# Shirland Road Medical Centre

## Quality Report

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

# Summary of findings

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# Summary of findings

## Overall summary

Shirland Road Medical Centre is a GP service located in the London Borough of Kensington and Chelsea. The provider is registered with the Care Quality Commission to provide two regulated activities: diagnostic and screening procedures and treatment of disease, disorder or injury at one location, Shirland Road Medical Centre.

During our visit which took place over one day, we spoke with two GP's, two practice nurses, the practice manager and three administrative staff. We spoke with nine patients and a member of the patient participation group (PPG).

Shirland Road Medical Centre provided a caring, effective and responsive service. Patients' needs were suitably assessed and care and treatment was delivered in line with current legislation and best practice.

Medicines for dealing with medical emergencies were held at the practice and staff had received training in cardiopulmonary resuscitation (CPR). However, some improvements were needed to ensure the safe management of medicines, specifically controlled drugs which had not been monitored and recorded in line with requirements.

The practice was clean but regular infection control audits had not been undertaken and not all staff had received annual training in infection control as identified by the practice as mandatory training.

The practice had inter-agency safeguarding policies and procedures. All staff had received training in safeguarding children and some staff had received training in safeguarding vulnerable adults but training had not always been within the timescale outlined in the policy or to the required level.

There were formal processes in place for the recruitment of staff. However, a disclosure and barring service (DBS) check (formally known as a criminal record bureau (CRB) check) had not been obtained for all staff and a risk assessment had not been completed for those staff assessed as not in need of a check. This meant patients were not fully protected against the risks associated with the recruitment of staff.

The practice was well-led on a day-to-day basis but improvements were needed to develop a more strategic approach to the management and planning of the service.

The practice delivered high quality patient care through an ethos and culture that was caring and responsive. All staff were clear about their role and responsibilities and the ethos and values of the practice. However staff were not always given the support they needed to do their job.

The practice experienced a high turnover of patients and the demographics of the population indicated that patients had complex needs with crisis situations being dealt with on a daily basis. Despite the complexities, the doctors offered 15 minute appointments for most of their practice hours.

# 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 service was not safe and improvements were needed.

Appropriate policies and procedures were accessible to all staff.

Staff demonstrated a good awareness of safeguarding children but held only a basic knowledge in safeguarding vulnerable adults. The provider had not made suitable arrangements to ensure that patients were safeguarded against the risk of abuse (Regulation 11 (1)(a)(b)).

Staff were aware of how and to whom they should report accidents, incidents and concerns. Where reports had been made, staff had learnt from these through discussion in practice meetings.

The practice did not have a controlled drugs register for the recording of those controlled drugs held for medical emergencies. Staff told us if the controlled drug needed to be administered, a record would be made on the patient file. However it would not be possible to audit trail this and there was no stock control record in place. Patients were not protected against the risks associated with the unsafe use and management of medicines (Regulation 13).

The practice was clean and an appropriate infection control policy was in place. Although a policy was in place the practice had not undertaken any infection control audits in line with their own policy and as set out in The Health and Social Care Act 2008 Code of Practice on prevention and control of infections and related guidance. In addition, the providers infection control policy stated that all staff should receive annual infection control training. Training records demonstrated that non-clinical staff had not received any training and the practice manager and the two doctors had last undertaken infection control training in December 2012. Patients were therefore not protected against the risks associated with the prevention and spread of infection (Regulation 12 (2)(a)).

There were formal processes in place for the recruitment of staff. The practice manager confirmed that a disclosure and barring service (DBS) check (formally known as a criminal record bureau (CRB) check) had been obtained for all clinical staff, however these were not available for inspection. The practice manager also confirmed that a risk assessment had not been undertaken for those non-clinical staff who had not had a DBS check as part of their recruitment. This meant patients were not fully protected against the risks associated with the recruitment of staff (Regulation 21 (a)(i)(b)).

# Summary of findings

**Are services effective?**

The service was effective but some improvements were needed.

Staff kept up to date with current good practice and engaged appropriately with the local Clinical Commissioning Group (CCG).

The doctors worked long hours to meet the demands of the practice and due to time and financial constraints non-clinical staff support, training and additional learning was not prioritised. The provider had not made suitable arrangements to ensure staff were appropriately supported in relation to their responsibilities (Regulation 23 (1)).

The practice nurses ran chronic disease management clinics, such as diabetes, asthma and chronic obstructive pulmonary disease (COPD).

The nurses were also responsible for new patient medicals which they said they aimed to complete within one week of registration. Reception staff confirmed that a new patient registration always included a medical with the nurse before seeing a doctor, however in an emergency a new patient could be seen if this had not taken place.

The nurses kept up to date with good practice by attending the local practice nurse monthly forum meetings, and specific annual training updates such as travel vaccinations and cardiopulmonary resuscitation. The doctors attended three monthly local learning network forums which covered topics such as dementia, end of life care, smoking cessation and primary care emergencies.

Policies and procedures were clear and accessible to all staff.

**Are services caring?**

The service was caring.

Many patients had been using the practice all their life which meant the doctors and nurses were able to build a trusting relationship and offer continuity of care.

We observed staff speaking with patients in a helpful and polite manner. Patients were positive about the service and told us staff were caring and treated them with dignity and respect and involved them in making decisions about their care.

Staff held a basic understanding of the Mental Capacity Act 2005. However it was unclear how healthcare decisions would be made for those patients who lacked capacity. Additional training would improve staff knowledge and ensure the practice operated under 'Best interests' guidance should a patient choose to attend an appointment independently.

# Summary of findings

The doctors were able to make referrals for bereavement counselling where needed. One patient told us that the doctor had been very helpful following the death of their mother.

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

The service was responsive to the needs of the patients.

The practice had a caring and responsive approach to the needs of the patients. This was demonstrated by the doctor's flexibility with appointment times, their use of I.T. for repeat prescriptions and home visits for those who are unable to attend the practice.

Staff were familiar with and able to explain their complaints process but there was no information on display to inform patients of their right to make a complaint and the process to follow.

Staff said a doctor would always see a vulnerable patient and they had been advised by the doctors to do all they could for a patient known to be homeless or a refugee. The provider could however do more to support this vulnerable group of people by letting them know that the services they provided were available to them.

**Are services well-led?**

The service was well-led on a day to day basis but there was no long term planning in place.

The practice delivered high quality patient care through the completion and review of clinical audits.

The ethos and culture of the practice was caring and responsive. Patients were positive about the care and treatment provided by the doctors and practice nurses but their feedback did reflect the time constraints on doctors. Patients told us that waiting times could be a problem, particularly for urgent appointments.

All staff were clear about their role and responsibilities however, not all staff had received training and adequate support in line with their role and responsibilities.

Whilst the doctors strove to provide a good service to the community, insufficient time was allocated to the future planning of and an overall strategy for service development and staff training.

# 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 provided a safe, effective, caring, responsive and well-led service to older patients.

Staff attended monthly multi-disciplinary meetings and had a good working relationship with other community health care services such as the district nurse and tissue viability nurse.

The doctors offered flexible appointment times and home visits for those patients who were unable to attend the practice.

Patients could obtain repeat prescriptions via their local pharmacy who could act as a liaison between the patient and the practice.

**People with long-term conditions**

The practice provided a safe, effective, caring, responsive and well-led service to patients with long term conditions. There were appropriate end of life arrangements in place. Patients who were terminally ill received regular reviews and there was a multi-disciplinary approach to care with good links to community nurses.

Home visits were arranged for patients who were housebound, terminally ill or too ill to attend the practice.

**Mothers, babies, children and young people**

The practice provided a safe, effective, caring, responsive and well-led service to mothers, babies, children and young people.

There were a large number of children registered at the practice. Staff recognised and responded to the needs of mothers, babies, children and young people on a day to day basis.

There were appropriate safeguarding procedures in place, staff were trained and aware of how to raise any concerns.

**The working-age population and those recently retired**

The practice provided a safe, effective, caring, responsive and well-led service to those patients who were of a working age and those who had recently retired.

The practice had responded positively to patient feedback regarding access to the practice for working people through the introduction of extended hours. Patients could also make appointments for telephone consultations.

# Summary of findings

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

The practice provided a safe, caring, effective and responsive service to people in vulnerable circumstances who may have poor access to primary care.

Patients who were travellers, refugees or within other categories of no fixed abode were able to access all NHS services, as they were able to register with the practice. Staff said they had good links with district nurses and local pharmacists who would tell vulnerable people about the practice however the practice could do more to make the practice and its services known to these groups of people.

**People experiencing poor mental health**

The practice provided a generally safe, caring, effective and responsive service to patients experiencing poor mental health.

The practice supported patients with mental health problems through initial assessment and referral to a specialist service where appropriate. The practice had also taken action to promote the physical health and wellbeing of it's patients experiencing poor mental health by taking up a Local Enhanced Services (LES) scheme.

# Summary of findings

## What people who use the service say

We spoke to nine patients at the practice patients were positive about the care and treatment provided by the doctors and practice nurses.

Most patients told us they usually had to wait 15 minutes beyond their appointment time but most were understanding of the reasons and said they were never rushed out of the door and felt that the doctors genuinely cared.

Feedback from the Patient Participation Group was positive. Patients reported that the doctors were very responsive to comments and concerns and changes had been made to the appointment process and access to repeat prescriptions as a result of feedback.

## Areas for improvement

**Action the service MUST take to improve**

The practice must put systems in place to protect patients from the risks associated with the unsafe use and management of medicines (Regulation 13)

The practice must make suitable arrangements to ensure staff are appropriately supported in relation to their responsibilities (Regulation 23 (1))

The practice must put systems in place to protect patients against the risks associated with the prevention and spread of infection (Regulation 12(2)(a))

The practice must put systems in place to ensure patients are protected against the risks associated with unsafe recruitment of staff (Regulation 21 (a)(i) (b))

The practice must make suitable arrangements to ensure patients are safeguarded against the risk of abuse (Regulation 11 (1)(a)(b))

**Action the service COULD take to improve**

Whilst the doctors strove to provide a good service to the community, insufficient time was allocated to the future planning and an overall strategy for service development and staff training.

# Shirland Road Medical Centre

**Detailed findings**

## Our inspection team

**Our inspection team was led by:**

Our inspection team was led by a CQC Lead Inspector and a GP. The team included a second CQC Inspector and an Inspection manager. The GP was granted the same authority to enter Shirland Road Medical Centre as CQC inspectors.

## Background to Shirland Road Medical Centre

Shirland Road Medical Centre is a single location practice which provides a primary medical service to approximately 3,700 patients in the Maida Vale and Queens Park areas of West London. The patient population groups served by the practice include a cross-section of socio-economic and ethnic groups. The majority of patients registered with the practice were English, Caribbean or Polish. The area is deprived with high unemployment and this is reflected in a transient patient population of approximately 30 patients joining and leaving the practice each week. A large number of patients are children and those over the age of 65.

The practice team was made up of two GP partners, three part time practice nurses, a practice manager, a medical secretary, an administrator/receptionist and three receptionists.

Surgery hours operate 9am – 1pm Monday to Friday and 4pm – 7.30pm Monday, Tuesday, Wednesday and Friday.

## Why we carried out this inspection

We inspected this service as part of our new inspection programme to test our approach going forward. This provider had not been inspected before.

## How we carried out this inspection

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

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

The inspection team always looks at the following six population areas at each inspection:

- Vulnerable older people (over 75s)
- People with long term conditions
- Mothers, children and young people
- Working age population and those recently retired
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing a mental health problem.

Before visiting, we reviewed a range of information we hold about the service and asked other organisations to share what they knew about the service. We liaised with the West London Clinical Commissioning Group (CCG), NHS England and Healthwatch.

# Detailed findings

We carried out an announced visit on 19 May 2014. During our visit we observed how people were being cared for and spoke with a range of staff, two GP's, the practice manager, three administrative staff. We also spoke with nine patients who used the service and a member of the patient participation group (PPG).

Following our visit we spoke with two practice nurses by telephone.

We reviewed information that had been provided to us during the visit and we requested additional information which was reviewed after the visit. Information included policies and procedures, audits, staff records and minutes from meetings.

# Are services safe?

## Summary of findings

The service was not safe and improvements were needed.

Appropriate policies and procedures were accessible to all staff.

Staff demonstrated a good awareness of safeguarding children but held only a basic knowledge in safeguarding vulnerable adults. The provider had not made suitable arrangements to ensure that patients were safeguarded against the risk of abuse (Regulation 11 (1)(a)(b)).

Staff were aware of how and to whom they should report accidents, incidents and concerns. Where reports had been made, staff had learnt from these through discussion in practice meetings.

The practice did not have a controlled drugs register for the recording of those controlled drugs held for medical emergencies. Staff told us if the controlled drug needed to be administered, a record would be made on the patient file. However it would not be possible to audit trail this and there was no stock control record in place. Patients were not protected against the risks associated with the unsafe use and management of medicines (Regulation 13).

The practice was clean and an appropriate infection control policy was in place. Although a policy was in place the practice had not undertaken any infection control audits in line with their own policy and as set out in The Health and Social Care Act 2008 Code of Practice on prevention and control of infections and related guidance. In addition, the providers infection control policy stated that all staff should receive annual infection control training. Training records demonstrated that non-clinical staff had not received any training and the practice manager and the two doctors had last undertaken infection control training in December 2012. Patients were therefore not protected against the risks associated with the prevention and spread of infection (Regulation 12 (2)(a)).

There were formal processes in place for the recruitment of staff. The practice manager confirmed that a disclosure and barring service (DBS) check (formally known as a criminal record bureau (CRB) check) had been obtained for all clinical staff, however these were not available for inspection. The practice manager also confirmed that a risk assessment had not been undertaken for those non-clinical staff who had not had a DBS check as part of their recruitment. This meant patients were not fully protected against the risks associated with the recruitment of staff (Regulation 21 (a)(i) (b)).

# Are services safe?

## Our findings

### Safe patient care

There were appropriate and comprehensive policies and procedures in place, such as health and safety, infection control and dealing with significant events. All had been recently reviewed and were stored electronically and were easily accessible to all staff. Staff we spoke with demonstrated a clear understanding of how and to whom they should report any concerns. We spoke with nine patients on the day of our inspection visit none of whom raised any concerns about patient safety.

There was a comprehensive safety alert policy. The policy was clear and detailed timescales and responsibilities. If anything was found to be relevant to the practice a list of patients affected was produced. Although the policy was detailed the corresponding procedure failed to identify who would be responsible for ensuring the next steps were carried out within the agreed timescale.

### Learning from incidents

An incident management procedure and a significant events toolkit was seen. Non-clinical staff were aware of how to record and report significant events.

Staff told us that they had not had any significant events this year. Staff said if a significant event occurred, this would be discussed in the practice meeting so they could learn from this to help prevent a reoccurrence.

There was an incident management procedure in place. Non-clinical staff told us that accidents/incidents and complaints were also discussed at practice meetings. We were told that there had been an incident which occurred in August 2013 requiring police assistance which we found had been recorded appropriately.

### Safeguarding

There was an inter-agency safeguarding children's policy and procedure in place and one of the practice doctors had been allocated as the safeguarding lead for the practice. All staff spoken with were aware of who this person was and had an understanding of the indicators of abuse. The doctors told us that they had not had to refer any child directly for safeguarding within the past two years but were aware of a number of children in the practice who were on the child protection register. Both doctors said they liaised with social workers as necessary regarding safeguarding children. Although the doctors provided relevant information for safeguarding children case reviews they had not attended any due to work pressures.

We were told that safeguarding children training was mandatory for all staff each year. Clinical staff had completed the required level 3 training and non-clinical staff level 1. It was acknowledged that flowing recent changes non-clinical staff were now required to undertake the level 2 training which was being arranged by the practice manager. Training records however, evidenced that it had been more than two years since most non-clinical staff had received any safeguarding children training.

Although a vulnerable adult's policy and procedure was in place most staff had not received any training. Not all staff we spoke with were able to demonstrate adequate knowledge in the area of safeguarding vulnerable adults, what to look for and how to report any concerns. The provider had not made suitable arrangements to ensure that patients were safeguarded against the risk of abuse.

A chaperone policy was in place and staff were aware that a patient could bring or request a chaperone.

### Monitoring safety and responding to risk

A system was in place for receiving and acting on national safety alerts.

Non-clinical staff were provided with a lockable door, panic button and perspex barrier to deter and minimise any potential risks of physical violence. Staff told us that they occasionally worked alone. A lone working policy was in place but staff had not received any specific training on personal safety in the work place.

We were told that the practice had a large number of patients registered with a mental health issue and one of the doctors had been physically attacked whilst on duty. The practice manager attended a multidisciplinary clinical meeting each month to discuss high risk patients, however it was unclear what precautions were in place to protect patients from the risk of harm by another patient or person.

### Medicines management

The practice had safe and clear systems in place for the prescribing and repeat prescribing of medicines. We were told that it was the practice's policy that only a doctor could prescribe a medicine and repeat prescriptions

# Are services safe?

needed to be requested by a patient using the computer ordering slip. Where a patient requested a medicine which was not showing on the computer order slip, this was referred to a doctor. We were able to observe this in practice when a patient requested a medicine with a receptionist which was not recorded as a prescribed medicine by the doctor. The patient was advised that they would need to see the doctor for this to be authorised and this was arranged.

We were told that patients could visit in person or email the practice for a repeat prescription request, though there were occasional exceptional circumstances where a telephone request would be accepted. As a result of patient feedback staff said the collection of repeat prescriptions had been reduced from 48 hours to 24 hours. We noted that the patient information leaflet did not inform patients that they could request repeat prescriptions by email and the provider's website had not been updated to show collection in 24 hours.

Patients we spoke with said that having the online system now made getting repeat prescriptions quicker.

We were told by staff that the local Clinical Commissioning Group (CCG) pharmacy advisor visited most weeks to offer advice and undertake prescription audits.

We were told by the practice nurse responsible for emergency medicines that they checked these on a daily basis to ensure they were in date and did not require replacement. They were also responsible for the daily checks of the vaccine fridge used for the storage of immunizations and travel vaccinations, to ensure it was operating at the correct temperature and locked at night. Stock checks were made once a week and all checks were recorded.

We were concerned to find that a controlled drug which was held as part of the emergency medicines kit had not been recorded in line with good practice. There was no controlled drugs register and when we spoke to staff about this we were told that if the controlled drug needed to be administered, a record would be made on the patient file.

The provider has since informed us that this controlled drug was no longer held as part of the emergency medicines kit as it had not been used for a number of years and was not considered necessary.

### Cleanliness and infection control

On the day of the inspection visit the practice was clean and hand cleansing gel was available for use at reception. The practice had an infection control policy which covered all relevant areas. This included a bi-monthly inspection checklist for audit purposes. We requested the infection control audit and risk assessments records but the practice manager said these had not been completed.

The infection control policy for the practice stated that all staff should receive annual infection control training. However training records demonstrated that the last infection control training had been undertaken in December 2012.

We spoke with nine patients on the day of our inspection visit. We did not receive any concerns about cleanliness and infection control.

### Staffing and recruitment

There were formal processes in place for the recruitment of staff. We were told that the majority of both clinical and non-clinical staff had worked at the practice for a number of years.

We were able to speak to a newly appointed member of staff who said they were mentored for six weeks by an experienced member of staff and confirmed they had received an induction. The induction process covered all policies and procedures and mandatory training in I.T, basic life support and the information governance toolkit.

The doctors told us that locum doctors were only used to cover absences due to leave or sickness.

The practice manager stated that a disclosure and barring service (DBS) check (formally known as a criminal record bureau (CRB) check) had not been obtained for all staff.

### Dealing with Emergencies

The practice had sufficient emergency medicines to enable them to respond to a medical emergency. All staff had received training in cardiopulmonary resuscitation (CPR).

# Are services effective?

(for example, treatment is effective)

## Summary of findings

The service was effective but some improvements were needed.

Staff kept up to date with current good practice and engaged appropriately with the local Clinical Commissioning Group (CCG).

The doctors worked long hours to meet the demands of the practice and due to time and financial constraints non-clinical staff support, training and additional learning was not prioritised. The provider had not made suitable arrangements to ensure staff were appropriately supported in relation to their responsibilities (Regulation 23 (1)).

The practice nurses ran chronic disease management clinics, such as diabetes, asthma and chronic obstructive pulmonary disease (COPD).

The nurses were also responsible for new patient medicals which they said they aimed to complete within one week of registration. Reception staff confirmed that a new patient registration always included a medical with the nurse before seeing a doctor, however in an emergency a new patient could be seen if this had not taken place.

The nurses kept up to date with good practice by attending the local practice nurse monthly forum meetings, and specific annual training updates such as travel vaccinations and cardiopulmonary resuscitation. The doctors attended three monthly local learning network forums which covered topics such as dementia, end of life care, smoking cessation and primary care emergencies.

Policies and procedures were clear and accessible to all staff.

## Our findings

### Promoting best practice

We were told by both doctors that they were able to keep up to date with and had access to the latest National Institute for Health and Care Excellence (NICE) guidance via the internet and through attendance at educational events and local Clinical Commissioning Group (CCG) meetings.

### Management, monitoring and improving outcomes for people

The provider ensured the practice delivered high quality patient care through the completion and review of clinical audits. These included urology, gastroenterology and prescription prescribing.

We were told that the doctors met with the local Clinical Commissioning Group (CCG) every two weeks. For example, to analyse and discuss patient referrals to accident and emergency (A&E) services. The practice was aware that compared to the national average they had high A&E attendance, particularly for children. The doctors felt this was partly because the local hospital provided a very good children's service which parents chose to use and because they also had a number of patients with complex needs who were very high users of A&E. Although the doctors said this had been analysed there had been no suggested resolutions to this situation. Clinical practice meeting minutes evidenced that staff had explored ways to reduce inappropriate A&E use such as offering lifestyle advice at initial new patient medicals and on-going education during consultations.

### Staffing

The nurses we spoke with said they met with the doctors on a weekly basis to discuss clinical practice and could seek advice from the doctors as and when needed.

The provider's policies and procedures were clear and staff were able to locate these with ease and explain how they applied them to their day to day work.

All staff had received an annual appraisal. We were told by the practice manager that training had been identified as part of the appraisal system, which staff confirmed. We found however that although training had been identified for staff there was no allocated learning time which meant

# Are services effective?

## (for example, treatment is effective)

staff might not prioritise or have time to undertake all necessary learning. We were also told that financial constraints meant training was not always accessed as and when needed.

We looked at three individual staff files which showed that staff had received an annual appraisal. Training had been identified as part of the appraisal system and we were shown the mandatory training matrix for each job role. Not all staff however had received training in line with their expected mandatory training. For example, non-clinical staff were expected to attend infection control and safeguarding adults and children training each year. The training records for seven non-clinical staff evidenced that one person had attended safeguarding children and none had attended infection control or safeguarding adults training in the last 12 months

We spoke to a new member of staff who told us they had received a comprehensive induction which included shadowing another staff member for the first six weeks of their employment. We were told that they had received cardiopulmonary resuscitation (CPR) training within their first month of employment and training in safeguarding children in the first five months.

Most staff had been in post for a number of years and those we spoke with said they felt equipped to do their job and valued for their contribution to the team. Most staff said they felt supported in their role and could access a manager for advice whenever they needed.

### Working with other services

The practice engaged appropriately with the local services. They were able to demonstrate multidisciplinary working with community services such as hospitals, social workers, midwives district and palliative care nurses.

The practice had a large number of older patients registered. Clinical meeting minutes demonstrated that the practice were aware of and able to access the services of the local 'Older Persons Rapid Access Clinics' which were consultant-led assessment clinics for frail elderly patients requiring urgent geriatric assessment.

The doctors also met with the local Clinical Commissioning Group (CCG) every two weeks to analyse and discuss patient referrals to accident and emergency (A&E) services. Clinical practice meeting minutes evidenced that staff had explored ways to reduce inappropriate A&E use through patient education.

### Health, promotion and prevention

The nurses told us that they ran chronic disease management clinics, such as diabetes, asthma and chronic obstructive pulmonary disease (COPD). The nurses felt they had a good relationship with their patients and encouraged them to engage with chronic disease management. Where patients missed appointments the nurses said they followed these up with letters or telephone calls

The nurses were also responsible for new patient medicals which they said they aimed to complete within one week of registration. Reception staff confirmed that new patient registration always included a medical with the nurse before seeing a doctor, however in an emergency a new patient could be seen if this had not taken place.

The nurses said they kept up to date with good practice by attending the local practice nurse monthly forum meetings, and attending specific annual training updates such as travel vaccinations, safeguarding children and vulnerable adults and cardiopulmonary resuscitation.

The clinical practice meeting minutes showed that the doctors attended local learning network forums every three months. These covered topics such as dementia, end of life care, smoking cessation and primary care emergencies.

# Are services caring?

## Summary of findings

The service was caring.

Many patients had been using the practice all their life which meant the doctors and nurses were able to build a trusting relationship and offer continuity of care.

We observed staff speaking with patients in a helpful and polite manner. Patients were positive about the service and told us staff were caring and treated them with dignity and respect and involved them in making decisions about their care.

Staff held a basic understanding of the Mental Capacity Act 2005. However it was unclear how healthcare decisions would be made for those patients who lacked capacity. Additional training would improve staff knowledge and ensure the practice operated under 'Best interests' guidance should a patient choose to attend an appointment independently.

The doctors were able to make referrals for bereavement counselling where needed. One patient told us that the doctor had been very helpful following the death of their mother.

## Our findings

### Respect, dignity, compassion and empathy

Staff told us that many patients had been using the practice all their life. This meant the doctors and nurses were able to build a trusting relationship and offer continuity of care. We were told the local area was deprived and there was high unemployment. There was also a high turnover of patients and the demographics of the population indicated that patients had complex needs, with crisis situations being dealt with on a daily basis. Despite the complexities, the doctors offered 15 minute appointments for most of their practice hours. Although this is commendable, this meant that the doctors worked up to 13 hours a day / shift and took some work home in order to complete all the necessary administrative work such as reading letters and to action the results of any tests.

The majority of patients we spoke with were very positive about the service they received, saying all staff were respectful and kind and it felt like the doctors genuinely cared. Patients said they could see the same doctor each time if they wanted to and many patients had been using the service for many years.

Staff were aware of the practice ethos and values and felt these were important to providing a service that they were proud of. Staff told us that the doctors always made time for patients and really listened. Staff were proud that patients were treated as people and not numbers and they did not have a policy of one appointment one ailment.

Staff told us that issues around bereavement were recognised and that the doctors could refer patients to counselling services. One patient told us that the doctor had been very helpful following the death of their mother.

### Involvement in decisions and consent

We were told that a proportion of patients were from Poland. As both doctors were Polish, patients were able to discuss their healthcare needs in their first language. Patients told us they were given sufficient information by the doctor or nurse regarding their condition and were involved in making a choice about their treatment options.

Staff we spoke with had a basic understanding of the Mental Capacity Act 2005. However it was unclear how healthcare decisions would be made for those patients who lacked capacity, as staff said these patients always

# Are services caring?

attended appointments with a carer or family member. Additional training would improve staff knowledge and ensure the practice operated under 'Best interests' guidance should a patient choose to attend an appointment independently.

# Are services responsive to people's needs?

(for example, to feedback?)

## Summary of findings

The service was responsive to the needs of the patients.

The practice had a caring and responsive approach to the needs of the patients. This was demonstrated by the doctor's flexibility with appointment times, their use of I.T. for repeat prescriptions and home visits for those who are unable to attend the practice.

Staff were familiar with and able to explain their complaints process but there was no information on display to inform patients of their right to make a complaint and the process to follow.

Staff said a doctor would always see a vulnerable patient and they had been advised by the doctors to do all they could for a patient known to be homeless or a refugee. The provider could however do more to support this vulnerable group of people by letting them know that the services they provided were available to them.

## Our findings

### Responding to and meeting people's needs

Staff told us that they had access to an interpreter and translation service via the NHS language service. However, they rarely used this as they said most patients in need of this type of service came with the support of a family member or carer.

We were told that a proportion of patients were from Poland and that both doctors spoke Polish. Although we were told that a number of languages were spoken amongst the staff team, there was no written information available in an alternative language to English other than that provided nationally by the NHS. This meant patients had limited accessibility to information once away from the practice.

Staff told us that the majority of their patients were either children or the elderly and staff recognised and responded to the needs of these patients on a day to day basis.

We spoke with staff about vulnerable patient groups and what measures the practice had taken to engage with these groups and ensure that services were accessible. Staff told us that they had good links with district nurses and local pharmacists who would tell vulnerable people about the practice. Staff also said that local charities sometimes called the practice to ask if they could register a new patient, giving an example of a women's refuge who had contacted them. We were told that a doctor would always make time to see a vulnerable patient.

We saw evidence that the practice had responded to patient feedback through the introduction of telephone consultations, online appointment booking and repeat prescription ordering.

### Access to the service

Access to the practice for those patients with mobility difficulties was limited to the ground floor as there were no lifts in the building. We were assured by staff that anyone with mobility restrictions needing to see a doctor or nurse would be accommodated in one of the treatment or consultations rooms on the ground floor.

Staff told us that patients could use the online service to book appointments and make repeat prescription

# Are services responsive to people's needs?

## (for example, to feedback?)

requests. Home visits were arranged for those patients who were housebound, terminally ill or too ill to attend the practice. We saw that this information was contained in the practice information leaflet.

It was evident from our observations, and discussions with patients and staff that the doctors promoted a caring approach with a focus on responding to patient need on a daily basis. There were a variety of appointment choices to support the various patient groups such as 'walk in clinics' for urgent appointments and extended hours for working people who found it difficult to access the practice during usual daytime hours.

All patients we spoke with said they had to wait beyond their appointment time to be seen by the doctor. Some patients said the doctors were inundated and because the doctors offered a caring and responsive service this sometimes meant patients needed more than their allocated 15 minutes which caused some of the problems with waiting times. We were told by staff that both doctors had three allocated emergency appointments for each session they worked but they would always see a patient in an emergency if these had been filled. We were told that on these occasions a patient would be asked to come to the surgery and wait in case a vacancy arose due to a missed or cancelled appointment. One patient told us that although they were pleased to get an appointment this had meant they had waited three hours to see a doctor on this occasion.

### Concerns and complaints

Although staff were familiar with and able to explain their complaints process there was no information on display to inform patients of their right to make a complaint and the process to follow. Staff said they would record the complaint and pass it onto the practice manager. Any serious or urgent complaints could be emailed directly to the practice manager or a doctor. Most patients we spoke with said they had not needed to make a complaint. However, those that had raised concerns either with the doctors directly or through the patient participation group (PPG) (a group of volunteer patients who form a link between the patients and the practice with a view to making a useful contribution to the improvement of existing services and help the practice to develop new services to meet and identify patients' needs) said they had been responded to appropriately.

# Are services well-led?

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

## Summary of findings

The service was well-led on a day to day basis but there was no long term planning in place.

The practice delivered high quality patient care through the completion and review of clinical audits.

The ethos and culture of the practice was caring and responsive. Patients were positive about the care and treatment provided by the doctors and practice nurses but their feedback did reflect the time constraints on doctors. Patients told us that waiting times could be a problem, particularly for urgent appointments.

All staff were clear about their role and responsibilities however, not all staff had received training and adequate support in line with their role and responsibilities.

Whilst the doctors strove to provide a good service to the community, insufficient time was allocated to the future planning of and an overall strategy for service development and staff training.

## Our findings

### Leadership and culture

All staff we spoke with were able to clearly explain their role and responsibilities for managing and improving quality and the ethos and values of the practice.

Although there was no written service level development plan in place, the doctors recognised that they needed to review their working hours and consider the employment of an additional doctor to meet patient capacity.

They also recognised the need to dedicate more business and planning time with the practice manager to further develop the practice and offer more support to the practice manager. Particularly in the area of human resources which we were told used to be supported by the local Primary Care Trust (PCT) and had not been replaced since the change from these to the Clinical Commissioning Group (CCG).

### Governance arrangements

Although appropriate policies and procedures were in place these were not always followed. For example, the infection control policy stated that a bi-monthly inspection checklist for audit purposes should be undertaken but these had not been completed.

Although we saw evidence of regular meetings to discuss practice issues, insufficient time was devoted to the leadership of the practice. Through discussions with staff and the review of records it was evident that the doctors had little time available for the development of the service.

### Systems to monitor and improve quality and improvement

Reviews of performance under the 'Putting Patients First' Local Enhanced Services (LES) scheme were regularly reported and action planned at practice and multi-disciplinary team meetings.

The practice undertook regular patient feedback via 'Patient Satisfaction Questionnaires'. We looked at these for the year 2013 to 2014 and found most patients rated the practice as excellent or very good for access and helpfulness of staff. Appointment waiting times from check in for those patients seeing a doctor scored slightly less than that scored for the patients seeing the practice nurses.

# Are services well-led?

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

### Patient experience and involvement

There was a 'Patient Participation Group' (PPG) which we were told had been running for three years. Staff we spoke with were aware of the practice Patient Participation Group (PPG) and its function. Some staff attended this group and one said they were given feedback in practice meetings and arrangements had been made for them to meet with the PPG in the near future.

We met with a member of the PPG. We were told that feedback from patients about the practice was generally positive and where concerns were raised these were fed back to the practice via the staff members who attended the PPG.

We viewed the latest (2013/14) patient questionnaire which showed the majority of patients were happy with most issues, though access to doctors recorded a lower score than other areas surveyed. Comments included 'brilliant practice' and 'no complaints' and 'excellent apart from waiting times'. Although the practice had responded positively to concerns raised regarding access through the introduction of an online service for telephone consultations, extended hours and walk in clinics for urgent appointments. It was not clear who was responsible for, or how the practice planned to address the concerns patients had raised regarding waiting times.

We were also told about the introduction of an online service for repeat prescription requests and a patient passport system which was available through the practice. This system enabled patients to access emergency medicine from the pharmacist who then passed the information onto the doctors.

### Staff engagement and involvement

All staff had received an annual appraisal which identified their training needs in line with the responsibilities of their job. However we found that not all staff had received their expected training. For example, non-clinical staff were expected to attend infection control and safeguarding adults and children training each year. The training records for seven non-clinical staff evidenced that two had attended safeguarding children, one had attended safeguarding adults and none had attended infection control in the last 12 months.

### Learning and improvement

We were told that the time allocated for the practice manager and the doctors to meet to discuss practice issues and plan improvements was limited to half an hour once a week. This was considered insufficient and should be reviewed as a matter of priority.

Practice meetings were held each month to discuss issues and address any concerns, for example we saw that the meetings during 2014 had looked at problems with referral letters and pathology samples. Appropriate actions were noted and identified the person responsible for implementing these but timescales had not been included.

Clinical meeting minutes evidenced that Commissioning Clinical set meetings were attended by staff on a regular basis.

# Older people

All people in the practice population who are aged 75 and over. This includes those who have good health and those who may have one or more long-term conditions, both physical and mental.

## Summary of findings

The practice provided a safe, effective, caring, responsive and well-led service to older patients.

Staff attended monthly multi-disciplinary meetings and had a good working relationship with other community health care services such as the district nurse and tissue viability nurse.

The doctors offered flexible appointment times and home visits for those patients who were unable to attend the practice.

Patients could obtain repeat prescriptions via their local pharmacy who could act as a liaison between the patient and the practice.

## Our findings

### Safe

Staff told us that the practice had a good relationship with the district nurse and community matron who visited the practice on a regular basis to discuss patient care. The practice also liaised with the tissue viability nurses for 'Doppler' assessments (a blood circulation test using ultrasound) and wound care advice.

### Caring

Most patients we spoke with told us they had been registered with the practice for many years and felt the doctors understood their needs.

The doctors and practice nurses provided home visits to those patients who were housebound, terminally ill or too ill to attend the practice.

Staff told us that locum doctors were only used to cover absences due to planned leave or sickness. This they felt helped to build a trusting relationship and provide patients with reassurance and a continuity of care.

The staff at the practice said that when needed they accepted repeat prescription requests over the telephone for those older patients who were unable to attend the practice. The prescription was then faxed to a local pharmacy to make access to medication easier. The practice was also aware of which pharmacies provided a dosset box service and liaised with them on behalf of patients who required this service.

### Effective

We saw evidence that the practice worked with multi-disciplinary teams. Monthly multi-disciplinary meetings were held to discuss prevention measures and identify and target older patients at risk of emergency hospital admissions due to conditions such as urinary tract infections (UTI's). We were told by staff that these meetings also identified those patients who needed to be added to the end of life care register.

# Older people

The practice participated in the Local Enhanced Services (LES) scheme providing weekly clinics for influenza and pneumococcal immunisations.

### Responsive

There were a large number of older patients registered with the practice. The clinical meeting minutes demonstrated that the practice were aware of and able to access the services of the local 'Older Persons Rapid Access Clinics' which were consultant-led assessment clinics for frail elderly patients requiring urgent geriatric assessment.

### Well-led

The practice had a caring and responsive approach to the needs of the patients. This was demonstrated by the doctor's flexibility with appointment times, their use of I.T. for repeat prescriptions, and home visits for those who were unable to attend the practice.

The practice was well-led in this area. We found the doctors and practice manager promoted good links with other older people's services, promoting a caring and responsive service to it's older patients. Training for staff in the safeguarding of vulnerable adults should, however, be prioritised.

# People with long term conditions

People with long term conditions are those with on-going health problems that cannot be cured. These problems can be managed with medication and other therapies. Examples of long term conditions are diabetes, dementia, CVD, musculoskeletal conditions and COPD (this list is not exhaustive).

## Summary of findings

The practice provided a safe, effective, caring, responsive and well-led service to patients with long term conditions. There were appropriate end of life arrangements in place. Patients who were terminally ill received regular reviews and there was a multi-disciplinary approach to care with good links to community nurses.

Home visits were arranged for patients who were housebound, terminally ill or too ill to attend the practice.

## Our findings

### Safe

The practice supported patients with long term conditions. Their care was regularly reviewed, with follow-up telephone calls and or letters for those patients who failed to attend an appointment. Clinical meeting minutes demonstrated that housebound patients were identified for inclusion in flu vaccination programmes.

The nurses said they kept up to date with good practice by attending the local monthly practice nurse forum meetings, and attending specific annual training updates such as travel vaccinations, safeguarding children and vulnerable adults and cardiopulmonary resuscitation.

A chaperone policy was in place and staff were aware that a patient could bring or request a chaperone.

Staff we spoke with had a basic understanding of the Mental Capacity Act 2005.

### Caring

The doctors told us that locum doctors were only used to cover absences due to leave or sickness.

Patients were very positive about the service they received and told us they could see the same doctor each time which was important for building a relationship and continuity of care.

Staff told us that issues around bereavement were recognised and that the doctors could refer patients to counselling services.

### Effective

The doctors and practice nurses provided home visits to those patients who were housebound, terminally ill or too ill to attend the practice.

One nurse we spoke with recognised the challenges they faced in meeting the needs of patients with chronic conditions as they often presented late, did not always

# People with long term conditions

prioritise their health and it could be difficult to get them to engage. They said they focused on building a good relationship with the patient and encouraged them to engage with the management of their own care.

### Responsive

Staff told us that the practice provided Cardiovascular disease (CVD) NHS health checks and had signed up to the Local Enhanced Services (LES) scheme for the assessment and support of patients with dementia care needs.

The nurses told us that they ran chronic disease management clinics for conditions such as diabetes, asthma and chronic obstructive pulmonary disease (COPD). The nurses felt that they had a good relationship with their patients and encouraged them to engage with chronic disease management. Where patients missed appointments the nurses said they followed these up with letters or telephone calls.

Staff told us that the practice had signed up to the NHS England 'putting patients first' business plan. We were told that this included case management and care planning following a multi-disciplinary review for patients who were assessed as having a high risk of hospital admission.

### Well-led

We saw evidence that the practice manager attended monthly meetings with multidisciplinary teams and information was fed back to the doctors and nurses at clinical meetings. The clinical practice meeting minutes evidenced that the doctors attended local learning network forums every three months. These covered topics such as dementia, end of life care, smoking cessation and primary care emergencies. Minutes also evidenced multidisciplinary working with community services and social workers.

We were told by both doctors that they were able to keep up to date with and had access to the latest National Institute for Health and Care Excellence (NICE) guidance via the internet and through attendance at educational events and local Clinical Commissioning Group (CCG) meetings.

# Mothers, babies, children and young people

This group includes mothers, babies, children and young people. For mothers, this will include pre-natal care and advice. For children and young people we will use the legal definition of a child, which includes young people up to the age of 19 years old.

## Summary of findings

The practice provided a safe, effective, caring, responsive and well-led service to mothers, babies, children and young people.

There were a large number of children registered at the practice. Staff recognised and responded to the needs of mothers, babies, children and young people on a day to day basis.

There were appropriate safeguarding procedures in place, staff were trained and aware of how to raise any concerns.

## Our findings

### Safe

The practice nurses provided weekly childhood immunisation clinics for new born babies, one year olds and pre-school children and liaised with health visitors about the babies and young children.

Staff demonstrated a good awareness of safeguarding children. There was an effective inter-agency safeguarding children policy and procedure in place. A safeguarding lead had been appointed in the practice and staff had been trained and knew how to report any concerns.

We were told by the doctors that they had not had to refer any child directly for safeguarding but were aware of a number of children in the practice who were on the child protection register. Both doctors said they liaised with social workers as necessary regarding safeguarding children.

### Caring

The practice demonstrated a caring ethos by being responsive to patient needs.

### Effective

The practice provided antenatal and post-natal care for mothers and babies, six week baby checks by the lead doctor for mothers and babies, and some shared antenatal care with hospitals.

### Responsive

The doctors and practice nurses responded to the needs of the large number of mothers, babies, children and young people registered with the practice. They said they did this by keeping up to date with current good practice, attending multi-disciplinary care meetings, good communication and building positive relationships with other agencies involved in the care and wellbeing of patients such as midwives and social services.

# Mothers, babies, children and young people

**Well-led**

The nurses said they kept up to date with good practice by attending the local monthly practice nurse forum meetings and had attended specific annual training updates in safeguarding children.

Clinical meeting minutes evidenced multi-disciplinary working with community services and social workers.

# Working age people (and those recently retired)

This group includes people above the age of 19 and those up to the age of 74. We have included people aged between 16 and 19 in the children group, rather than in the working age category.

## Summary of findings

The practice provided a safe, effective, caring, responsive and well-led service to those patients who were of a working age and those who had recently retired.

The practice had responded positively to patient feedback regarding access to the practice for working people through the introduction of extended hours. Patients could also make appointments for telephone consultations.

## Our findings

**Safe**
Staff told us that the practice offered cardiovascular disease (CVD) NHS health checks which was aimed at preventing heart disease, stroke, diabetes and kidney disease to enable the practice to make early interventions and monitor and manage patients on a long term basis.

**Caring**
Staff demonstrated a caring attitude to all of their patients.

**Effective**
The practice offered an online service for the booking of appointments and repeat prescription requests. They also offered telephone consultations for those patients who found it difficult to access the practice.

There were a variety of appointment choices such as 'walk in clinics' for urgent appointments and extended hours for working people who found it difficult to access the practice during usual daytime hours. Telephone consultations had also been introduced to provide a service to those patients who were unable to attend the practice.

Patients told us that they were aware of contact numbers and where they needed to go out of hours.

Patients we spoke with said that having the online system now made getting repeat prescriptions quicker.

**Responsive**
We saw evidence that the practice had responded to patient feedback through the introduction of telephone consultations, online appointment booking and repeat prescription ordering and extended hours.

**Well-led**
The practice had signed up to a Local Enhanced Services (LES) scheme for the enhanced hours / extended access, enabling working patients who found it difficult to access the practice during usual daytime hours to book an appointment outside of work hours.

# Working age people (and those recently retired)

The practice had also signed up to the Local Enhanced Services (LES) schemes for smoking cessation and the screening of bowel, breast and cervical cancers.

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

There are a number of different groups of people included here. These are people who live in particular circumstances which make them vulnerable and may also make it harder for them to access primary care. This includes gypsies, travellers, homeless people, vulnerable migrants, sex workers, people with learning disabilities (this is not an exhaustive list).

## Summary of findings

The practice provided a safe, caring, effective and responsive service to people in vulnerable circumstances who may have poor access to primary care.

Patients who were travellers, refugees or within other categories of no fixed abode were able to access all NHS services, as they were able to register with the practice. Staff said they had good links with district nurses and local pharmacists who would tell vulnerable people about the practice however the practice could do more to make the practice and its services known to these groups of people.

## Our findings

### Safe

Staff confirmed that new patient registration always included a medical with the nurse before seeing a doctor, but in an emergency a new patient could be seen if this had not taken place.

A chaperone policy was seen to be in place and staff were aware that a patient could bring or request a chaperone.

### Caring

We spoke to staff about vulnerable patient groups and what measures the practice had taken to engage with these groups to ensure that services were accessible. Staff told us that they had good links with district nurses and local pharmacists who would tell vulnerable people about the practice. Staff also said that local charities sometimes called the practice to ask if they could register a new patient, giving an example of a women's refuge who had contacted them.

Staff told us that the doctors had advised them that they should do all they can if a patient was known to be homeless or a refugee.

### Effective

Staff told us that they had access to an interpreter and translation service via the NHS language service. However, they rarely used this as they said most patients who needed an interpreter came with the support of a family member or carer.

There was a flexible appointment system. For example, walk in clinics for urgent appointments.

Information leaflets were stored behind reception so were not readily available to patients. Staff said these were given

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

to new patients when they registered. General NHS information leaflets were available in a number of languages but the practice specific information leaflet was only available in English.

### Responsive

The practice had signed up to a Directed Enhanced Services (DES) scheme for walk in and extended hours offering appointments up to 7.30pm enabling people in vulnerable circumstances who may have poor access to primary care to have a greater opportunity to access the service.

The practice was also signed up to a Local Enhanced Services (LES) scheme to provide annual health checks for adults with a learning disability which included the completion of an action plan to be followed up. Staff said doctors and practice nurses liaised with carers where appropriate to ensure appointments were kept and discuss any issues arising from the annual health checks.

### Well-led

Although a vulnerable adult's policy and procedure was seen to be place most staff had not received any training. Therefore not all staff we spoke with were able to demonstrate adequate knowledge in the area of safeguarding vulnerable adults, what to look for and how to report any concerns.

We were told by staff that when people in vulnerable circumstances presented at the practice they were encouraged to register. The practice had taken steps to improve its response in this area by signing up to the Directed Enhanced Services (DES) scheme detailed above. However, although patients who were travellers, refugees or within other categories of no fixed abode were able to access all NHS services when they registered with the practice there was no proactive approach taken by the practice to make these groups of people aware of the practice and its services.

# People experiencing poor mental health

This group includes those across the spectrum of people experiencing poor mental health. This may range from depression including post natal depression to severe mental illnesses such as schizophrenia.

## Summary of findings

The practice provided a generally safe, caring, effective and responsive service to patients experiencing poor mental health.

The practice supported patients with mental health problems through initial assessment and referral to a specialist service where appropriate. The practice had also taken action to promote the physical health and wellbeing of it's patients experiencing poor mental health by taking up a Local Enhanced Services (LES) scheme.

## Our findings

**Safe**
We were told that the practice had a large number of patients registered with mental health issues. The practice manager attended a multi-disciplinary clinical meeting each month to discuss high risk patients.

**Caring**
Staff demonstrated a caring attitude to all of their patients.

**Effective**
The practice supported patients with mental health problems through initial assessment and referral to a specialist service where appropriate. Patients assessed as having a severe mental illness were referred to a secondary care service who usually took over the management of the patient and the medication. Staff told us that where this happened the patient would remain on the practice's register for patients experiencing poor mental health, so the doctor could follow this up.

We were told by staff that the doctors liaised with representatives from mental health teams at multi-disciplinary meetings, by telephone and email. Clinical meeting minutes evidenced multi-disciplinary working with community services and social workers.

**Responsive**
The practice had signed up to the SMI (Serious Mental Health) Local Enhanced Services (LES) scheme which enabled the doctors to take over the care of a patient experiencing poor mental health provided this had been agreed with the secondary mental health service.

**Well-led**
Staff with spoke with had a basic understanding of the Mental Capacity Act 2005.

This section is primarily information for the provider

# Compliance actions

## Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

| Regulated activity | Regulation |
|---|---|
| Treatment of disease, disorder or injury | Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines<br>**The provider must ensure patients are protected against the risks associated with the unsafe use and management of medicines.** |

| Regulated activity | Regulation |
|---|---|
| Treatment of disease, disorder or injury | Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff<br>**The provider must make suitable arrangements to ensure staff are appropriately supported in relation to their responsibilities.**<br>**Regulation 23 (1)** |

| Regulated activity | Regulation |
|---|---|
| Treatment of disease, disorder or injury | Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control<br>**The provider must ensure patients are protected against the risks associated with the spread of infection.**<br>**Regulation 12 (2)(a)** |

| Regulated activity | Regulation |
|---|---|
| Treatment of disease, disorder or injury | Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers<br>**The provider must ensure patients are protected against the risks associated with unsafe recruitment of staff.**<br>**Regulation 21 (a)(i) (b)** |

| Regulated activity | Regulation |
|---|---|

This section is primarily information for the provider

# Compliance actions

Treatment of disease, disorder or injury

Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse

**The provider must make suitable arrangements to ensure patients are safeguarded against the risks of abuse.**

Regulation 11 (1)(a)(b)