# Portchester Practice

## Quality Report

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

## Ratings

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

# Summary of findings

## Contents



## Overall summary

**Letter from the Chief Inspector of General Practice**

This was a comprehensive inspection of Portchester Practice and was carried out on 18 December 2014.

We have rated the practice as requires improvement overall. Specifically, we found the practice required improvement for providing safe, effective, well led services. The practice was good for providing a responsive and caring service.

Patients were positive about the services they had received from the practice. The practice provided caring and sympathetic, patient-centred care. Policies and procedures were in place for reporting concerns in relation to both adult and child protection issues. The practice was a training practice for student GP registrars.

Our key findings were as follows:

- There were systems in place to ensure effective patient care and patients were satisfied with the services provided.
- Patients were cared for and treated with dignity and respect and staff ensured their privacy.
- Patients were given enough time to discuss their concerns or treatments when they attended for appointments and were given longer appointments when they needed to discuss more than one concern or complex problems.
- Significant events and complaints were investigated on an individual basis.
- The practice was rated highly by patients who described the overall experience of the practice as good or very good.
- The practice provided GP appointments at times that met the needs of their patients.
- The practice list size had increased by over 500 patients in the last 12 months.

The areas where the provider must make improvements are:

- Ensure there is a system of regular appraisals and training and that personal development plans are in place for all staff.

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- Ensure there is an infection control policy and systems in place to monitor infection control procedures and the quality of environmental cleaning and have a policy for the management, testing and investigation of Legionella
- Ensure there are mechanisms in place to seek feedback from staff and this feedback is responded to.
- The practice must ensure they aware of the risks in relation to the internal and external premises as part of their lease and use of the property to include the environment and emergency systems meeting the needs of the practice and safety of the patients.

**Professor Steve Field CBE FRCP FFPH FRCGP**
Chief Inspector of General Practice

# Summary of findings

## The five questions we ask and what we found

We always ask the following five questions of services.

**Are services safe?**

**Requires improvement**

The practice is rated as requires improvement for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. There were enough staff to keep people safe.

However we found there was no infection control policy in place and we saw areas of the waiting room were visibly dirty. The practice had not carried out an audit of infection control procedures since 2013 or assured themselves of the effectiveness of the cleaning schedule.

**Are services effective?**

**Requires improvement**

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 promoting good health. Staff worked with multidisciplinary teams to provide care and support that met patients' needs. GPs and nurses had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs however not all staff had received regular appraisals.

**Are services caring?**

**Good**

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

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

**Good**

The practice is rated as good for providing responsive services. 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 understood the system for making appointments and were

# Summary of findings

able to speak with the daily duty doctor who would assess their need for an appointment. They were able to get an urgent same day appointment when it was necessary, although to get a routine appointment with a named GP often took a number of days.

We found the practice had initiated many positive service improvements for their patient population such as a phlebotomy service and the services of a midwife based at the practice. The practice 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?**

**Requires improvement**

The practice was rated as requires improvement for well-led as there were areas where improvements should be made. The practice had a vision and a strategy but not all staff were aware of this and their responsibilities in relation to it. Staff satisfaction in relation to the support they received was mixed. Staff did not always feel actively engaged or empowered. There was some evidence of divides between groups of staff.

The practice had not gathered feedback from all staff through staff surveys, appraisals or discussions. Staff told us that they did not think that if they made suggestions they would be listened to and if they were they did not feel confident that the GPs would act on their suggestions. Although staff told us they would not hesitate to discuss any concerns or issues relating to patient safety with a GP or the practice manager.

Staff told us that they worked well in their individual teams and enjoyed their working environment but felt the practice did not work together as a whole team

All staff had received inductions, but not all staff had received regular performance reviews and attended staff meetings and events

There were not quality systems in place to ensure the premises met the need of the practice and patients which had been left to the landlord to address and manage.

There were delegated responsibilities to named GPs, such as a lead for the safeguarding of vulnerable adults and children, a prescribing and a clinical governance lead.

The practice proactively sought feedback from patients and had an active patient participation group (PPG).

# 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**

Requires improvement

The practice is rated as requires improvement for the care of older people. Each patient over 75 years of age had a named GP, but were able to see any GP of their choice for continuity of care when necessary or specialised care and treatment if needed. We saw that the practice responded to the needs of this population group by improving access to the services they needed.

The practice had a number of older patients who lived in three local care homes. If these patients required a GP they were visited in their home. GPs visited housebound patients in their home to do annual reviews or when it was identified that this would be beneficial to the patient. The practice worked closely with local pharmacies and arranged for some patients to have their medicines delivered to their home in daily dosage boxes.

The practice worked closely with the community nursing team and palliative care team to ensure good provision of end of life care.

**People with long term conditions**

Requires improvement

The practice is rated as requires improvement for the care of people with long term conditions. These patients had a structured annual review to check that their health and medicine needs were being met. For those people with the most complex needs, the GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Practice nurses held clinics for certain long term conditions to monitor patients' health and to provide information and support to help them manage their condition. The nurses had completed specific training for this role.

**Families, children and young people**

Requires improvement

The practice is rated as requires improvement for the care of families, children and young people. The practice had a practice based midwife who provided weekly ante natal clinics.

The practice offered a full range of immunisations for children and data showed that the practice had vaccinated a high percentage of eligible children.

The practice worked closely with midwives and health visitors who used the practice premises to meet with their patients. Health visitors attended the practice's vulnerable children's meetings to share information and discuss best practice.

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The practice provided antenatal care for service personnel and provided continued care for their babies and children when the parent returned to the services' health care system.

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

Requires improvement

The practice is rated as requires improvement for the care of working age people (including those recently required and students). The needs of this population group had been identified and the practice had adjusted the services it offered to ensure these were accessible to patients who worked. Early morning appointments were available two days a week and evening appointments one day a week with one Saturday morning surgery each month available for patients; this increased the accessibility of their service to people who were unable to attend during the day due to work commitments.

GPs offered telephone appointments for patients each morning with the duty doctor who could also refer them for a telephone consultation with their usual GP.

There was capacity within the appointment system for all patients to be seen the same day if urgent.

**People whose circumstances may make them vulnerable**

Requires improvement

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

Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

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

Requires improvement

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, especially those with dementia. A consultant in old age psychiatry held clinics at the practice each month. The practice had good links with this service who they worked with to identify and support those people diagnosed with dementia.

# Summary of findings

The practice had sign-posted patients experiencing poor mental health to resources such as a talking therapies service and a nearby walk in centre. Patients could be referred by their GP or were able to self-refer to these services.

Patients told us that the practice ensured they were not stigmatised by their diagnosis of depression and had been involved in the planning of their care and decisions around specialist referrals and medicines.

# Summary of findings

## What people who use the service say

We spoke with 30 patients on the day of our inspection. We reviewed 8 comment cards which had been completed by patients in the two weeks leading up to our inspection.

We spoke with patients from a number of population groups. These included mothers and children, people of working age, people with long term conditions, people with a diagnosis of poor mental health and people aged over 75 years of age.

Patients were generally complimentary about the practice staff who they said were helpful cooperative and cheerful. All the patients we spoke with praised the caring and professional GPs and nurses and their ability to respond to both young and older patients' needs promptly. Most patients commented positively on the way GPs and nurses listened to them and the way they explained their diagnosis or medicines, they told us that they didn't feel rushed or that they were wasting anybody's time. One patient told us how their GP had drawn a diagram to explain their diagnosis which had ensured they understood their plan of treatment. One patient told us the practice staff made them feel important. Two of the patients we spoke with felt that they would have liked the GP to warn them of any possible side effects of their medicines.

Patients understood the practice's appointment system. There was a triage system in operation at the practice; patients were able to call for advice or to be assessed to see if a same day appointment was required. Most of the patients we spoke with had used this option and thought the system worked well. We had mixed comments about the availability of appointments and the length of time patients had waited for a routine appointment. However everybody agreed that if they needed to be seen urgently it was possible to get a same day appointment. Parents of young children told us that sick children were prioritised by the practice and were always seen very quickly in an emergency.

Without exception the patients we spoke with, and the comments we read, praised the polite and helpful reception staff. Patients felt that the practice was organised and efficient.

Of the three comments had been posted on the NHS choices website in the past 12 months, two praised the care they had received with one patient commenting on the long wait at the surgery. There had been 837 responses to the patient survey that the practice had conducted between September and November 2014. This survey showed that over 82% of the patients who responded felt the triage system for emergency consultations worked well and 93% agreed or strongly agreed that they were satisfied with the service and care provided by the GPs and staff. However the survey was not a representative sample of the practice population in respect of age. The 2013 National Patient Survey results showed that 85.2% of the respondents described the overall experience of the practice as good or very good and 86.1% would recommend the practice.

## Areas for improvement

**Action the service MUST take to improve**

- Ensure there is a system of regular appraisals and training and that personal development plans are in place for all staff.
- Ensure there is an infection control policy and systems in place to monitor infection control procedures and the quality of environmental cleaning and have a policy for the management, testing and investigation of Legionella
- Ensure there are mechanisms in place to seek feedback from staff and this feedback is responded to.
- The practice must ensure they aware of the risks in relation to the internal and external premises as part of their lease and use of the property to include the environment and emergency systems meeting the needs of the practice and safety of the patients.

# Portchester Practice

**Detailed findings**

## Our inspection team

**Our inspection team was led by:**

Our inspection team was led by a CQC Lead Inspector. The team included a GP, a specialist advisor in practice management and an Expert by Experience. Experts by Experience are members of the inspection team who have experienced care or treatment from a similar service.

## Background to Portchester Practice

Portchester Practice is located in West Street, Portchester near Fareham Hampshire PO16 9TU. The practice is operated from Portchester Health Centre, which is attached to the local library in the centre of Portchester. The premises were purpose built and owned by NHS property services. The practice building has ten consulting rooms and three treatment rooms. The health centre is also used by members of the primary health care team with community nurses and heath visitors based in the building. The practice hosts a community midwife and provides a phlebotomy service (a service where blood samples are taken for testing) to meet the needs of their patients.

The practice does not provide an out of hours service for their patients. Outside normal surgery hours patients are able to access urgent care from the 111 Out of Hours service.

The practice provides a range of primary medical services to approximately 8,900 patients. Patients are supported by three female and two male GP partners a GP registrar and two retained GPs. (A GP registrar has completed their medical training to be a doctor but needs to complete another year in primary care to specialise as a GP. A retained GP supports the practice part time, they are able to maintain their skills and keep up-to-date until such time as other commitments allow them to commit to a substantive post in a GP partnership or salaried position.) Further support is provided by a practice manager, an assistant practice manager, three practice nurses, two health care support workers, a phlebotomist and administrative and reception staff. The practice is a member of the Fareham and Gosport Clinical Commissioning Group (CCG).

Portchester Practice has a General Medical Services (GMS) contract. The GMS contract is the contract between general practices and NHS England for delivering primary care services to local communities.

Fareham and Gosport CCG covers a less deprived area than the average for England. The Portchester Practice covers an area equal to the least deprived 20% of England.

## Why we carried out this inspection

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

We carried out a comprehensive inspection of this practice 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 practice, and to provide a rating for the service under the Care Act 2014.

# Detailed findings

Please note that when referring to information throughout this report, for example any reference to the Quality and Outcomes Framework data, this relates to the most recent information available to the CQC at that time.

## How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations such as; the NHS England Area Team, Healthwatch and the Fareham and Gosport Clinical Commissioning Group to share what they knew.

We carried out an announced visit on 18 December 2014. During our visit we spoke with a range of staff including GPs, practice nursing staff, the practice manager, assistant practice manager and reception and administrative staff. We spoke with patients who used the service and representatives of the Patient Participation Group (PPG). We observed how people were being cared for and reviewed some of the practice's policies and procedures. We also reviewed eight comment cards where patients had shared their views and experiences of the practice.

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
- 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)

The Portchester Practice has a high percentage of their patients over 50 years of age compared with the average for England. The percentage of patients under 40 years of age is lower than the average for England. The practice list size had increased by over 500 patients in the last 12 months.

Requires improvement

# Are services safe?

## Our findings

### Safe track record

The practice used information gathered both externally and internally to identify risks and improve quality in relation to patient safety. For example, reported incidents, national patient safety alerts as well as comments and complaints received from patients. Potential safety incidents had been acted on promptly and cascaded to practice staff to mitigate future risks. All the staff we spoke with demonstrated an understanding of their responsibilities to raise concerns, and how to report incidents and near misses. For example, a safeguarding concern or an issue relating to patient treatment

A programme of regular meetings, clinical meetings, significant events analysis, multi-disciplinary meetings and gold standard framework (GSF) meetings were used to highlight and discuss any patient safety or medical alerts to ensure verbal and written information was passed to appropriate staff, GPs and nurses. (GSF is an evidence based approach to providing the best care possible for all patients approaching the end of life) There was a system in place to ensure that medicine alerts received from external bodies such as the Medicines and Healthcare Regulatory Agency (MHRA) were shared by the practice manager with the appropriate staff.

We reviewed safety records, incident reports and minutes of meetings where these were discussed. This showed the practice had managed these consistently over time and so could evidence a safe track record over the long term.

### Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. Records were kept of significant events that had occurred and a record of the last 12 months was made available to us. Significant events and complaints were discussed at quarterly meetings which provided GPs, the practice manager and nurses with the opportunity to discuss any incident and to record any actions. Records confirmed that appropriate learning had taken place and that the findings were disseminated to relevant staff. For example, GPs had discussed how they should investigate certain recurrent infections to avoid any possible missed diagnosis.

Staff, including receptionists, administrators and nursing staff were aware of the system for raising issues to be considered at the meetings. Forms for recording significant events were available in the reception area.

Incident and complaint forms once completed were dealt with by the practice manager who showed us the system they used to oversee and ensure these were managed and monitored. We saw that incidents and complaints were dealt with in a comprehensive and timely manner. There was evidence of action taken as a result, for example the practice had discussed the way in which they communicated with patients to ensure they did not cause any distress when requesting information.

### Reliable safety systems and processes including safeguarding

We were told that all staff had received relevant training on safeguarding vulnerable adults and children. This had been provided by the practice as part of their target training. GPs attended target events organised by the clinical commissioning group and the practice organised specific in house training for other staff. Staff knew which GP was the lead for safeguarding. The GP lead for safeguarding and the practice nurse manager had received level three training in children's safeguarding, other GP partners had received either level two or level three training on this. All staff knew their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact the relevant agencies in and out of hours. Contact details were posted throughout the practice and were easily accessible for all staff.A chaperone policy was in place and visible on the waiting room noticeboard and in consulting rooms. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure.) We noted that GPs undertook procedures such as for fitting contraceptive devices without the support of any other staff. There was not a clear risk assessment or procedure for calling for assistance in a medical emergency.

### Medicines management

There were systems in place for managing medicines within the practice. Suitable lockable cupboards were provided for medicines to be stored securely. There was a designated refrigerator for storing medicines which needed to be kept at a low temperature. Records we looked at showed the refrigerators were operating within safe limits. Staff were clear about the actions they should take if there

was an interruption in the cold chain of vaccines. When nurses administered prescription only medicines for example vaccines, specific directions were in place in line with current legislation.

The practice had a dedicated prescription desk where a member of administration staff could work uninterrupted to manage patient prescriptions. Patients were able to request repeat prescriptions at the practice or online. The practice had a protocol for repeat prescribing which was in line with General Medical Council guidance. This covered how changes to patients' repeat medicines were managed and the system for reviewing patients' repeat medicines to ensure the medicine was still safe and necessary. Blank prescriptions were stored securely.

Emergency medicines for cardiac arrest, anaphylaxis (a severe allergic reaction) and hypoglycaemia (low blood sugar levels) were available and all staff knew their location.

### Cleanliness and infection control

The practice was cleaned by a company contracted by the landlord; this included arrangements for laundry and also for waste disposal.

We observed the rooms used to consult or treat patients were visibly clean, tidy and well maintained. Work surfaces could be cleaned easily and were clutter free. Patients we spoke with told us they always found these areas of practice clean and had no concerns about infection control. However we found that chairs in the waiting room were stained and ripped, with wooden chair arms visibly dirty.

The practice did not have copies of the cleaning schedule or access to any cleaning records. The practice did not have their own system in place to audit or check the standard of environmental cleaning. Although we were told that the landlord audited the standard of cleaning these audits were not available at the practice.

The practice did not have an infection control policy for staff to refer to. The last recorded audit of infection control in the practice had taken place in April 2013. Although there had been a hand wash audit completed by the GPs and nurses there had been no recent audit of infection control procedures which would have identified any risks relating the control of the spread of infection. Other documents relating to infection control checks had not been dated or completed. The April 2013 audit had identified issues that required action, including the ripped and stained chairs which were in the same condition at the time of our inspection. The audit had also identified that laundering of fabric curtains in consulting rooms was overdue. We noted that treatment rooms had disposable curtains which had recently been replaced. The practice was not able to confirm the date when the fabric curtains in consulting rooms had been laundered. Staff told us they believed the last time these were laundered was more than six months ago.

Personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these to protect themselves and patients.

We saw there was appropriate waste disposal in place in the treatment rooms with appropriately labelled clinical waste bins and medicines and sharps waste containers. There were no records available to confirm the safe disposal of waste.

The practice did not have a policy for the management, testing and investigation of Legionella (a bacterium found in the environment which can contaminate water systems in buildings). The practice was not aware of the water storage systems in the building and the level of risk to patients and staff from Legionella had not been formally assessed.

### Equipment

Staff we spoke with did not raise any concerns about the safety, suitability or availability of equipment. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. We saw that medical equipment had been calibrated, to the frequency recommended by manufacturers, and was functioning correctly and accurately. (Calibration is a means of testing that measuring equipment is accurate). Electrical items had been portable appliance tested (PAT tested) and were deemed safe to use.

### Staffing and recruitment

Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, evidence of satisfactory conduct in previous employment, qualifications and registration with the appropriate professional body. Criminal records checks through the

Requires improvement

# Are services safe?

Disclosure and Barring Service (DBS) had been recorded for GPs and nurses with other staff checked as necessary following a risk assessment into whether it was required. The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff.

The GPs and practice manager told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a rota system in place for the different staffing groups to ensure that enough staff were on duty. There was also an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's sickness or annual leave.

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. Although we could not see a formal audit of the appointment system a member of the administration team told us how they reviewed appointments regularly to ensure there was sufficient capacity to meet the needs of patients.

### Monitoring safety and responding to risk

There were systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. Most aspects were managed and monitored by arrangement with the landlord.

Checks included the building, the environment and emergency alarms, their fire risk assessments and annual checks of fire extinguishers and fire evacuation drills. The practice believed that a system of spot checks was in place for the maintenance and cleanliness of the building but was not informed of their outcome.

The practice was able to contact the landlord to request repairs and maintenance. They reported that this worked well for minor issues but major changes to the building were not easy to action.

There was a system for requesting a rapid response team from the landlord that was posted prominently in a number of areas in the practice. Staff told us that the system of rapid response worked very well. The team attended the practice quickly to deal with any emergency such as a spillage, significant equipment failure or building safety issue.

The practice had not carried out a risk assessment in relation to the building as they believed this was the responsibility of the landlord from whom they leased the building. However the practice could not show us a lease agreement in or specification of the support services provided.

The electronic system at the practice provided alerts for staff in relation to patient safety issues, for example alerts appeared to warn of drug allergies. There were processes in place to identify those patients at high risk of hospital admission with an alert attached to their electronic patient record.

### Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. We saw records to show that all staff had received training in basic life support.

The practice had appropriate equipment, emergency medicines and oxygen to enable them to respond to an emergency should it arise. Processes were in place to check emergency medicines were within their expiry date and suitable for use. The practice nurse checked the emergency medicines were in date to ensure they would be safe to use should an emergency arise.

We were told that the practice had a business continuity plan which included what the practice would do in an emergency which caused a disruption to the service; however we were unable to see a copy as these were held off the premises by each of the GP partners, the practice manager and the assistant practice manager.

Requires improvement

# Are services effective?

(for example, treatment is effective)

## Our findings

### Effective needs assessment

Patients' needs were assessed and treatment was delivered in a way which followed national standards and guidance. Patients confirmed that they received an assessment of their symptoms before GPs and nurses recommended treatment. Nursing staff at the practice were responsible for patients' chronic disease management, for example diabetes and asthma.

The practice provided specialised appointments to meet the needs of patients. These included diabetes, asthma and chronic obstructive pulmonary disease (COPD), a disease which results in breathing difficulties. These specialised appointments were carried out by the practice nurse, who had a specialist qualification in asthma and further relevant training, with support from the GPs. There were arrangements in place to ensure all patients with a long term medical condition received an annual health check.

All new patients were offered a health check by the health care support worker or practice nurse to identify potential health conditions; this gave them the opportunity to work proactively with patients about how to manage their health. Records for new patients were transferred to the practices electronic system. Staff responsible for this work had the experience to appropriately book any patient, identified as having a long term condition, to the appropriate clinic to monitor their disease. However there had not been any audit of this work to assess the effectiveness of the process of identifying the needs of patients in this way.

Patients who relied on long term medicines were regularly assessed and their medicines needs reviewed. There were systems in place to ensure the GPs reviewed the diagnostic and blood test results of their patients. If a GP requested a diagnostic test such as a blood test the results would be returned to them electronically. All other results returned by letter were forwarded to the appropriate GP or checked by the senior GP partner.

The practice used a software system that had assessment and treatment templates based on best practice guidance. They said that if needed they were able to add additional information to the patient record about treatment given.

The practice was aware of their patients at most risk of frequent hospital admission. The practice used computerised tools to identify patients with complex needs. The practice held weekly informal GP meetings and monthly clinical meetings these provided GPs with the opportunity to discuss patient care. Patients who required a multi-disciplinary approach to their ongoing complex health and social needs were discussed at meetings every three months when community and palliative care teams attended.

Patients who regularly attended the hospital A and E department were contacted by the practice to discuss how their health needs could be managed more effectively.

### Management, monitoring and improving outcomes for people

The practice had a system in place for completing clinical audit cycles. For example we saw an audit regarding the prescribing of a certain antibiotic for patients with renal impairment. Following the audit the GPs and nurses discussed the findings and altered their prescribing practice, in line with the recommended guidelines. The repeat audit showed that improvements had been made to ensure that prescribing was within line with recommended guidance. Actions had been taken following the audit and the learning points identified to improve patient care.

The practice routinely collected information about patients' care and outcomes. The Quality and Outcomes Framework (QOF) was used to assess the practice's performance (QOF is a voluntary system where GP practices are financially rewarded for implementing and maintaining good practice in their surgeries). The practice regularly reviewed their achievements against QOF. The figures for the year 2013 to 2014 showed the practice had achieved 867 points out of a possible 900.The QOF data was actively monitored at the practice and GPs were made aware of any shortfalls that needed to be addressed. At the time of our inspection the practice were able to tell us that they had identified the need to provide more support to those patients with asthma and chronic obstructive pulmonary disease (COPD) (a collection of diseases which cause breathing difficulties) to be able to reach their QOF target. QOF data showed the practice performed in line with local practices and was better than average in a number of areas such as; completing a register of all patients in need of palliative support, holding regular

Requires improvement

# Are services effective?

(for example, treatment is effective)

multi-disciplinary case review meetings, the percentage of patients diagnosed with dementia who had received face to face reviews and the percentage of patients aged 65 and older who had revived a seasonal flu vaccination.

### Effective staffing

The practice maintained a record of individual staff's training, but there was no overview of all training provided to staff. Nursing staff had attended a range of training courses relevant to their role. The practice was not able to show us training records to confirm the training that had been provided to administrative and reception staff. Some of the administration and reception staff we spoke with could not recall having had recent training in medical emergencies. They felt that some of the training organised within the practice was not always relevant to their roles.

All GPs had either been revalidated or had a date for revalidation. (Every GP is appraised annually and every five years undertakes a fuller assessment called revalidation. Only when revalidation has been confirmed by NHS England can the GP continue to practice and remain on the performers list with the General Medical Council).

Nursing staff had all received an annual appraisal from the nurse manager. A number of administrative and reception staff told us that although they had received an appraisal in the past they had not had an appraisal in over 12 months. This was confirmed by the practice manager who told us that staff appraisals had lapsed in the last two years. One of the GPs told us that they considered the nurses had received sufficient training but not reception staff. Staff told us that they felt that not all their learning needs had been identified.

Practice nurses had defined duties they were expected to perform and were able to demonstrate they were trained to fulfil these duties. For example, on administration of vaccines and cervical cytology. Those with extended roles for seeing patients with long-term conditions such as diabetes were also able to demonstrate they had appropriate training to fulfil these roles. Nursing staff described a learning environment where their team were actively encouraged to develop and maintain their clinical skills.

### Working with colleagues and other services

The practice worked with others to improve the service and care of their patients. The practice operated from a health centre where other members of the primary health care team were also based. These included community nurses and health visitors.

Antenatal and postnatal care was provided by a practice based midwife and the health visitors. We spoke with a number of patients who were attending an ante natal clinic on the day of our inspection. They told us that communication between the midwife and their GP was good and any shared care had worked well for them. The midwife at the practice was able to ask a GP for advice which often meant the GP saw the patient immediately without the need to make another appointment. GPs and nurses worked closely with health visitors, the community care team, social workers and counsellors. The practice held meetings every six weeks with allied staff; these multidisciplinary meetings were held to discuss the health and social needs of specific patients and were attended by health care professionals as appropriate.

The practice provided antenatal care for service personnel, members of the armed forces, and provided continued care for their babies and children when the parent returned to the services' health care system.

There were systems in place to ensure that the GPs reviewed communication from other health care providers, for their patients. The practice received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. The practice had a procedure for passing on, reading and acting on any issues arising from communications with other care providers on the day they were received. Administration staff date stamped and scanned all letters relating to patients from the Out of Hours provider or from other organisations. These communications and any information received electronically were passed to the relevant GP. There was a system in place to ensure all results and letters were seen by the senior GP partner if they were not linked to a named GP or if the patient's GP was not working that day. They were then able to take immediate action if required.

All staff we spoke with understood their roles and felt the system in place worked well. There were no instances within the last year of any results or discharge summaries not followed up appropriately.

Requires improvement

# Are services effective?

(for example, treatment is effective)

## Information sharing

Patient information was stored securely on the practice's electronic record system. Patient records could be accessed by appropriate staff in order to plan and deliver patient care. The practice had historic paper patient records which were used if necessary to review medical histories.

There were systems in place to add information received from other healthcare providers to patient records. We saw that information was transferred to patient records promptly following out of hours or hospital care. One of the patients we spoke with said that transition from hospital care to GP care had been seamless and that their initial referral to hospital had been through choose and book which had been organised efficiently by the practice. (The Choose and Book system enables patients to choose which hospital they will be seen in and to book their own outpatient appointments in discussion with their chosen hospital).

The weekly GP lunchtime meetings and monthly clinical meetings had time set aside for information sharing. Three monthly palliative care meetings had multidisciplinary input for discussions of complex patients.

The practice ensured that the out of hours and ambulance service were aware of any relevant information relating to their patients. For example care plans that were in place for patients with complex medical needs were shared with the out of hours and ambulance services. These services were also made aware of any patient whose end of life was being managed in their own home.

## Consent to care and treatment

Staff were able to describe the principles, relevant to their role, of the Mental Capacity Act 2005 when assessing whether a patient was able to give informed consent, we were told they had received specific training on this area approximately three years ago, a number of staff we spoke with could not recall this training.

The GPs and nurses we spoke with understood the key parts of the legislation in relation to the Mental Capacity Act 2005 (MCA) and were able to describe how they implemented it in their practice. For some specific scenarios where capacity to make decisions was an issue for a patient, the practice staff were clear how patients should be supported to make their own decisions and how these should be documented in the medical notes. Patients with learning disabilities and those with dementia were supported to make decisions with their families or carers.

GPs we spoke with demonstrated a clear understanding of Gillick competencies, to identify children aged under 16 years of age who have the capacity to consent to medical examination and treatment and were familiar with using the assessment.

One nurse explained how they would obtain consent from patients and ensure that the patient understood treatment options prior to proceeding. Consent in relation to immunisations had been part of the discussions at a recent immunisations study day.

Patients said that they felt involved in decisions about their care and treatment. They said they were given time to consider options available and were never rushed.

There were systems in place to record patients' consent to share information with a relative. This was clearly highlighted by the practice's electronic record system. For example a patient had given permission to share all appointment information with a family member to make sure they did not forget their appointment. They had also consented to being accompanied to consultations to ensure they did not forget the discussions with their GP.

## Health promotion and prevention

Patients were encouraged to take an interest in their health and take action to improve it. We saw a range of health promotion information available at the practice and on its website. New patients to the practice were encouraged to have a health assessment to ensure the practice was aware of their health and care needs.

The practice had a range of health promotion leaflets in their waiting rooms and other areas. Noticeboards were used to signpost patients to relevant support organisations.

Practice nurses had specialist training and skills, for example in the treatment of asthma, diabetes and travel vaccinations. This enabled nurses to advise patients about the management of their own health in these specialist areas.

Requires improvement

# Are services effective?

## (for example, treatment is effective)

The practice offered NHS Health Checks to all its patients aged over 40. These were carried out by the practice nurses who would discuss the findings with patients and refer to a GP if a medical opinion or diagnosis was required.

All patients with a learning disability were offered a physical health check every 12 months. These appointments were carefully planned by the practice to ensure they had sufficient time to see the health care support worker followed by the GP.

One of the patients we spoke with told us that the nurses had offered a lot of healthcare advice and another told us about the written information and dietary advice they had been given when their blood test had shown a raised level of cholesterol.

Good

# Are services caring?

## Our findings

### Respect, dignity, compassion and empathy

During our inspection we spoke with 30 patients and reviewed eight comment cards. Everybody was complementary about the care that they received from all the practice staff. We spoke with patients of varying ages. They all said that they had been dealt with courteously by all staff. We observed staff interacting with patients and we saw that patients were treated with dignity and respect.

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the NHS England GP patient survey, NHS Choices and the practice's own satisfaction survey conducted between September and November 2014. The evidence from all these sources showed patients were very satisfied with how they were treated and described the staff as friendly and approachable. The practice's survey showed that 93% of the respondents either agreed or strongly agreed that overall they were satisfied with the care provided by GPs and staff at the practice.

Staff told us how they respected patients' confidentiality and privacy. All telephone calls were made and answered by staff who were situated away from at the reception desk. This helped keep patient information private and ensured that confidential information could not be overheard. We saw this in operation during our inspection and noted that it was effective in maintaining confidentiality. There was also a side window to the office behind reception where patients could have a more private discussion.

Curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation and treatment room doors were closed during consultations. However during our observations in the waiting room we were able to hear one of the GPs talking loudly to a patient by telephone. Although the patient was not named symptoms were discussed.

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

Patients told us that their GP explained their treatment and all commented that there was enough time to discuss their needs. They also told us they felt listened to and supported by staff. They understood what had been said in order to make an informed decision about the choice of treatment they wished to receive; one person was keen to tell us how their GP had drawn a diagram to help them understand their medical condition. The comment cards we received were also positive and praised the caring, helpful attitude of staff.

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

The patients we spoke with were positive about the emotional support provided by the practice. For example one patient told us about the emotional support they received from their GP and the practice when they had to move to using a wheelchair. Other patients described the emotional support they had received during their treatment for depression.

Patients commented that they never felt rushed and that the nurses and GPs spent time reassuring them about their treatment and after care. One patient told us how they had been contacted by their GP following discharge from hospital they had been asked how they were coping both medically and emotionally.

Notices in the patient waiting room informed patients how to access a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer, which may be relevant to the treatment, care or support they needed.

The practice met regularly with the community care team and the palliative care team to ensure all professionals are aware of end of life wishes. GPs told us that they involved families and carers in end of life care and worked to provide help and support for those patients at the end of life.

The practice ensured that the out of hours service was aware of any information regarding patients' end of life needs and ensured they received specific patient notes. This included individualised information about patient's complex health, social care or end of life needs.

Good

# Are services responsive to people's needs?

(for example, to feedback?)

## Our findings

### Responding to and meeting people's needs

The practice was aware of the practice population in respect of age, culture, and number of patients with long term conditions. We found the practice was responsive to people's needs and had systems in place to maintain the level of service provided. The practice had developed an appointment system to ensure that any person who needed advice about their health or to see a GP or nurse was able to do so the same day.

The practice worked collaboratively with Fareham and Gosport Clinical Commissioning Group (CCG) and other practices to discuss local needs and service improvements that needed to be prioritised.

The practice had a patient participation group (PPG). The practice's patient feedback survey had been designed based on issues raised by the group. The PPG had carried out the survey, analysed the results and presented the findings to the practice. The most recent annual patient survey had been carried between September and November 2014. Most of the questions were aimed at finding out how much patients knew about the practice and its appointment system and to assess their level of satisfaction. The survey had been handed to patients who were encouraged to complete with the aim of collecting as large a sample as possible. Members of the PPG had given their time to be present at the practice to collect completed surveys. However the majority of surveys had been completed at the flu clinics which meant that most people expressing their views were in the older age group, 837 surveys were completed with over 600 completed by patients over 65 years of age so was not representative of the patient population. At the time of our inspection the results of the survey had just been collated and a plan of action in response to the outcome of the survey had been produced but not agreed with the practice.

One of the GPs and the deputy practice manager attended the PPG meetings. The representatives from the PPG told us the practice was very receptive to suggestions made to improve the service to patients. They told us following the results of the last PPG survey the practice had increased the number of available appointments and introduced a new booking in system. They told us they felt valued by the practice and involved in making positive changes at the practice.

Patients were positive about the responsiveness of the practice and individual GPs for example a patient received a call from their GP to discuss the results of their blood test when immediate action was required. On the day of our inspection and during our observations in reception we were aware of a receptionist dealing with a caller whose family member was experiencing chest pain. There were systems in place to immediately alert the duty doctor with a message on their screen. Patients also commented that children were always prioritised and the practice always ensured they were seen the same day.

We also spoke with a patient who told us their condition meant frequent visits to the practice and often needed longer appointments. The practice was able to meet their need; they did not feel rushed and felt important.

### Tackling inequity and promoting equality

The practice provided care to patients in three care homes in the form of home visits. The practice provided health checks for patients who had a learning disability. GPs carried out annual health reviews in patients' homes if they were housebound or if it was beneficial to the patient to have the health check in familiar surroundings.

Staff had not received formal training in equality and diversity; however they could demonstrate that they promoted equality in the practice.

The premises were purpose built; we saw that the waiting area was large enough to accommodate patients with wheelchairs and prams. The reception area was at a high level which could be a barrier to anybody who used a wheelchair, reception staff would have to stand up and lean over to communicate with these people. Patient toilets were available, these were accessible to patients who used a wheelchair. All treatment and consultation rooms were on the ground floor.

### Access to the service

The practice could be contacted between 8am and 6.30pm Monday to Friday for enquiries or emergencies. Appointments were available at these times with opening until 7.30 pm on Mondays and early appointments from 7am Tuesdays and Wednesdays. One Saturday each month the practice offered appointments from 7.30am until 11am

Patients could book routine appointments with their preferred GP; we found that these were available either the next day or up to 10 days ahead depending on the GP. The practice operated a GP triage system every day run by a

Good

# Are services responsive to people's needs?

## (for example, to feedback?)

duty doctor. Patients were able to call for advice or to be assessed to see if a same day appointment was required. The duty doctor had no booked appointments so was able to see those patients they had assessed as requiring an appointment that day. They were also able to book patients in the same day with their own GP or for a telephone consultation if required.

Information was available to patients about appointments on the practice website and in the practice leaflet. This included how to arrange routine and urgent appointments and home visits. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients. Information about out of hours care was published on the practice website.

Longer appointments were also available for people who needed them and those with long-term conditions. Longer appointments were made for patients with a learning disability to ensure they could be treated in a relaxed manner.

Patients were generally satisfied with the appointments system but some commented on the long waiting times for routine appointments with their preferred GP. They confirmed that they could see a doctor on the same day if they needed to and they could see another doctor if there was a wait to see the doctor of their choice. Comments received from patients showed that patients in urgent need of treatment had been triaged by the duty doctor and had been offered a same day appointment if it had been medically necessary.

### Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Their complaints policy was in line with recognised guidance and contractual obligations for GPs in England. The practice manager was responsible for managing complaints. Information on how to make a complaint was displayed in the surgery.

All complaints coming to the practice GPs were copied to the practice manager and assistant practice manager to ensure there was no delay in responding to the complaint should the GP be unavailable.

We reviewed a sample of complaints the practice had received. These had been investigated and resolved as far as possible to the complainant's satisfaction. Patients told us they know how to complain should they need to.

We noted that an analysis of complaints had not been carried but were discussed at significant event meetings to ascertain whether more action was needed or how the practice had learnt from the complaint to improve the service to their patients.

# Are services well-led?

Requires improvement

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

## Our findings

### Vision and strategy

The registered manager told us the practice aimed to deliver traditional family medicine and to provide high quality continuity of care. We were given details of the practice's vision and strategy in relation to workforce planning and a six phase plan of building improvements agreed with the landlord. The practice vision and values included offering a friendly accessible practice for their patients and to increase the type of services available to patients. This formed the basis of their negotiations for increased space allocation and prioritisation of rooms to be upgraded.

We spoke with thirteen members of staff and they all knew and understood the aims of the practice and their responsibilities in relation to these. However not all staff were aware of the vision and strategy of the practice and had not been consulted or informed about the future plans for improvement.

### Governance arrangements

The practice had systems in place to govern activity and minimise risk, but these were not consistently implemented. The practice had arrangements for identifying, recording and managing some of the risks associated with the running of the practice, for example whether administration staff required disclosure and barring checks (DBS).

The practice had not ensured they were aware of the risks in relation to the internal and external premises as part of their lease and use of the property and had not monitored the environment or emergency systems.

The practice had a number of policies and procedures in place to govern activity and these were available to staff on any computer within the practice, with hard copies available in a file in the reception area. We looked at a number of these policies and procedures and the system by which new policies were notified to all staff for reference. However the lack of an infection control policy and monitoring of infection control procedures meant that risks had not been identified and managed.

There was a leadership structure with named members of staff in lead roles. For example, there was a lead nurse for infection control; the senior partner was the lead for safeguarding and medicines management. Other GP partners took the lead for training and clinical commissioning group (CCG) contact and liaison. We spoke with thirteen members of staff in a variety of positions such as GPs, nurses and reception and administration staff, they were all clear about their own roles and responsibilities. They all told us they knew who to go to in the practice with any concerns. Nurses felt well supported and valued by the GPs. Although staff said they felt supported by the practice manager some did not find the GPs as approachable or supportive.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed it was performing in line with national standards. We saw that QOF data was discussed at monthly clinical and quarterly partnership meetings to identify progress and address shortfalls, with action plans produced to maintain or improve outcomes. The practice had identified the need to increase the number of annual reviews for patients with asthma or COPD and was working towards an improvement. The practice had a programme of clinical audits, managed by the partnership, which it used to monitor quality and systems to identify where action should be taken. For example the practice had worked with the CCG medicines management team in response to changes the guidance for drug prescribing. They had audited the use of medicines for patients with urinary tract infections.

### Leadership, openness and transparency

There was a regular programme of meetings for GPs and nurses to discuss matters relating to patients. There were monthly administration meetings which the nurses also attended. Reception and administration staff told us that the practice manager or nurses gave them updates on developments within the practice but GPs were not present. The practice did not hold full staff meetings due to a large number of staff working part time. The staff meetings held every six weeks were for GPs, nurses, management and administration staff who were available to attend.

We saw the minutes from a meeting in November 2014 which showed that no GPs had attended. Reception and administration staff told us that GPs rarely attended these meetings. We were also made aware at inspection of challenges facing the GP team and how there were sometimes delays in sharing information about the running of the practice.

# Are services well-led?

Requires improvement

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

The weekly clinical meetings were used for GPs to cascade information to colleagues. The GPs all felt they had a collective responsibility for making decisions and monitoring the effectiveness of clinical practice through audits or specialist training.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example the anti-discrimination and equal opportunities policy, which were in place to support staff.

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

The practice had an active patient participation group (PPG). The PPG included representatives from various population groups; such as patients with long term conditions and those of working age. The PPG had carried out annual surveys and met every three months. One of the practice GPs and the assistant practice manager attended meetings, their presence formed part of the PPGs constitution. The practice and the PPG worked together to organise speakers to attend the meetings.

The practice had gathered feedback from patients through patient surveys, complaints and compliments received. Representatives of the patient participation group told us that the practice was responsive to the suggestions they made following feedback from patients and supported the work of the PPG. We saw as a result of this the practice had introduced early morning appointments and a new booking in system to reduce the time spent by patients waiting at the reception desk.

The practice had not gathered feedback from other staff through staff surveys, appraisals or discussions. Staff told us that they did not think that if they made suggestions they would be listened to and if they were they did not feel confident that the GPs would act on their suggestions. Although staff told us they would not hesitate to discuss any concerns or issues relating to patient safety with a GP or the practice manager.

Administration and reception staff told us that they worked well as a team and enjoyed their working environment but felt the practice did not work together as a whole team.

### Management lead through learning and improvement

The practice manager and GPs used the information from incidents and significant events to minimise risk by identifying trends and themes that may affect care and service quality.

GPs and nurses told us that the practice supported them to maintain their clinical professional development through training and mentoring. We saw that for nursing and healthcare staff regular appraisals took place which included a personal development plan. However other staff told us that they had not had a recent appraisal or the opportunity to discuss their training and development needs. We were made aware of ongoing concerns related to staff performance. The practice partners had implemented support systems where needed and monitored performance on a regular basis.

The practice was a GP training practice and one of the GPs was an approved trainer who took the lead for training GP registrars (a GP who has completed their medical training to be a doctor but needs to complete another year in primary care to specialise as a GP) and another for newly qualified doctors (foundation doctors).

The practice had completed reviews of significant events and other incidents but had not shared with the wider staff group, unless the person was directly involved, to ensure the practice learnt from events and improved outcomes for patients.

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<br>Family planning services<br>Maternity and midwifery services<br>Surgical procedures<br>Treatment of disease, disorder or injury | Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment<br><br>We found staff knowledgeable about infection control systems that were in place to prevent the control and spread of infections. However improvements were needed to the systems and processes in relation to infection control. There was no infection control policy available and the auditing of infection control procedures had not taken place since 2013. The practice did not have a system in place to monitor the environmental cleaning of the premises and furnishings. They had not assessed the risks relating to Legionella.<br><br>How the regulation was not being met: The provider had not ensured that patients were protected against identifiable risks of acquiring a health care associated infection by the effective operation of systems designed to assess the risk of and to prevent, detect and control the spread of infection and the maintenance of appropriate standards of cleanliness and hygiene in relation to premises occupied for the purpose of carrying on the regulated activity. Regulation 12 (2)(h)<br><br>This was a breach of Regulation 12 (1) (a) (2) (a) (c) (I) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 12 (2)(h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. |

| Regulated activity | Regulation |
|---|---|
| Diagnostic and screening procedures<br>Family planning services<br>Maternity and midwifery services<br>Surgical procedures<br>Treatment of disease, disorder or injury | Regulation 18 HSCA (RA) Regulations 2014 Staffing<br><br>We found some staff did not feel they had received appropriate training and support. There was no system of appraisal in place for some staff groups.<br><br>How the regulation was not being met: The provider did not have suitable arrangements in place to ensure that |

This section is primarily information for the provider

# Requirement notices

persons employed for the purposes of carrying on a regulated activity were appropriately supported in relation to their responsibilities, to enable them to deliver care and treatment to patients to an appropriate standard, including by, receiving appropriate training, personal development and appraisal. Regulation 18 (2)(a)

This was a breach Regulation 23 (1) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 18 (2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

| Regulated activity | Regulation |
| --- | --- |
| Diagnostic and screening procedures<br>Family planning services<br>Maternity and midwifery services<br>Surgical procedures<br>Treatment of disease, disorder or injury | Regulation 17 HSCA (RA) Regulations 2014 Good governance<br><br>There were no mechanisms in place to seek and respond to feedback from staff. The practice was not aware of the risks in relation to the premises; environment and emergency systems to ensure the needs of the practice and safety of the patients were met.<br><br>How the regulation was not being met: The provider had not protected patients from the risk of inappropriate or unsafe care and treatment, by means of effective systems designed to regularly assess and monitor the quality of services and to identify, assess and manage risks relating to the health welfare and safety of patients. The provider had not regularly sought the views of persons employed to enable them to come to an informed view in relation to the standard of care provided. Regulation 17 (2)(b)(e)<br><br>This was a breach of Regulation 10 (1) (a) (b) (2) (e) of the Health and Social Care Act 2008 (Regulated Activities) 2010, which corresponds to Regulation 17 (2)(b)(e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. |