered the particular needs of patients who were vulnerable such as people with long term health conditions, dementia, learning disabilities and older people. Clear and well organised systems were in place to ensure these vulnerable patient groups were able to access medical screening services such as annual health checks, monitoring long term illnesses, smoking cessation, weight management, immunisation programmes, or cervical screening. The practice provided counselling services on site for people with drug and alcohol dependency issues. A smoking cessation service was also available at the practice.

We saw that the practice carried out regular checks on how it was responding to patients' medical needs. This assisted the clinicians to check that all relevant patients had been called in for a review of their health conditions and for

completion of medication reviews. A documented system was in place to ensure that people who required regular reviews were contacted and a suitably long appointment was scheduled in order to meet their individual needs.

Springfield House Medical Centre had a reception area and sufficient consultation and treatment rooms. There were also facilities to support the administrative needs of the practice (including reception offices, practice manager's office and meeting rooms). The building was easily accessible to patients including those with a disability.

The practice had recognised that it could improve the way it listens to its patients by setting up a PPG; the Practice Manager told us that this was a priority, although it had proved difficult to maintain a PPG when one was set up some years ago. The practice did not have a suggestion box but used word of mouth to listen to what patients thought. In March 2015 the practice had undertaken a patient survey, the previous one having been completed in 2012; we noted the survey did not show the numbers of people surveyed and what action the practice intended to take as a result of comments made. The Practice Manager told us that they intended to continue to survey patients for their views on this and other aspects of the service provided. One example provided of how the practice responded to its patient's request related to the changing of the telephone number from a peak rate number.

### Tackling inequity and promoting equality

The practice had taken steps to remove barriers to accessing the services of the practice. The practice team had taken into account the differing needs of people by planning and providing a care and treatment service that was individualised and responsive to individual need and circumstances. This included having systems in place to ensure patients with complex needs were enabled to access appropriate care and treatment such as patients with a learning disability or dementia.

We saw that the practice provided services for some homeless patients and made provision for appointments for these patients and encouraged them to attend for health promotion reasons. The practice provided information for people whose first language was not English as well as interpreter services. There were good communication links with the local homeless and vulnerable people services, which were able to provide information on the medical requirements of this group of people.

# Are services responsive to people's needs?

(for example, to feedback?)

## Access to the service

There were some negative comments about being able to access the services at the practice; however the practice had recently changed the system for accessing appointments, which had seen some success, with an "on call" GP having been recently introduced. We looked the results of the 2014 GP survey 87% of respondents found the receptionists at the practice helpful, 92% of respondents said the last appointment they got was convenient and 66% of respondents described their experience of making an appointment as good. These percentages were average or above when compared with other practices in the area.

The opening hours and surgery times at the practice were prominently displayed in the reception area, on the practice website and were also contained in the practice information leaflet readily available to patients in the reception area. The practice was open every weekday 8.30am to 6.00pm. Extended hours were operated on Mondays until 7.30pm to provide services for people who could not generally attend during office hours. There were arrangements in place to ensure patients received urgent medical assistance when the practice was closed.

GP appointments were provided in ten minute time slots and were pre bookable up to four weeks in advance; longer appointments were available for patients with more than one issue for discussion. Urgent appointment slots were kept available throughout the day with one of the GPs always 'on call' during surgery hours. This "on call" service had been recently introduced and had proved popular with patients as it improved access to same day appointments. Telephone consultations were used when appropriate. Two female and three male GPs were available at the practice and every effort was made to ensure that a GP of either sex was available every day. We saw that there were rotas and appointment planning in place to facilitate this. The Practice Manager told us that they were constantly reviewing patient demand and responding to it by altering the patients booking system to ensure it was always effective. All children under five years of age were guaranteed a same day appointment.

The practice used an electronic messaging system to aid communication between administration staff and clinicians. We saw that this worked very effectively in ensuring that patients received a prompt and effective service. The practice operated an effective referral system to secondary care (hospitals). This was a choose and book system where all but one of the GPs used a Dictaphone to prompt the administration staff to create an appropriate appointment based on patient choice, the other GP preferred to write the referral note. The Practice Manager told us the system worked well and that all letters were dealt with the same day.

## Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Their complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. The Office Manager was the designated responsible person who handled all complaints in the practice.

We saw that information was available to help patients understand the complaints system both within a practice complaints and comments leaflet as well as the practice website. Patients we spoke with were aware of the process to follow should they wish to make a complaint.

In line with good practice all written complaints and concerns were recorded and investigated and the record detailed the outcome of the investigation and how this was communicated to the person making the complaint. We established from reception staff that they were confident with dealing with verbal complaints. However they were often not recorded and when they were, they were recorded only on patient notes, making them difficult to review and identify any trends. We saw no evidence of complaints having been systematically reviewed to identify trends and potential learning.

# 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

There was a clear leadership structure at the practice and staff were aware of how the management structure operated and their responsibilities. Staff we spoke to were unable to describe the practice vision but knew they formed part of a team which was aiming to provide the best care possible. We spoke to the Practice Manager and the GPs about the vision and values of the practice; they told us that these would be forming part of their improvement plan at the practice. We asked them about how vision and values were formalised with staff so that they became part of their overall personal objectives. We were told that whilst not formally documented, they already formed part of a team goal of continuous improvement. The Practice Manager told us that focus would be given to making the practice vision more visible to staff and patients and that individual objectives to achieve the practice vision would form part of the appraisal regime in future.

We saw that the practice had a documented statement of purpose and included in their aims and objectives 'To provide a high standard of medical care to patients; to be committed to patients' needs and requirements; to treat all patients with dignity and respect; to ensure safe and effective services and to ensure the health and safety of all patients and staff.'

### Governance arrangements

The practice held regular documented meetings for clinicians and the management team. We looked at minutes from recent meetings and found them to be brief and unstructured, meetings lacked consistency with no apparent standing agenda items, for example safeguarding, significant events or safety alerts. Discussion with GPs and other members of the practice team demonstrated that a fair and open culture at the practice enabled staff to contribute to arrangements and improve the service being offered, the Practice Manager told us that they had identified that improvements were required around documentation.

The practice used the Quality and Outcomes Framework (QOF) to measure their performance. The QOF data for this practice showed it was performing over 3% above the level of the average for the area. We saw that QOF data was regularly discussed at practice meetings and actions were

agreed to maintain or improve outcomes, although these actions were not documented and reviewed. We saw evidence that showed the GP and practice manager met with the (CCG) on a regular basis to discuss current performance issues and how to adapt the service to meet the demands of local people.

The practice undertook clinical audits cycles; we saw several examples of these having taken place. Clinical audits are quality improvement processes that seek to improve patient care and outcomes through the systematic review of patient care and the implementation of change. Clinical audits were instigated from within the practice or as part of the practice's engagement with the CCG, these audits lacked overall planning and strategy and were undertaken on an ad hoc basis by each GP.

### Leadership, openness and transparency

Staff told us that felt valued and well supported and knew who to go to in the practice with any concerns. The reception team had worked together for many years and had been afforded opportunities to develop both within their role and into clinical roles. The culture at the practice was one that was open and fair. Discussion with members of the practice team and patients demonstrated this perception of the practice was widely shared.

We saw staff undertook annual appraisals and these were completed in a timely manner. We looked at some of these and saw they were well documented and took notice of the views of the staff member in their review of performance.

The Practice Manager was responsible for human resource policies and procedures. We looked at a number of policies, for example health and safety and infection control, and we saw they were in need of review as they had not been updated for some years. Some policies such as a chaperoning had been reviewed more recently. The recruitment policy had a reviewed date of December 2014, but was not fit for purpose as it did not contain reference to the required recruitment checks necessary when employing new members of staff. Staff we spoke with were not sure where to find these policies if they required them for review.

We were told that support for learning and development was very good, however gaps in training needed to be effectively identified and actioned. Documented peer review was not evident but the GPs told us that this took place informally. Staff told us that the GPs encouraged

# Are services well-led?

Requires improvement 

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

other members of staff to contribute to the way the practice was run and that any suggestions for meeting agenda items could be made to the practice manager. Staff felt empowered to make suggestions and where appropriate make challenges to management decisions.

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

The practice had gathered feedback from patients through comment cards and complaints received. We looked at the results of the 2014 GP patient survey it reflected high levels of satisfaction with the care, treatment and services provided at Springfield House Medical Practice.

Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and the management team. Staff told us that they had no problems accessing training and were actively encouraged to develop their skills; one nurse told us how they had been provided with additional training in spirometry and asthma. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

The practice did not currently have a patient participation group (PPG) but had plans in place to reform one despite difficulty in maintaining interest when one was initiated previously. The Practice Manager told us they understood the importance of listening to patient's views and provided examples of how changes had been made based on patient comments. For example to introduce name badges for staff.

## **Management lead through learning and improvement**

Staff told us that the practice supported them to maintain their clinical professional development through training and appraisal. Staff told us that the practice was very supportive of them accessing training relevant to their role and personal development. Staff we spoke to had not been asked to complete any staff satisfaction surveys, the Practice Manager told us that this was an initiative that they were considering introducing in the near future.

The practice undertook reviews to ensure quality; including reviews of referrals to ensure they were made appropriately, the results had led to some adjustments being made which reduced the number of unnecessary referrals.

GPs were supported to obtain the evidence and information required for their professional revalidation. Every GP is appraised annually and every five years undergoes a process called revalidation. When revalidation has been confirmed by the General Medical Council the GP's licence to practice is renewed which allows them to continue to practice and remain on the National Performers List held by NHS England. All clinical staff attended meetings with other healthcare professionals to discuss and learn about new procedures, best practice and clinical developments.

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	<p>Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment</p> <p>The provider must ensure that all equipment used by the service provider must be:</p> <p>clean, secure, suitable for the purpose for which they are being properly used, properly maintained, and appropriately located for the purpose for which they are being used. The provider must, in relation to such equipment, maintain standards of hygiene appropriate for the purposes for which they are being used.</p> <p>Regulation above corresponds to regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.</p>

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services 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>The provider must ensure that care and treatment must be provided in a safe way for service users by:</p> <p>assessing the risks to the health and safety of service users of receiving the care or treatment;</p> <p>doing all that is reasonably practicable to mitigate any such risks;</p> <p>ensuring that persons providing care or treatment to service users have the qualifications, competence, skills and</p> <p>experience to do so safely (to include ensuring all staff are suitable to be employed in their role);</p> <p>ensuring that the equipment used by the service provider for providing care or treatment to a service user is safe for such use and is used in a safe way;</p>

This section is primarily information for the provider

## Requirement notices

ensuring the proper and safe management of medicines;  
assessing the risk of, and preventing, detecting and controlling the spread of, infections, including those that are health care associated.

Regulation above corresponds to regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

### Regulated activity

Diagnostic and screening procedures  
Family planning services  
Maternity and midwifery services  
Surgical procedures  
Treatment of disease, disorder or injury

### Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

The provider must ensure that systems or processes are established and operated effectively to ensure compliance with the regulations in particular:

assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services);

assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity;

maintain securely such records as are necessary to be kept in relation to—

persons employed in the carrying on of the regulated activity, and

the management of the regulated activity;

evaluate and improve their practice in respect of the processing of the information referred to above.

Regulation above corresponds to regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

### Regulated activity

### Regulation

This section is primarily information for the provider

## Requirement notices

Diagnostic and screening procedures  
Family planning services  
Maternity and midwifery services  
Surgical procedures  
Treatment of disease, disorder or injury

Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed

The provider must ensure that systems or processes are established and operated effectively to ensure:

Persons employed for the purposes of carrying on a regulated activity must be of good character, have the qualifications, competence, skills and experience which are necessary for the work to be performed by them, and be able by reason of their health, after reasonable adjustments are made, of properly performing tasks which are intrinsic to the work for which they are employed.

Recruitment procedures must be established and operated effectively to ensure that persons employed meet the conditions above.

Regulation above corresponds to regulation 21(a)(i)(ii)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.