Dr Starling and Partners

Quality Report

Anchor Healthcare Centre,
Meridian Way,
Peacehaven,
East Sussex
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Website: www.meridian-surgery.co.uk

Date of inspection visit: 19 February 2015
Date of publication: 25/06/2015

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection of Dr Starling and Partners, also known as Meridian Surgery, on 19 February 2015. We visited the practice location at Anchor Healthcare Centre, Meridian Way, Peacehaven, East Sussex, BN10 8NF.

Overall the practice is rated as good. Specifically, we found the practice to be good for providing well-led, effective, caring and responsive services. It required improvement for providing safe services. It was good for providing services for older people, people with long-term conditions, families, children and young people, working age people (including those recently retired and students), people whose circumstances may make them vulnerable and people experiencing poor mental health (including people with dementia).

The inspection team spoke with staff and patients and reviewed policies and procedures. The practice understood the needs of the local population and engaged effectively with other services. The practice was committed to providing high quality patient care and patients told us they felt the practice was caring and responsive to their needs.

Our key findings across all the areas we inspected were as follows:

- Patients' needs were assessed and care was planned and delivered following best practice guidance.
- Staff had received training appropriate to their roles and any further training needs had been identified and planned. However, staff had not received training in the safeguarding of vulnerable adults.
- Patients said they were treated with compassion, dignity and respect and they were involved in care and decisions about their treatment.
- The practice engaged effectively with other services to ensure continuity of care for patients.
- The practice understood the needs of the local population and planned services to meet those needs.

There were also areas of practice where the provider needs to make improvements.

Summary of findings

Importantly, the provider must:

- Ensure that all staff are trained in safeguarding of vulnerable adults.
- Ensure staff have appropriate policies, procedures and guidance to carry out their role in relation to safeguarding vulnerable adults.
- Ensure criminal records checks are undertaken via the Disclosure and Barring Service for staff trained to provide chaperone services or that risk assessment is undertaken to establish the reason why those staff should not be subject to a criminal records check.

In addition the provider should:

- Include advocacy and ombudsman details in information given to patients about how to make a complaint.

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. Staff had some understanding of procedures relating to the safeguarding of children and vulnerable adults. Staff had received training in child safeguarding at a level appropriate to their role. However, the majority of staff within the practice had not received training in safeguarding vulnerable adults. There was no policy in place to support staff in the safeguarding of vulnerable adults. Risks to patients were assessed and generally well managed. However, reception staff trained to provide chaperone services had not been subject to a criminal record check via the Disclosure and Barring Service and the practice had not undertaken a risk assessment to support this decision. The practice had assessed other risks such as those associated with potential exposure to legionella bacteria. There were enough staff to keep patients safe.

Are services effective?

Good

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

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice higher than others for several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information to help patients

Summary of findings

understand the services available was easy to understand. We also saw that staff treated patients with kindness and respect, and maintained confidentiality. The practice promoted local support groups so that patients could access additional support if required.

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. Some patients reported difficulty in accessing the practice by telephone at peak times during the day. Urgent appointments were available on the same day. The practice was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand and the practice responded quickly to issues raised.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt well supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. Staff had received inductions, regular performance reviews and attended staff meetings and events.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older patients. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older patients in its population and had a range of enhanced services, for example, in dementia and end of life care. It was responsive to the needs of older patients, and offered home visits and rapid access appointments for those with enhanced needs. All patients over the age of 75 years had a named GP. The practice ensured early referral to services for memory assessment.

People with long term conditions

Good

The practice is rated as good for the care of patients with long-term conditions. Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. Care plans had been introduced to minimise the risk of unplanned hospital admissions. Longer appointments and home visits were available when needed. All of these patients had a named GP and a structured annual review to check that their health and medication needs were being met. For those patients with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. Practice staff had received training in the safeguarding of children relevant to their role. Staff were aware of child safeguarding procedures and how to respond if they suspected abuse. Immunisation rates were relatively high for all standard childhood immunisations. Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals. Appointments were available outside of school hours and the premises were suitable for children and babies.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students). The needs of the

working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. The practice offered extended hours by opening late on one evening each week and on some Saturday mornings, to meet the needs of patients who worked during the day. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflected the needs for this age group. Health checks were available to all new patients registering with the practice. NHS health checks were available to all patients aged from 45-74 years. The practice participated in the C card scheme which enabled card carriers under the age of 25 years to access free of charge contraception and relevant advice. Staff within the practice had recently received updated training in providing sexual health and contraceptive services. The practice ran a sexual health clinic one evening per week. This included a drop-in service for any young person, regardless of the practice where they were registered, as well as a comprehensive range of contraceptive services and sexual health screening and treatment. The practice had developed links with a local community college and provided regular talks to young people about sexual health.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including those with a learning disability. It had carried out annual health checks for patients with a learning disability. Longer appointments were available to patients where needed, for example when a carer was required to attend with a patient. The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. The practice had identified those vulnerable patients requiring support to minimise the risk of accident and emergency attendance and unplanned hospital admissions. Care planning was in place to support those patients. Patients receiving palliative care were supported by regular multidisciplinary team reviews of their care needs. 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)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). People experiencing poor mental health had received an annual physical health check. The practice regularly worked with multi-disciplinary

Summary of findings

teams in the case management of people experiencing poor mental health, including those with dementia. GPs in the practice worked closely with the community mental health team to refer patients for counselling or cognitive behavioural therapy via the Health in Mind programme. The practice had identified a lead GP for the management of patients with poor mental health. It carried out care planning for patients with poor mental health such as dementia and learning disabilities. The practice undertook dementia screening of patients and ensured early referral to memory assessment services. The practice provided information to patients experiencing poor mental health about how to access various support groups and voluntary organisations. Longer appointments were available to patients if required.

Summary of findings

What people who use the service say

Patients told us they were satisfied overall with the practice. Comments cards had been left by the Care Quality Commission (CQC) before the inspection to enable patients to record their views on the practice. We received 12 comment cards all of which contained positive comments about the practice. We also spoke with three patients on the day of the inspection.

The comments we reviewed were extremely positive about the service experienced. Patients said they felt the practice offered a caring service and staff were efficient, helpful and took the time to listen to them. They said staff treated them with dignity and respect. Two comment cards indicated the respondents sometimes found it difficult to access the practice by telephone. All of the patients we spoke with on the day of inspection told us that all staff were helpful, caring and professional. They told us they felt listened to and well supported.

We reviewed recent GP national survey data available for the practice on patient satisfaction. The evidence from the survey showed patients were satisfied with how they were treated and this was with compassion, dignity and respect. Data from the national patient survey showed that 94% of patients rated their overall experience of the practice as good. The practice was above average for its satisfaction scores on consultations with doctors, with 92% of practice respondents saying the GP was good at treating them with care and concern. We also noted that 89% of patients had responded that the nurse was good at treating them with care and concern.

Areas for improvement

Action the service MUST take to improve

- Ensure that all staff are trained in safeguarding of vulnerable adults.
- Ensure staff have appropriate policies, procedures and guidance to carry out their role in relation to safeguarding vulnerable adults.
- Ensure criminal records checks are undertaken via the Disclosure and Barring Service for staff trained to provide chaperone services or that risk assessment is undertaken to establish the reason why those staff should not be subject to a criminal records check.

Action the service SHOULD take to improve

- Include advocacy and ombudsman details in information given to patients about how to make a complaint.

Dr Starling and Partners

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 CQC Inspector, a GP specialist advisor and a practice manager specialist advisor.

Background to Dr Starling and Partners

Dr Starling and Partners provides primary medical services to approximately 11,000 registered patients. The practice delivers services to a slightly higher number of patients who are aged 65 years and over, when compared with the local clinical commissioning group (CCG) and England average. Care is provided to patients living in several residential and nursing home facilities and one local hospice. Data available to the Care Quality Commission (CQC) shows the number of registered patients suffering income deprivation is similar to the national average.

Care and treatment is delivered by five GP partners and one salaried GP. Three of the GPs are female and three are male. The practice employs a team of six practice nurses and four healthcare assistants. GPs and nurses are supported by the practice manager and a team of reception and administration staff.

The practice is a GP training practice and supports new registrar doctors in training and medical students. The training of practice nurses and general nurses is also supported by the practice.

The practice was open from 8.30am to 6.00pm on weekdays. Extended hours consultations were available one evening per week from 7:00pm until 8:00pm and on Saturday mornings from 8.30am to 12.30pm. The practice operated a flexible appointment system to ensure all patients who needed to be seen the same day were accommodated.

Services are provided from:

Anchor Healthcare Centre, Meridian Way, Peacehaven, East Sussex, BN10 8NF.

The practice has opted out of providing out of hours services to its own patients and uses the services of a local out of hours service.

Why we carried out this inspection

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

How we carried out this inspection

Before visiting the practice we reviewed a range of information we hold. We also received information from local organisations such as NHS England, Health watch and the NHS High Weald Lewes Havens Clinical Commissioning Group (CCG). We carried out an announced visit on 19 February 2015. During our visit we spoke with a range of staff, including GPs, practice nurses and administration staff.

Detailed findings

We observed staff and patient interaction and spoke with three patients. We reviewed policies, procedures and operational records such as risk assessments and audits. We reviewed 12 comment cards completed by patients, who shared their views and experiences of the service in the two weeks prior to our visit.

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

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

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

- Older 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)

Requires improvement

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts, as well as comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses.

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 show evidence of 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. There were records of significant events that had occurred and we were able to review these. Significant events were discussed at monthly meetings. There was evidence that the practice had learned from these and that the findings were shared with relevant staff. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so. We saw evidence that representatives from each team within the practice attended the meetings. The minutes of each meeting were then circulated to all members of staff.

Records of significant events and complaints were completed in a comprehensive and timely manner. Evidence of action taken as a result was shown to us. For example, one significant event recorded had highlighted miscommunication between the practice and a patient requiring hospital admission following the receipt of urgent blood results. The practice had reviewed their protocol for ensuring more effective communication in such circumstances.

National patient safety alerts were disseminated to practice staff. Staff we spoke with were able to give examples of recent alerts relevant to the care they were responsible for.

They also told us alerts were discussed at monthly clinical meetings to ensure all staff were aware of any that were relevant to the practice and where they needed to take action.

Reliable safety systems and processes including safeguarding

The practice had systems in place to manage and review risks to vulnerable children, young patients and adults. A designated GP partner was the practice lead for safeguarding children and vulnerable adults. Safeguarding policies and procedures for vulnerable children were consistent with local authority guidelines and included local authority reporting processes and contact details. However, the practice did not have a written policy for the safeguarding of vulnerable adults.

The GP partners and all staff within the practice had undertaken training in the safeguarding of children at a level appropriate to their role. However, the majority of staff, including the GP partner who was the nominated safeguarding lead, had not received training in the safeguarding of vulnerable adults. The GP lead told us that their training was booked for May 2015.

Staff could demonstrate they had some knowledge to enable them to identify concerns. All of the staff we spoke with knew who the practice safeguarding lead was and who to speak to if they had a safeguarding concern. Staff described the open culture within the practice whereby they were encouraged and supported to share information within the team and to report their concerns. Information on safeguarding and domestic abuse was displayed in the patient waiting room and other information areas.

There was a system to highlight vulnerable patients on the practice computer system and patient electronic records. This included information to make staff aware of specific actions to take if the patient contacted the practice or any relevant issues when patients attended appointments. For example, children subject to child protection plans.

The practice had a chaperone policy. A chaperone is a person who can offer support to a patient who may require an intimate examination. The practice policy set out the arrangements for those patients who wished to have a member of staff present during clinical examinations or treatment. We were told that reception staff had been

trained to undertake chaperone duties. However, those staff had not been subject to a criminal records check via the Disclosure and Barring Service and the practice had not carried out a risk assessment to support this decision.

Patients' individual records were written and managed in a way to help ensure safety. Records were kept on an electronic system, which collated all communications about the patient including clinical summaries, scanned copies of letters and test results from hospitals.

GPs were appropriately using the required codes on their electronic system to ensure risks to children and young people who were looked after or on child protection plans were clearly flagged and reviewed. GPs were aware of vulnerable children and adults and records demonstrated good liaison with partner agencies such as social services.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators. We found they were stored securely and were only accessible to authorised staff. There was a clear process for ensuring medicines were kept at the required temperatures. We reviewed records to confirm this. The correct process was understood and followed by the practice staff and they were aware of the action to take in the event of a potential power failure.

The practice had processes to check medicines were within their expiry date and suitable for use. All the medicines we checked at the time of inspection were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

The practice held stocks of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse) and had in place standard procedures that set out how they were managed. These were being followed by the practice staff. For example, controlled drugs were stored in a controlled drugs cupboard and access to them was restricted and the keys held securely. There were arrangements in place for the destruction of controlled drugs. Staff were aware of how to raise concerns around controlled drugs with the controlled drugs accountable officer in their area.

The nurses administered vaccines using directions that had been produced in line with legal requirements and national guidance. We saw that nurses had received appropriate training to administer vaccines.

The practice implemented a comprehensive protocol for repeat prescribing which was in line with national guidance. The protocol complied with the legal framework and covered all required areas. For example, how staff who generate prescriptions were trained and how changes to patients' repeat medicines were managed. This helped to ensure that patients' repeat prescriptions were still appropriate and necessary. Reviews were undertaken for patients on repeat medicines. All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were handled in accordance with national guidance and kept securely at all times.

The practice had identified a lead GP for medicines management. The practice prescribing lead worked closely in conjunction with the local Clinical Commissioning Group (CCG) and the practice participated in prescribing audits and reviews. Three of the practice nurses were nurse prescribers. They told us they participated in monthly prescribing updates with the GPs and received update training and dissemination of prescribing information via the clinical commissioning group.

Cleanliness and infection control

We observed the premises to be clean and tidy. We saw there were cleaning schedules in place and that daily cleaning records were kept. Monthly equipment cleaning audits were undertaken. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

Hand washing notices were displayed in all consulting and treatment rooms. Hand wash solution, hand sanitizer and paper towels were available in each room. Disposable gloves were available to help protect staff and patients from the risk of cross infection. Eye shields, face masks and plastic aprons were also available when staff required additional protection. Disposable curtains were in place in clinical and consulting rooms. Spillage kits were available within the practice. The practice offered some minor procedures for patients, such as joint injections and minor excisions. Single use instruments were used for those interventions.

Requires improvement

Are services safe?

The practice had a lead nurse for infection control who had received training to enable them to provide advice on the practice infection control policy and to carry out staff training. The lead had recently provided an infection control update for staff within the practice.

The practice had carried out a comprehensive and ongoing audit of all infection control processes. We saw that monthly auditing of infection control processes had been recorded and any improvements identified had been responded to.

We saw that the practice had arrangements in place for the segregation of clinical waste at the point of generation. Colour coded bags were in use to ensure the safe management of healthcare waste. An external waste management company provided waste collection services. Sharps containers were available in all consulting rooms and treatment rooms, for the safe disposal of sharp items, such as used needles.

The practice had identified the risks associated with potential exposure to legionella bacteria which is found in some water systems and had steps to reduce those risks. A legionella risk assessment had been undertaken by an external organisation. We saw that monthly water testing checks were carried out.

Equipment

Staff we spoke with told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. We saw evidence of calibration of relevant equipment which had been carried out in January 2015. For example, digital blood pressure machines and weighing scales. Portable electrical equipment was routinely tested and we saw evidence that this had last been carried out in January 2015.

Records showed essential maintenance was carried out on the main systems of the practice. For example the boilers and fire alarm systems were serviced in accordance with manufacturers' instructions. We saw that fire extinguishers had been serviced in April 2014.

Staffing and recruitment

Records we examined contained all the evidence required to show that recruitment procedures were in place and that appropriate checks had been undertaken prior to employment. For example, files reviewed contained proof of identification including photographic identification, evidence of professional registration and evidence of professional qualifications achieved.

Induction timetables were in place to support administration and reception staff. We were told that some reception and administration staff had been trained to undertake chaperone duties. These staff had not been subject to a criminal records check via the Disclosure and Barring Service and the practice had not undertaken a risk assessment of each role to support this decision.

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. There had been several new staff appointed to the reception team recently due to an increase in the number of patients registered with the practice.

Monitoring safety and responding to risk

The practice was located in modern, purpose built premises with good access for disabled patients. We observed the practice environment was organised and tidy. Safety equipment such as fire extinguishers and the defibrillator were checked regularly and sited appropriately.

The practice had considered some of the risks of delivering services to patients and staff and had implemented systems to reduce risks. We reviewed the risk assessments and audits in place to minimise risks. These included assessment of risks associated with fire safety arrangements and waste management.

We saw that staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies. For patients with long term conditions and those with complex needs there were processes to ensure these patients were seen in a timely manner. Staff told us that these patients could be urgently referred to a GP and offered longer appointments when necessary.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that staff had received training in basic life support. Emergency equipment was

Requires improvement

Are services safe?

available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly. Panic buttons were available within consulting rooms which staff were able to use in an emergency.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Risks identified included power failure, adverse weather, unplanned sickness and access to the building.

Records showed that fire alarms were routinely tested. The practice had very recently carried out a full evacuation of the premises.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff were familiar with current best practice guidance, accessing guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. The staff we spoke with and evidence we reviewed confirmed these actions were aimed at ensuring that each patient was given support to achieve the best health outcome for them. We found from our discussions with the GPs and nurses that staff completed, in line with NICE guidelines, thorough assessments of patients' needs and these were reviewed when appropriate.

GPs and nurses within the practice held lead roles in specialist clinical areas such as diabetes, mental health and respiratory conditions. GPs and nurses were well supported in their specialist roles and described a culture of information sharing, transparency and continual learning. For example, the practice employed three nurse practitioners who were also nurse prescribers. The nurse team met regularly with the GPs to review best practice guidelines. A practice nurse told us how the practice ensured they had identified external support where appropriate for the long term conditions they routinely managed. For example, the nurses worked closely with a specialist tissue viability nurse in order to ensure the appropriate management of patients with venous leg ulcers.

We saw that patients received appropriate treatment and regular reviews of their condition. The practice used computerised tools to identify and review registers of patients with complex needs. For example, patients with learning disabilities or those requiring end of life care. The practice provided support to high numbers of patients with palliative care needs using the Gold Standards Framework. The practice worked closely with the local hospice to ensure continuity of care for patients.

National data showed the practice was in line with referral rates to secondary and other community care services for all conditions. GPs used national standards and best practice for all referrals to secondary care. For example, patients requiring a referral into secondary care with suspected cancers were referred and seen within two weeks.

GPs and nurses were clear about how they would apply the Mental Capacity Act 2005 (MCA) and how they would assess mental capacity. Patients who were either unable or found it difficult to make an informed decision about their care could be supported appropriately.

Management, monitoring and improving outcomes for people

Staff across the practice had key roles in the monitoring and improvement of outcomes for patients. These roles included data input and quality, clinical review scheduling, long term condition management and medicines management. The information staff collected was used to determine clinical audits.

The practice had systems in place for completing clinical audit cycles. The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). (QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). For example, the practice had undertaken an audit review of the long term prescribing of benzodiazepine medicines in patients over the age of 65 years. (Benzodiazepines are medicines used in the management of anxiety disorders, insomnia and alcohol withdrawal). The completed audit cycle had resulted in a number of actions which were implemented within the practice. These included, for example, the sending of a letter to all identified patients inviting them for a medication review. The practice had introduced a flagged warning system on the patients' electronic notes to prompt GPs to discuss their prescription at the patients' next visit to the practice. A practice education session had been implemented and the dissemination of relevant guidelines had promoted awareness within the GP and nurse teams. Other clinical audits undertaken included a review of care provided to patients with osteoporosis, a review of the accuracy of diagnosis of patients with chronic kidney disease and a review of patients prescribed a medicine to treat arrhythmias of the heart.

The practice achieved 94.9% of the maximum Quality and Outcomes Framework (QOF) results 2012/13. The practice used the information they collected for the QOF and their performance against national screening programmes to monitor outcomes for patients. QOF data showed the

Good

Are services effective?

(for example, treatment is effective)

practice performed well in comparison to the regional and national average. For example, the number of patients with diabetes who had received an influenza immunisation was recorded as 86%. The percentage of patients with diabetes whose last measured total cholesterol was five mmol/l or less was 83.71% compared with a national average of 81.6%. The practice was not an outlier for any QOF clinical targets.

The GPs we spoke with discussed how as a group they reflected upon the outcomes being achieved and areas where this could be improved. Regular clinical meetings provided GPs and nurses with the opportunity to regularly review outcomes, new guidance and alerts and for the dissemination of information. The team was making use of clinical audit tools, clinical supervision and staff meetings to assess the performance of clinical staff. Staff spoke positively about the culture in the practice around education, audit and quality improvement.

Effective staffing

Practice staffing included GPs, nursing, managerial and administrative staff. We reviewed staff training records and saw that staff were mainly up to date with attending mandatory training courses. However, the majority of staff, including the GP safeguarding lead, had not received training in adult safeguarding procedures.

A good skill mix was noted amongst the GPs. The practice had identified GPs to undertake lead roles in clinical areas such as palliative care, diabetes and mental health. All GPs were up to date with their yearly continuing professional development requirements and had either been revalidated or had a date for revalidation. (Every GP is appraised annually and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practice and remain on the performers list with NHS England).

Staff we spoke with told us they had participated in regular appraisals which gave them the opportunity to discuss their performance and to identify future training needs. Personnel files we examined confirmed this. A practice nurse told us they last had an appraisal with the lead GP partner. This had included a detailed review of performance and the setting of objectives and learning needs. We saw evidence which confirmed this. The practice manager demonstrated that they were well supported in their own personal development and objective setting.

Staff interviews confirmed that the practice was proactive in providing training and funding for relevant courses. We spoke with the lead nurse who told us the practice was supportive of education and ongoing professional development. The practice supported the training of student nurses and practice nurses. Two of the nurses were trained to provide education and training support to practice nurses. Three of the practice nurses were nurse prescribers. They told us they participated in monthly prescribing updates with the GPs and received update training and dissemination of prescribing information via the clinical commissioning group.

The nursing team were able to attend additional training in specialist areas such as spirometry, cervical screening and immunisations. Those nurses with extended roles had undertaken advanced training in the management of conditions such as chronic obstructive pulmonary disease, asthma and diabetes. We spoke to a healthcare assistant who told us they felt well supported in their role and had been provided with relevant training. The healthcare assistant had been supported by the practice in completing a Level 3 National Vocational Qualification (NVQ) in Care.

Working with colleagues and other services

The practice worked with other service providers to meet patient needs and manage complex cases. The practice effectively identified patients who needed ongoing support and helped them plan their care. For example, the practice demonstrated they had developed effective working relationships with local residential care homes and a local hospice. A named GP carried out regular visits to the homes. The practice had a lead GP for palliative care and held a register of patients receiving palliative care who were being supported by the practice. Care plans were in place for those patients with complex needs.

The practice held regular multidisciplinary team meetings to review the care of patients with complex needs and those at risk of unplanned hospital admissions or accident and emergency attendance. For example, those receiving end of life care. These meetings were attended by district nurses, social workers and palliative care nurses and decisions about care planning were documented in a

shared care record. The practice worked closely with staff and palliative care nurses at a local hospice to support those patients receiving end of life care. Patients with palliative care needs were supported using the Gold Standards Framework.

Blood results, X ray results, letters from the local hospital including discharge summaries, out of hours providers and the 111 service were received both electronically and by post. All relevant staff were clear on their responsibilities for passing on, reading and acting upon any issues arising from communications with other care providers on the day they were received. The GP seeing these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system worked well. The practice had a policy for communicating with the out of hours service via a system of special notes.

GPs in the practice worked closely with the community mental health team to refer patients for counselling or cognitive behavioural therapy via the Health in Mind programme.

The practice hosted a number of additional services for patients within its premises. These included for example, access to a community podiatrist, a geriatrician, a stoma nurse and physiotherapy services.

Information sharing

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

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

Consent to care and treatment

The GPs we spoke with told us they always sought consent from patients before proceeding with treatment. GPs told us they would provide patients with information on specific conditions to assist them in understanding their treatment and condition before consenting to treatment. Patients consented for specific interventions for example, minor surgical procedures, by signing a consent form. Patient's verbal consent was also documented in the electronic patient notes with a record of the relevant risks, benefits and complications of the procedure discussed with the patient.

Patients with more complex needs, for example dementia or long term conditions, were supported to make decisions through the use of care plans, which they were involved in agreeing. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it) and had a section stating the patient's preferences for treatment and decisions.

Health promotion and prevention

Patients who registered with the practice were offered a health check if they were over 45 years of age or had a long term condition for which they required regular medicines. Health checks were also available with a nurse or healthcare assistant to any new patient who requested a check.

We noted a culture amongst the GPs and nurses of using their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering smoking cessation advice to smokers and opportunistic chlamydia screening to patients aged 18-25. The practice nurse manager provided a daily clinic for patients to manage minor ailments.

The practice participated in the C Card scheme which enabled card carriers under the age of 25 years to access free of charge contraception and relevant advice. Members of the practice nursing team had received training in the support of patients participating in the C Card scheme. The practice provided a sexual health clinic supported by one GP and a practice nurse on one evening per week. This service included a 'drop in' facility for any young person, regardless of the practice where they were registered, as well as a comprehensive range of contraceptive services

Good

Are services effective?

(for example, treatment is effective)

and sexual health screening and treatment. The practice had developed links with a local community college and provided regular talks to young people about sexual health.

GPs and nurses we spoke with told us that regular health checks were offered to those patients with long term conditions and those experiencing mental health concerns. We noted that medical reviews took place at appropriately timed intervals. The practice had ways of identifying patients who needed additional support, and were pro-active in offering additional help. For example, the practice kept a register of all patients with learning disabilities, for whom they carried out annual health checks. The practice carried out dementia screening and ensured prompt referral for memory assessment to local community services.

The practice offered a full range of immunisations for children, travel vaccines, flu, pneumococcal and shingles vaccinations in line with current national guidance. We reviewed our data and noted that 95% of children aged up to 24 months had received their mumps, measles and rubella vaccination. This was higher than the regional average. Data we reviewed showed that 86% of patients with diabetes had a flu vaccination within the six month period between September and March.

We noted that a wide range of health promotion information was available in leaflets in the waiting rooms and on the practice website. Such information was also given to patients during consultations and clinics.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

Patients told us they were satisfied overall with the practice. Comments cards had been left by the Care Quality Commission (CQC) before the inspection to enable patients to record their views on the practice. We received 12 comment cards all of which contained positive comments about the practice. We also spoke with three patients on the day of the inspection.

The comments we reviewed were extremely positive about the service experienced. Patients said they felt the practice offered a caring service and staff were efficient, helpful and took the time to listen to them. They said staff treated them with dignity and respect. All of the patients we spoke with on the day of inspection told us that all staff were helpful, caring and professional. They told us they felt listened to and well supported.

We reviewed recent GP national survey data available for the practice on patient satisfaction. The evidence from the survey showed patients were satisfied with how they were treated and this was with compassion, dignity and respect. Data from the national patient survey showed that 94% of patients rated their overall experience of the practice as good. The practice was above average for its satisfaction scores on consultations with doctors, with 92% of practice respondents saying the GP was good at treating them with care and concern. We also noted that 89% of patients had responded that the nurse was good at treating them with care and concern.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Curtains were provided in the consulting room and treatment room so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

We observed staff were careful to follow the practice's confidentiality policy when discussing patient treatment in order that confidential information was kept private. The main reception area and waiting room were combined. Telephone calls were taken away from the reception desk so staff could not be overheard. Staff were able to give us practical ways in which they helped to ensure patient confidentiality. This included not having patient information on view, speaking in lowered tones and asking patients if they wished to discuss private matters away from the reception desk.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example, data from the national patient survey showed 85% of practice respondents said the GP was good at involving them in decisions about their care and 92% felt the nurse was good at involving them in decisions about their care.

Patients we spoke with on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. Patient feedback on the comment cards we received was also positive and aligned with these views.

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

Patient/carer support to cope emotionally with care and treatment

The results of the national GP survey showed that 92% of patients said the last GP they saw or spoke to was good at treating them with care and concern and that 89% of patients said the nurses were also good at treating them with care and concern. Patients we spoke with on the day of our inspection and some of the comment cards we received gave examples of where patients had been well supported.

The practice held a register of patients who were carers and new carers were encouraged to register with the practice. The practice computer system then alerted GPs and nurses if a patient was also a carer. One patient we spoke with described the high level of support they received as a carer. We saw written information was available for carers to

Good

Are services caring?

ensure they understood the various avenues of support available to them. Notices in the patient waiting room and patient website signposted patients to a number of support groups and organisations.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patients' needs and had systems in place to maintain the level of service provided. The Clinical Commissioning Group (CCG) told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised. The practice had responded in a timely manner to the needs of the local population by facilitating the registration of approximately 1,000 additional patients when another local practice closed in 2014.

The needs of the practice population were well understood and systems were in place to address identified needs in the way services were delivered. For example, the practice had recognised the needs of the high number of vulnerable patients within the local population. The practice told us they provided care and support to high numbers of patients with poor mental health. Practice nurses and GPs were able to give examples of ways in which they had worked closely with community mental health teams to ensure patients received timely and appropriate care and support. The practice had identified a lead GP for the management of patients with poor mental health.

We spoke with the practice nurse manager who was the lead nurse for the management of patients with a learning disability. The practice held a register of all patients with a learning disability. They offered them annual health checks and longer appointments as required. The lead nurse told us the practice provided care and support to residents with a learning disability living within a local supported housing facility. The practice worked closely with community services if additional support needs were determined following a review.

The practice worked collaboratively with other agencies and regularly shared information to ensure good, timely communication of changes in care and treatment. For example the practice provided care to patients who required support to manage substance misuse. They worked closely with external agencies to access timely support for those patients. The practice held multidisciplinary team meetings monthly to discuss the needs of complex patients, for example those with end of life care needs. The practice invited representatives from social services, mental health, district nursing, the community matron and local hospice teams.

The practice had implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from patients and through the Patient Participation Group (PPG). The practice had recognised the difficulty experienced by some patients in accessing the practice by telephone at peak times during the day and the high demand for appointments. The practice had responded to patient feedback in this regard had reviewed ways in which it implemented the appointments system. A review of the distribution and availability of appointments had been carried out and a wider range of appointments introduced in 2014. These included GP led- triage appointments, telephone consultations and on the day appointments. The practice had also placed a focus upon providing patients with improved information about other local services and support networks which may reduce the need for appointments with their GP.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. Vulnerable patients were well supported.

The practice was located in modern purpose built premises over four floor levels. The premises and services had been adapted to meet the needs of patients with disabilities. Access to the premises by patients with a disability was supported by an automatic door and accessible front reception desk which had been installed with wheelchair users in mind. The waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Patient services were provided on the ground and first floor levels. Some independent healthcare services were provided on the second floor. The third floor was dedicated to administrative functions. Lift services were available to all floors. We noted there were car parking spaces for patients with a disability. Toilet facilities were accessible for all patients and contained grab rails for those with limited mobility and an emergency pull cord. Baby changing facilities were available for mothers with young babies.

Good

Are services responsive to people's needs?

(for example, to feedback?)

The number of patients with a first language other than English was low. Staff knew how to access language translation services if these were required. Staff within the practice were able to give examples of how they supported individual patient needs in order to promote equality. For example, one staff member was trained in sign language in order to provide support to a number of patients attending the practice who were deaf. Patients who were unable to use public transport were made aware of a community transport scheme which enabled them to request free of charge transport from their homes directly to the practice.

Access to the service

The practice was open from 8.30am to 6.00pm on weekdays. Extended hours consultations were available one evening per week from 7:00pm until 8:00pm and on Saturday mornings from 8.30am to 12.30pm. The practice operated a flexible appointment system to ensure all patients who needed to be seen the same day were accommodated.

Appointments were available in a variety of formats including pre-bookable appointments, urgent same-day appointments and telephone consultations. Routine appointments could be booked in advance. Patients could book appointments and organise repeat prescriptions via the practice website. Appointments could also be booked in person or by telephoning the practice directly. The practice acknowledged the difficulty experienced by some patients in accessing the practice by telephone at peak times during the day due to the high demand for appointments. They had taken steps to improve telephone and appointment access and continued to review patient feedback in this regard.

There were arrangements to ensure patients received urgent medical assistance when the practice was closed at weekends, after 6:00pm Monday to Friday and on bank holidays. If patients called the practice when it was closed, there was an answerphone message giving the telephone number they should ring depending on the circumstances. Information on the out of hours service was provided to patients on the practice website and in appointment information advertised in the practice.

Listening and learning from concerns and complaints

The practice had a system for handling complaints and concerns. Their complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. The practice manager handled all complaints in the practice.

We saw that information was available to help patients understand the complaints system. There were posters in the waiting rooms to describe the process should a patient wish to make a compliment, suggestion or complaint. Information was also advertised in the practice leaflet and website. However, we noted that information provided to patients did not include reference to advocacy or ombudsman details to help support patients through the complaints system. Patients we spoke with were aware of the process to follow should they wish to make a complaint. None of the patients spoken with had ever made a complaint about the practice.

We looked at the complaints log for those received in the last twelve months and found these were all discussed, reviewed and learning points were noted. Complaints were discussed at clinical meetings, partners meetings and practice team meetings. The practice reviewed complaints on an annual basis to detect themes or trends. Staff we spoke with knew how to support patients wishing to make a complaint and told us that learning from complaints was shared with the relevant team or member of staff.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. The practice was clinically well led with a core ethos to deliver the best quality clinical care whilst maintaining a high level of continuity.

We spoke with 13 members of staff and they all knew and understood the vision and values of the practice and were clear about what their responsibilities were in relation to these.

The practice had experienced an influx of over 1,000 additional patients who had registered with them following the closure of another local practice in 2014. This had put considerable strain on staffing resources within the practice and had led to the recruitment of additional staff.

The practice had undertaken a strategic review in November 2014. Senior managers and team leaders within the practice had attended a day away from the practice. This had provided them with the opportunity for consolidation and for review of their position following such a challenging period.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff. All policies and procedures we looked at had been reviewed and were up to date. However, we noted that the practice did not have a policy in place to support staff in the safeguarding of vulnerable adults.

The practice used the Quality and Outcomes Framework (QOF) to measure their performance. The QOF data for this practice showed it was performing in line with or above national standards.

A series of regular meetings took place within the practice which enabled staff to keep up to date with practice developments and facilitated communication between the GPs and the staff team.

These included weekly and monthly GP partner meetings, clinical review meetings with GP's, nurses and healthcare assistants and regular team meetings which included administration and reception staff. We looked at minutes from the most recent meetings and found that performance, quality and risks had been discussed. Significant events and complaints were shared with the practice team to ensure they learned from them and received advice on how to avoid similar incidents in the future. Meetings enabled staff to keep up to date with practice developments and facilitated communication between the GPs and the staff team.

The practice had systems in place for completing clinical audit cycles. The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). For example, the practice had undertaken an audit review of the long term prescribing of benzodiazepine medicines in patients over the age of 65 years. (Benzodiazepines are medicines used in the management of anxiety disorders, insomnia and alcohol withdrawal). The completed audit cycle had resulted in a number of actions which were implemented within the practice. These included, for example, the sending of a letter to all identified patients inviting them for a medication review and the introduction of a flagged warning system on the patients' electronic notes to prompt GPs to discuss their prescription at the patients' next visit to the practice. A practice education session had been implemented and the dissemination of relevant guidelines had been provided to promote awareness within the GP and nurse teams. Other clinical audits undertaken included the review of care provided to patients with osteoporosis, a review of the accuracy of diagnosis of patients with chronic kidney disease and a review of patients prescribed a medicine to treat arrhythmias of the heart.

The practice had considered some of the risks of delivering services to patients and staff and had implemented systems to reduce risks. We reviewed the risk assessments and audits in place to minimise risks. These included assessment of risks associated with fire safety arrangements and waste management.

Leadership, openness and transparency

GPs and staff told us about the clear leadership structure and which members of staff held lead roles. For example, there was a lead nurse for infection control and one GP partner was the prescribing lead. We spoke with 13 members of staff and they were all clear about their own roles and responsibilities. They all told us that felt valued, well supported and knew who to go to in the practice with any concerns.

Are services well-led?

Good

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

We saw evidence that the practice held regular clinical team meetings, staff meetings and partners meetings. We saw that information was shared between the different meetings to ensure that all staff were fully updated. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings. Administration and reception staff told us that they also attended meetings. All of the staff we spoke with reported that communication was good in the practice and they were always made aware of new developments and changes.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies to support and guide staff. These were reviewed regularly and up to date. Staff we spoke with knew where to find these policies if required.

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

The practice had gathered feedback from patients via patient surveys and via comments and complaints received. There was a comments box for patients located in the waiting area. We noted that the practice held a patients' compliment register which registered all positive comments received from patients. The practice had a small patient participation group (PPG) which met regularly. The last patient survey had been conducted in 2013. Members of the PPG told us that they were currently involved in planning the next patient survey with the practice. They told us they were developing the questions to be asked and methods of distributing the survey. The practice had in the meantime encouraged patients to provide feedback via the website 'I want great care'. We saw that the practice invited patients to provide feedback on 'I want great care' via a direct link from the practice website.

The practice had recognised the difficulty experienced by some patients in accessing the practice by telephone at peak times during the day and the high demand for appointments. The practice had responded to patient feedback in this regard and had reviewed ways in which it implemented the appointments system. A review of the distribution and availability of appointments had been carried out and a wider range of appointments was introduced in 2014. These included GP led- triage appointments, telephone consultations and on the day appointments. The practice had also placed a focus upon providing patients with improved information about other local services and support networks which may reduce the need for appointments with their GP. The practice highlighted the significant impact of approximately 1,000 additional patients registering with the practice over a short period when another local practice closed in 2014.

The practice gathered feedback from staff through informal discussions and via team meetings. Staff told us they felt able to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged within the practice to improve outcomes for both staff and patients.

The practice had a whistleblowing policy which was available to all staff. Staff we spoke with were aware of the policy and how they could whistleblow internally and externally to other organisations.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We spoke with 13 staff and they confirmed they participated in regular appraisals which identified their training and personal development needs. Staff told us that the practice was very supportive of training and education.

Nursing staff reported that training was available in order for them to maintain and update their skills and they were well supported to attend training events. The practice had appointed a lead nurse who provided developmental support to the nurse team.

The practice had completed reviews of significant events and other incidents. These were shared with staff via meetings to ensure the practice improved outcomes for patients. For example, the practice had recently reviewed their approach to managing aggressive patients within the practice following two recent incidents. The practice had provided appropriate support to the staff members and patients involved. Practice protocols for managing such situations had been reviewed and clearly communicated to staff teams within the practice.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment We found that the registered person had not ensured that systems and processes were established and operated effectively to prevent abuse of service users. This was in breach of regulation 11(1) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 13 (1) (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed We found that the registered person had not ensured that persons employed for the purposes of carrying on a regulated activity were of good character and that information specified in Schedule 3 was available in relation to each such person employed and such other information as appropriate. This was in breach of regulation 21(a) (i) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 19 (1) (a) (3) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.