

Conishead Medical Group

Quality Report

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

Ratings

Overall rating for this service

Good



Are services safe?

Good



Are services effective?

Requires improvement



Are services caring?

Good



Are services responsive to people's needs?

Good



Are services well-led?

Good



Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Conishead Medical Group on 28 April 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing safe, well-led, caring and responsive services. It was also good for providing services for the six key population group which are 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).

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Risks to patients were assessed and well managed.
- Patients' needs were assessed and care was planned and delivered following best practice guidance.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- Patients said they were able to get an appointment with a GP when they needed one, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which they acted on.

Summary of findings

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

Importantly the provider must:

- Implement a staff appraisal system to ensure staff are provided with adequate support to identify and address learning and development needs. In addition the practice should ensure that all staff have the necessary training to allow them to fulfil their roles and responsibilities.

In addition the provider should:

findings

- Ensure regular infection control audits are carried out and recorded
- Ensure that the practice receives assurance and verification that shared equipment such as the defibrillator is checked and maintained.

Professor Steve Field CBE FRCP FFPH FRCGP

Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

The practice is rated as good for providing safe services.

Staff understood and fulfilled their responsibilities with regard to raising concerns, recording safety incidents and reporting them both internally and externally. The partners and practice management team took action to ensure lessons were learned from incidents, concerns and complaints and shared these with staff as and when required to support improvement. There was evidence of good medicines management and there were enough staff on duty at all times to keep patients safe. Although the practice was clean and hygienic, not all staff had attended training on infection control and the practice had not carried out an audit of their infection control procedures. Not all staff who were called upon to act as a chaperone had received appropriate training to protect both the patient and themselves. However, the practice informed us that the majority of chaperoning was carried out by the practice nurses.

Good



Are services effective?

The practice is rated as requires improvement for providing effective services.

Nationally reported data showed patient outcomes for effectiveness were either in line with, or better than average, when compared to other practices in the local Clinical Commissioning Group (CCG). Patients' needs were assessed and care was planned and delivered in line with current legislation and best practice guidance produced by the National Institute for Health and Care Excellence (NICE). This included assessing capacity and promoting good health. The practice had systems in place for completing clinical audit cycles to review and improve patient care and to support multi-disciplinary working with other health and social care professionals in the local area. Staff had access to the information and equipment they needed to deliver effective care and treatment. Arrangements were in place to support clinical staff with their continual professional development and most staff had received training appropriate to their roles and responsibilities. However we found staff had not received training on infection control, health & safety, the Mental Capacity Act, Deprivation of Liberty Standards and chaperoning. In addition staff had not received annual appraisals. This would give them the opportunity to formally discuss personal and performance issues, identify training and development needs and feel assured that these will be formally recorded and action plans developed.

Requires improvement



Summary of findings

Are services caring?

The practice is rated as good for providing caring services.

Nationally reported data showed patient outcomes for caring were either in line with, or better than average, when compared to other practices in the local CCG area. Patients said they were treated well and were involved in making decisions about their care and treatment. Patients had access to information and advice on health promotion, and they received support to manage their own health and wellbeing. We saw staff treated patients with kindness and respect and were aware of their responsibilities with regard to maintaining patient confidentiality.

Good



Are services responsive to people's needs?

The practice is rated as good for providing responsive services.

Nationally reported data showed patient outcomes for this area were either in line with, or better than average, when compared to other practices in the local CCG area. Services had been planned so they met the needs of the key population groups registered with the practice. Patient feedback about the practice was good and most stated they found it was easy to make an appointment with a GP within an acceptable timescale. The practice had taken steps to reduce emergency admissions to hospital for patients with complex healthcare conditions, and fully comprehensive integrated care plans had been developed and were easily accessible. The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand and evidence showed the practice responded quickly to issues raised.

Good



Are services well-led?

The practice is rated as good for being well-led.

The leadership and management of the practice assured the delivery of person-centred care which met patients' needs. The practice had a clear vision for improving the service and promoting good patient outcomes. Staff were clear about their roles and responsibilities and felt well supported and valued. The practice had a range of policies and procedures covering its day-to-day activities which were easily accessible by staff. The practice proactively sought feedback from staff and patients, which they acted upon. A small patient participation group (PPG) had been established and the practice was looking to expand this.

Good



Summary of findings

The six population groups and what we found

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

Older people

The practice is rated as good for the care of older patients.

Nationally reported data showed the practice had achieved good outcomes in relation to the conditions commonly associated with older people. Patients within the 2% most at risk of hospital admission were routinely followed up on discharge from hospital to ensure they had appropriate support. Every patient over the age of 75 years had a named GP and these patients were offered an annual health check. This included the offer of a home visit facilitated by the practice nurse if the patient was housebound. The percentage of patients aged 65 and older who had received a seasonal flu vaccination was higher than the national average at 79.5% (national average 73.2%). The practice also actively identified and supported palliative care patients.

Good



People with long term conditions

The practice is rated as good for the care of patients with long term conditions.

The practice was able to demonstrate effective, comprehensive and regularly reviewed care planning for patients with long term conditions. The care plans detailed the involvement of other multi-disciplinary professionals and were easily accessible. Chronic disease management clinics were held to cover a wide variety of diseases and nursing staff were encouraged to seek and were given time to attend continuous professional development training courses in the treatment of such diseases. A recall system on the practice computer system identified patients requiring follow up appointments and tests. One of the practice GPs was actively involved in the design team for the development of a Clinical Commissioning Group (CCG) wide Integrated Care Team with the aim of tailoring care to help patients with long term conditions avoid unnecessary hospital admissions. This had led to the development of an assessment proforma, comprehensive care plans and analysis of all cases at Integrated Care Team meetings. This resulted in all appropriate agencies being informed of patients' needs and they were aware of the level of intervention required for each patient to prevent hospital admissions.

Good



Families, children and young people

The practice is rated as good for the care of families, children and young people.

Good



Summary of findings

There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example looked after children or children subject of a child protection plan. Immunisation rates were above or in line with local averages for all standard childhood immunisations. For example, meningitis c vaccination rates for 12 month old children were 88% compared to 84.4% locally; for two year old children 100% compared to 98.1% locally; and for five year old children 100% as compared to 97.9% locally. Children under the age of five years old were offered same day appointments and appointments were available outside of school hours. One of the GPs was a paediatric specialist and a Member of the Royal College of Paediatricians (MRCP). Cervical screening rates for women aged 25-64 were above the national average at 85.6% (national average 81.9%).

Working age people (including those recently retired and students)

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

The practice was proactive in offering on-line services to patients such as being able to order repeat prescriptions and book appointments. A text messaging appointment reminder service for patients was also available. Practice patients were able to pre book out of normal working hour's appointments at Riverview Health Centre, Sunderland as part of an extended hour's pilot scheme. Health promotion information was available in the waiting room and on the practice web site.

Good



People whose circumstances may make them vulnerable

The practice is rated as good for the population group of patients whose circumstances may make them vulnerable.

Nationally reported data showed the practice had achieved good outcomes in relation to meeting the needs of patients with learning disabilities. The practice kept a register of these patients and used this information to ensure they received an annual health review and other relevant checks and tests. Staff knew how to recognise signs of abuse in vulnerable adults and children and how to raise safeguarding concerns with the relevant agencies. The practice was proactive in identifying carers and had a named lead staff officer for carers as well as safeguarding children and adults. Carers were routinely offered annual health checks, priority appointments and flu immunisations and patients who were carers were offered a referral/signposting to their local carers centre.

Good



Summary of findings

People experiencing poor mental health (including people with dementia)

The practice is rated as good for the population group of patients experiencing poor mental health (including people with dementia).

The practice had exceeded the national average in ensuring comprehensive and agreed care plans were in place for patients with schizophrenia, bipolar affected disorder and other psychoses (92% compared to a national average of 86%) and also in relation to the number of patients diagnosed with dementia whose care had been reviewed in a face to face review in the preceding 12 months (84.6% compared to a national average of 83.8%). All practice staff including the GPs and practice nurses had attended dementia awareness training and are 'Dementia Friends' (Dementia Friends is an initiative to help people with dementia feel understood and included in their community). The practice had increased their diagnosis of patients with dementia by reviewing all patients in care homes as well as those on certain medications.

Good



Summary of findings

What people who use the service say

During the inspection we spoke with two patients and reviewed 43 Care Quality Commission (CQC) comment cards completed by patients. The feedback we received indicated the majority of patients were very happy with the care and treatment they received, felt they were treated with dignity and respect and received a service which met their needs.

Findings from the 2014 National GP Patient Survey published in January 2015 for the practice indicated most patients had a good level of satisfaction with the care and treatment they received. The results were generally in line with or better than other GP practices within the local Clinical Commissioning Group (CCG) area and nationally. For example:

- 81% of respondents usually wait 15 minutes or less after their appointment time to be seen. Local (CCG) average: 70%
- 91% of respondents find it easy to get through to this surgery by phone. Local (CCG) average: 81%
- 81% of respondents describe their experience of making an appointment as good. Local (CCG) average: 77%

These results were based on 120 surveys that were returned from a total of 340 that were sent out (response rate of 35%)

Areas for improvement

Action the service **MUST** take to improve

- Implement a staff appraisal system to ensure staff are provided with adequate support to identify and address learning and development needs. In addition the practice should ensure that all staff have the necessary training to allow them to fulfil their roles and responsibilities.

Action the service **SHOULD** take to improve

- Ensure regular infection control audits are carried out and recorded
- Ensure that the practice receives assurance and verification that shared equipment such as the defibrillator is checked and maintained.

Outstanding practice

Conishead Medical Group

Detailed findings

Our inspection team

Our inspection team was led by:

A Care Quality Commission (CQC) Lead Inspector. The team also included a second CQC Inspector, a GP and a specialist advisor with experience of practice management.

Background to Conishead Medical Group

The practice is based within Ryhope Health Centre and provides care and treatment to 3,062 patients of all ages mainly from the Ryhope, Sunderland East and Seaham areas. The practice is part of the Sunderland Clinical Commissioning Group (CCG) and since April 2015 operates on a General Medical Services (GMS) contract agreement for general practice.

The practice provides services from the following address, which we visited during this inspection:

Conishead Medical Group, Ryhope Health Centre, Black Road, Ryhope, Sunderland, Tyne and Wear, SR2 0RY

The practice offers on-site parking; including disabled parking bays and the premises provide fully accessible treatment and consultation rooms on the ground floor for patients with mobility needs. The practice is open between 8am and 6pm Monday to Friday and surgery appointment times are as follows:

8.30am to 11.40am and 12.30pm to 5.30pm on a Monday, Wednesday & Friday

9.30am to 11.40am and 3pm to 5.10pm on a Tuesday

8.30am to 10.30am and 3.30pm to 5.30pm on a Thursday

The service for patients requiring urgent medical attention out-of-hours is provided by the NHS 111 service and Nestor Primcare Services Limited (which trades as Primcare Primary Care, Sunderland and is known locally as Primcare). The practice also participates in the Riverview out of hour's scheme which operates weekdays from 6pm to 8pm and on weekends and bank holidays from 9am to 2pm from Riverview Health Centre in Sunderland. The scheme is an alliance of local GPs that was originally created with the intention of providing out of hours care on a trial basis to deal with the A&E admissions crisis and winter pressures. Patients are either triaged and referred through the participating practice or in some cases can pre book out of hours appointments themselves. Due to the success of this pilot funding was secured to enable the scheme to continue and a data sharing agreement has been reached to enable GP's on out of hours duty to be able to read and update patient records.

Conishead Medical Group offers a range of services and clinic appointments including chronic disease management clinics for patients with diabetes, hypertension, asthma, chronic obstructive pulmonary disease (COPD), ischemic heart disease (IHD) and heart failure as well as family planning, cervical screening, NHS health checks, well person clinics, over 75 years checks, immunisations and vaccinations and foreign travel advice. The practice consists of two GPs (one male and one female), a practice manager, an assistant practice manager, two nurses, a healthcare assistant and four reception/administrative staff.

The Care Quality Commission (CQC) intelligent monitoring tool placed the area in which the practice was located in the fifth most deprived decile. In general people living in more deprived areas tend to have greater need for health services. The practices age distribution profile showed higher percentages of patients aged 45-59 than the national averages.

Detailed findings

Why we carried out this inspection

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

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

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

How we carried out this inspection

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

- Is it safe?
- Is it effective?

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

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

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

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 28 April 2015. During our visit we spoke with a range of staff including two GPs; the practice manager and assistant practice manager; the practice nurse; the healthcare assistant and members of the administrative and reception team. We spoke to two patients and observed how staff communicated with patients who visited or telephoned the practice on the day of our inspection. We reviewed 43 CQC comment cards that had been completed by patients. We also looked at the records the practice maintained in relation to the provision of services.

Are services safe?

Our findings

As part of planning our inspection we looked at a range of information available about the practice including information from the latest GP Survey results published in January 2015 and the Quality and Outcomes Framework (QOF) results for 2013/14. None of this information identified any concerning indicators about the practice. The Care Quality Commission had not been notified of any safeguarding or whistleblowing concerns regarding patients who used the practice and the local Clinical Commissioning Group (CCG) did not raise any concerns with us about how the practice operated. Patients we spoke to told us they felt safe when they attended appointments and comments from patients who completed Care Quality Commission (CQC) comment cards reflected this.

The practice used a range of information to identify potential risks and to improve quality in relation to patient safety. For example, reported incidents, 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 accidents and near misses. For example staff told us of an incident where a patient had continued to be aggressive and intimidating towards staff. When the situation had not improved and the practice assessed this patient posed a risk to staff and other patients; the practice had taken the appropriate action by consulting with the NHS Area Team before deregistering the patient.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. We found the practice had recorded five significant events/incidents during the period 1.4.14 to 31.3.15. These included a query regarding the certification of an expected death of a patient and hospital correspondence being scanned on to the incorrect patient record. The practice was able to demonstrate the action taken to ensure these issues did not happen again and also how information regarding such incidents was disseminated to staff. Clinical and non-clinical staff knew how and when to raise an issue immediately or for future consideration at staff meetings.

The practice manager was responsible for cascading national patient safety alerts to relevant clinical staff and for carrying out audits of patients who had been prescribed

a particular medication if required. No formal process was in place to record action taken in relation to national safety alerts or to record that information received had been appropriately acted upon.

Reliable safety systems and processes including safeguarding

The practice had systems in place to manage and review risks to vulnerable children, young people and adults. Safeguarding policies and procedures were in place and information about how to report safeguarding concerns and contact the relevant agencies was easily accessible. Staff we interviewed stated they would feel confident in making a safeguarding referral and were aware of who the nominated safeguarding lead was within the practice. We saw practice training records that confirmed staff had received the appropriate level of safeguarding training relevant to their individual roles.

A system was in place to highlight vulnerable patients on the practice's electronic records so staff were aware of any relevant issues when patients rang to make or attended appointments. We saw evidence of how the practice had worked effectively with other multi-agency practitioners in relation to one child who had escalated from being classed as a child in need to a child subject of a child protection plan before becoming a looked after child. This case demonstrated a good example of a collaborative whole family approach taken with the active engagement of the clinical staff.

A chaperone policy was in place and information about this was displayed in the reception area. The practice manager told us that because non clinical staff had not attended training to act as a chaperone, although they were present in the room if requested, they did not stand within the curtained area. General Medical Council (GMC) best practice guidance concerning chaperoning dictates that if a member of staff carrying out chaperoning duties is not a healthcare professional the clinician should be assured the identified chaperone understands their responsibilities, stays for the whole examination and if practical able to see what the doctor was doing. All practice staff had undergone Disclosure and Barring Service (DBS) checks.

Patient's records were kept on an electronic system which stored all relevant medical information including scanned

Are services safe?

copies of communications from hospitals. As well as flagging vulnerable children and adults the system was also used to flag patients with dementia, mental health issues, learning difficulties and those receiving palliative care.

Staff were able to easily access the practice's policies and procedures. This helped to ensure that when required, all staff could access the guidance they needed to meet patients' needs and keep them safe from harm.

Medicines Management

Effective arrangements were in place to ensure medicines requiring cold storage such as vaccines were stored appropriately. A policy was in place to ensure fridge temperatures were checked and recorded daily by practice staff. This ensured that medication stored in the fridges was safe to use.

A member of the nursing team was responsible for ensuring all emergency drugs kept at the practice were in date and destroyed or reordered when necessary. All of the medicines we checked were within their expiry dates and stored securely in locked cupboards.

The practice manager had a process in place to handle medicines safety alerts which were cascaded to relevant clinical staff for action which included undertaking a computer search of patients who could be affected. However details of what action was taken as a result of these alerts was not recorded.

Patients were able to re-order repeat prescriptions in a variety of ways including ordering at the practice, on-line or by post. A system was in place to enable prescriptions to be sent directly to a pharmacy of the patient's choice. Staff were well aware of the processes they needed to follow in relation to the authorisation and review of repeat prescriptions and were clear about what action to take when a patient had reached the authorised number of repeat prescriptions. Blank prescription forms were stored securely and in line with best practice guidance issued by NHS Protect.

Cleanliness and infection control

The premises were clean and hygienic throughout. None of the patients we spoke to or who completed CQC comment cards had any concerns regarding the level of cleanliness at the practice. A cleaning schedule was in place and supervised audits of cleaning standards were carried out quarterly. Staff told us that clinicians assessed their own consultation rooms for cleanliness on a daily basis and

would report any concerns to the practice manager for immediate action. This had never been necessary. Antibacterial wipes were available in all of the clinical rooms.

An infection control policy was in place which provided guidance to staff about the standards of hygiene they were expected to follow. This included guidance on the use of personal protective equipment such as aprons and latex gloves as well as how to deal with patient specimens, needle stick injuries and the disposal and management of clinical waste. One of the nursing staff was designated as infection control lead and provided advice and guidance to colleagues when needed. However we found that not all staff had received infection control training. Apart from audits of cleaning standards the practice had not audited their adherence to their infection control policies and procedures to ensure staff were following them and they were effective in the prevention and control of infections.

The clinical rooms we inspected contained personal protective equipment and there were paper covers and privacy curtains for the consultation couches. A process was in place to ensure the curtains were checked on a monthly basis for cleanliness and changed as and when required or at least 3 monthly.

Spillage kits were available to enable staff to deal safely with any spills of bodily fluids. Sharps bins were available in treatment rooms and were appropriately labelled, dated and initialled. The treatment rooms also contained hand washing sinks, hand soap, antibacterial gel and hand towel dispensers to enable clinicians to follow good hand hygiene practice. The practice had a protocol for the management of clinical waste and a contract was in place to ensure safe disposal. All waste bins were visibly clean and in good working order.

The practice was able to demonstrate that a process was in place for the management, testing and investigation of legionella (a bacterium that can grow in water and can be potentially fatal) on a contract basis with NHS Property Services.

Equipment

Staff had access to the equipment they needed to carry out diagnostic examinations, assessments and treatments. The

Are services safe?

equipment was regularly inspected and serviced and we saw evidence to confirm that equipment was calibrated annually. Portable appliance testing was also carried out regularly.

Staffing and recruitment

The practice had a recruitment policy that set out the standards they intended to follow when recruiting staff. This included seeking proof of identification, references, qualifications, licence to practice if appropriate and Disclosure and Barring (DBS) checks. We checked the General Medical and Nursing and Midwifery Councils records and confirmed that all of the clinical staff were licensed to practice. DBS checks had been carried out for all staff.

Staff told us about the arrangements for planning and monitoring the number and mix of staff needed to meet patients' needs and to ensure there were enough staff on duty. Staff felt there were enough members of staff on duty at all times to ensure the smooth running of the practice and patient safety. The practice manager advised that staff would temporarily increase their weekly working hours to cover others annual leave commitments and winter pressures if required.

The two GP's at the practice covered each other's absences and planned leave well in advance. They felt that this system worked well and as a result the practice had not needed to use a locum GP for the previous 2 years. The GPs were able to demonstrate that they had given consideration to ways in which they could increase their capacity and acted upon this.

Monitoring Safety and Responding to Risk

The practice had systems in place to manage and monitor risks to patients, staff and visitors to the practice. This included regular checks of medicines management, premises, equipment and staffing. The practice had a health and safety policy although we found not all staff had received health and safety training. We checked the premises and found it to be safe and hazard free. None of the patients we spoke to raised any concerns about health and safety.

The practice did not, however have any formal system in place to record identified risks (i.e. a risk register or risk assessments).

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. We saw records confirming that staff had received training in basic life support and cardio-pulmonary resuscitation (CPR).

Emergency equipment was available including resuscitation equipment and a defibrillator (a device used to restart a person's heart in an emergency). The defibrillator was shared with the two other GP practices based in the same premises and a sticker on the device stated this was due to be serviced by May 2014. The practice manager told us that servicing of this equipment was the responsibility of City Hospitals, Sunderland who contracted the work to NHS Property Services. We raised this concern with the practice manager on the day of the inspection who provided us with reassurance after the inspection that they had raised this issue with NHS Property Services and confirmed the equipment would be serviced soon.

Emergency medicines were stored securely and only accessible by relevant practice staff. This included medicines for the treatment of cardiac arrest and life threatening allergic reactions. Arrangements were in place to regularly check these were within their expiry date and suitable for use.

The practice had a comprehensive business continuity plan for dealing with a range of potential emergencies that could impact on the day-to-day operation of the practice. Mitigating actions had been recorded to reduce and manage the risks. Risks identified included the loss of the building, utilities, equipment (including IT and telephones), personnel and supplies. The plan also set out the procedure to follow in respect of an infectious patient being identified and flu pandemic and included a full list of suppliers and emergency contact numbers.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessed

The clinical staff we spoke with were able to clearly explain why they adopted particular treatment approaches. They were familiar with current best practice guidance and were able to access National Institute for Health Excellence (NICE) guidelines. From our discussions with clinical staff we were able to confirm they completed thorough assessments of patients' needs and these were reviewed when appropriate. For example, the practice had identified 2% of their patients most at risk of unplanned hospital admission and had ensured that each patient had a fully comprehensive assessment and care plan. This had included carrying out 25 home visits. The practice was now in the process of extending this review to patients in other high risk groups such as those with Chronic Obstructive Pulmonary Disorder (COPD). The practice had also proactively increased the diagnosis of patients with dementia by reviewing all of their patients' resident in care homes, on relevant medication or where the patient had not been noted on the practice computer system as being diagnosed with dementia. We saw examples of comprehensive care plans and their regular review. One of the GPs was a member of the local Clinical Commissioning Group (CCG) integrated care design team whose aims included ensuring a multi practitioner approach and involvement in care planning and improved information sharing.

We reviewed the most recent Quality and Outcomes Framework (QOF) results for the practice for the year 2013/2014. 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. We saw the practice had achieved a score of 96.5% of the points available to them for providing recommended treatments for the most commonly found clinical conditions such as asthma and diabetes etc. This was 1.6% above the local CCG average and 2.5% above the national average.

The management of long term conditions was shared between the GPs and nursing staff. General chronic disease management clinics were delivered by one of the nursing staff and covered a wide variety of diseases including heart failure reviews. Due to a lack of demand the practice did

not offer a Tier 2 diabetes or intrauterine system (IUS - contraceptive coil) insertion services but would refer or signpost patients requiring these services to an alternative provider. Nursing staff were actively encouraged and allowed time off to attend continual professional development and training courses to ensure they were up to date with development in the treatment and prevention of chronic diseases.

Patients we spoke with and those who completed Care Quality Commission (CQC) comment cards said they felt well supported by the GPs and the nursing staff with regards to making choices and decisions about their care and treatment. Interviews with the clinical staff demonstrated the culture in the practice was that patients were referred to relevant services on the basis of need. Patients age, sex and ethnicity was not taken into account in the decision making process unless there was a clinical reason for doing so.

Management, monitoring and improving outcomes for people

The practice manager and GP partners monitored how well the practice performed against key clinical performance indicators such as those contained within the QOF. Staff across the practice had key roles in monitoring and improving outcomes for patients and had designated roles, including for example, making sure emergency medicines were in date and fit for use, managing the choose and book service and carers lead.

The practice had a system in place for completing clinical audits to help improve patient outcomes. We saw examples of a number of audits including a completed audit cycle in relation to the usage of asthma inhalers. As a result of this audit an increased number of practice patients with this condition were invited to and subsequently attended the surgery for an annual review. We also saw examples of other baseline audits where a second cycle review was planned. This included the prescribing of antibiotics and effervescent analgesia.

The practice used the information collected from QOF and performance against national screening programmes to monitor outcomes for patients. For example 97.1% of patients with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive care plan documented in their record in the preceding 12 months which had been agreed with the patient and their family/ carers. 98.1% of patients with Chronic Obstructive

Are services effective?

(for example, treatment is effective)

Pulmonary Disorder (COPD) had the condition confirmed by post bronchodilator spirometry (a spirometer measures the volume of air inspired and expired by the lungs) between 3 months before and 12 months after entering onto the register. We confirmed the practice had obtained the maximum number of points available to them for delivering a good standard of care to patients with a range of conditions including asthma, cancer, dementia, heart failure, hypothyroidism & rheumatoid arthritis as well as those patients with a learning difficulty.

Information we looked at prior to our inspection indicated that the practice fell below both the CCG and national average in relation to the percentage of patients aged between 50 and 75 who had a fragility fracture on or after 1 April 2012 in whom osteoporosis was confirmed and who were currently being treated with an appropriate bone-sparing medication. One of the GP partners explained they had audited patients through identified codes and medication searches and a review of hospital discharge notes but could not identify any patients registered with the practice who fell into this group. The GPs were also able to demonstrate action taken when the practice was identified as an outlier in other areas. This included reviewing why the number of unplanned hospital admissions for their patients with COPD was higher than average and why the number of patients with dementia identified was lower than average.

Effective systems were in place which helped to ensure patients received prompt care and treatment. For example, all hospital discharge and advisory letters were viewed by the GPs who would then advise administrative staff about what action, if any was necessary including the addition of a code onto a patient's record. An example of this would be the adding of an alert in respect of end of life care to a patient's record which could then subsequently be viewed by out of hour's providers as well as practice staff.

There was a protocol for repeat prescribing which was in line with national guidance. Staff also regularly checked that patients receiving repeat prescriptions had been reviewed by the GP as well as ensuring that all routine health checks were completed for long-term conditions such as diabetes.

The practice had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss the care and support needs of patients and their families.

Effective staffing

The staff team included medical, nursing, managerial and administrative staff. The partnership consisted of two GP partners. We reviewed staff training records and found that staff had received a range of training such as basic life support, fire safety, safeguarding children and adults and dementia awareness training. Not all staff, however had received training in infection control, health & safety, Mental Capacity Act, Deprivation of Liberty Standards or chaperoning.

The GPs were up to date with their yearly continuing professional development requirements and had been revalidated (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). Nursing staff reported that they were supported in seeking and attending continual professional development and training courses.

There was no formal appraisal system in place for nursing and non-clinical staff. Although all staff were very happy with the open door policy currently in place this meant that staff did not have a formal process of raising concerns or to identify or request development and training opportunities. In addition this informal approach did not allow for the recording of any performance issues or action plans. The practice manager told us that they intended to implement an appraisal system in the near future.

We looked at staff cover arrangements and identified that there was always a minimum of one GP on duty when the practice was open. Holiday, study leave and sickness was covered in house. The two GPs tried to ensure they were never off work at the same time negating the need to use locum GPs and administrative staff covered for each other increasing their working hours if necessary to meet demand. We saw evidence of discussions amongst the GP partners and practice manager regarding succession planning.

Working with colleagues and other services

The practice worked with other service providers to meet patients' needs and manage complex cases. The practice received written communication from local hospitals, the out-of-hours provider and the 111 service, both electronically and by post. Staff we spoke to were clear

Are services effective?

(for example, treatment is effective)

about their responsibilities for reading and actioning any issues from communications with other care providers. They understood their roles and how the practice's systems worked.

The practice demonstrated they worked with other services to deliver effective care and treatment across the different patient population groups. The practice held multidisciplinary team meetings every six weeks to discuss palliative care patients and held monthly pharmacy meetings. The practice also provided evidence of attendance at multi agency safeguarding meetings as and when required.

We found appropriate end of life care arrangements were in place. The practice maintained a palliative care register. We saw there were procedures in place to inform external organisations about any patients on a palliative care pathway. This included identifying such patients to the local out-of-hours provider and the ambulance service.

One of the GPs was involved in the design of a CCG wide integrated care team whose aims included establishing improved working relationships and information sharing between multi-disciplinary healthcare professionals. The practice was also involved in the Riverview extended hours scheme which enabled their patients to pre book out of hour's appointments.

Information sharing

The practice used electronic systems to communicate with other providers. Electronic systems were in place for making referrals, and the practice made referrals through the Choose and Book system. (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). Staff reported that this system was easy to use and patients welcomed the ability to choose their own appointment dates and times.

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

Consent to care and treatment

Patients were supported to express their views and were involved in making decisions about their care and treatment. Of the patients who participated in the 2014 National GP Patient Survey published In January 2015, 79% reported the GP they visited had been good at involving them in decisions about their care. This compares to a national average of 74% and a local (CCG) average of 78%. A similar level of satisfaction regarding this was noted in relation to nurses working at the practice.

We were told that before patients received any care or treatment they were asked for their consent and the practice acted in accordance with their wishes. Staff told us they ensured they obtained patients' verbal or implied consent to treatments.

GPs we spoke with showed they were knowledgeable of Gillick competency assessments of children and young people. Gillick competence is a term used in medical law to decide whether a child (16 years or younger) is able to consent to his or her own medical treatment, without the need for parental permission or knowledge.

Decisions about or on behalf of people who lacked mental capacity to consent to what was proposed were made in the person's best interests and in line with the Mental Capacity Act (MCA). We found the GPs were aware of the MCA and had received training on MCA principles at CCG 'Time In Time Out' teaching sessions. Both GPs were able to describe the procedure the practice would follow where people lacked capacity to make an informed decision about their treatment. The GPs gave us an example of where a patient did not have capacity to consent. They told us an assessment of the person's capacity would be carried out first. If the person was assessed as lacking capacity then a "best interest" discussion needed to be held. Both GPs knew these discussions needed to include people who knew and understood the patient, or had legal powers to act on their behalf.

Health promotion and prevention

The practice offered any new patients a health check with a practice nurse. These checks covered a range of areas including past medical history, ongoing medical problems and repeat prescription requirements. The practice also offered NHS Health checks to all patients aged between 40 and 74 years of age.

Are services effective?

(for example, treatment is effective)

There was a range of information on display within the practice reception area which included a number of health promotion and prevention leaflets, for example on cancer, allergies, sight and hearing loss, joint pain and mental health. The practice's website also included links to a range of patient information including family health, long term conditions and minor illnesses.

We found patients with long-term conditions were recalled to check on their health and review their medications for effectiveness. The practice's electronic system was used to flag when patients were due for review. This helped to ensure the staff with responsibility for inviting people in for review managed this effectively. Staff told us this system worked well and prevented any patient groups from being

overlooked. Processes were in place to ensure the regular screening of patients was completed, for example, cervical screening. Performance in this area for 2013/14 at 85.6% was above the national average of 81.9%.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. The practice performance for immunisations was in line with averages for the CCG. For example, meningococcal C (Men C) vaccination rates for 12 month old children were 88% compared to 84.4% locally; for two year old children 100% compared to 98.1%; and for five year old children 100% as compared to 97.9% locally. The percentage of patients in the 'influenza clinical risk group', who had received a seasonal flu vaccination, was 56.5% (national average 52.2%).

Are services caring?

Our findings

Respect, dignity, compassion and empathy

Patients we spoke with, including a member of the patient participation group said they were treated with respect and dignity by the practice staff. Comments left by patients on Care Quality Commission (CQC) comment cards reflected this. Of the 43 CQC comment cards completed 41 were very positive. Words used to describe the practice and staff included excellent, reliable, friendly, professional, efficient, helpful and pleasant.

We observed staff who worked in the reception area and other staff as they received and interacted with patients. Their approach was considerate and caring whilst remaining respectful and professional. This was clearly appreciated by the patients who attended the practice. We saw that any questions asked or issues raised by patients were handled appropriately and the staff involved remained polite and courteous at all times.

Reception staff made efforts to ensure patients' privacy and confidentiality was maintained. Voices were lowered and personal information was only discussed when absolutely necessary. Telephone calls from patients were taken away from the reception desk in an area where confidentiality could be maintained. A poster displayed in the reception area advised patients that a room was available if they wished to speak to a receptionist in private.

Staff were familiar with the steps they needed to take to protect patients' dignity. Consultations took place in purposely designed consultation rooms with an appropriate couch for examinations and curtains to maintain privacy and dignity. We noted that consultation and treatment room doors were closed during consultations and that conversations taking place in those rooms could not be overheard.

Patients' privacy, dignity and right to confidentiality were maintained. For example, the practice offered a chaperone service for patients who wanted to be accompanied during their consultation or examination.

Staff were aware of the need to keep records secure. We saw that patient records were computerised and systems were in place to keep them safe in line with data protection legislation.

Care planning and involvement in decisions about care and treatment

The National 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, the survey showed 79% of patients who responded to the survey said the last GP they saw or spoke to involved them in decisions about their care and 76% said the last nurse they saw or spoke to involved them in decisions about their care. Both these results were higher than the national averages of 75% and 66% respectively.

The majority of the most recently published National GP Survey results for the practice were above the national averages. For example, 92% of respondents stated that they felt the GP was good at listening to them and 83% of respondents reported the same for the last nurse they saw or spoke to (national averages 87% and 79% respectively).

The practice sought views from patients both in the surgery and on line as to whether they would recommend the practice to friends and family. 93% of respondents had said they would.

We saw that a translation and interpreter service was available for patients who did not have English as their first language. Providing this type of service helps to promote patients' involvement in decisions about their care and treatment.

Patient/carer support to cope emotionally with care and treatment

The patients we spoke with on the day of our visit told us staff responded compassionately when they needed help and provided support when required. The CQC comment cards we received were also consistent with this feedback. For example, patients commented that staff were caring, considerate and supportive.

We saw there was a variety of patient information on display throughout the practice. This included information on health conditions, health promotion and support groups.

The practice was proactive in identifying carers and had a named lead staff member for carers. The practice computer system alerted staff if a patient was a carer. Carers were

Are services caring?

routinely offered annual health checks, priority appointments and flu immunisations and patients who were carers were offered a referral/signposting to their local carers centre.

There was a palliative care register and regular multi-disciplinary palliative care meetings which involved GPs, district nurses and palliative care nurses.

Staff told us that if families had suffered bereavement a lead staff member would signpost or refer families to the appropriate support group or bereavement counselling services.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice had recognised the needs of different groups in the planning of its services. For example, the practices' involvement in the Riverview out of hours pilot meant that patients who worked full time could be booked an appointment between 6pm and 8pm on weekdays and from 9am to 2pm on weekends and could feel assured that the attending GP had access to their medical records.

The practice worked collaboratively with other agencies and regularly shared information to ensure timely communication of changes in care and treatment. For example, the practice had a palliative care register and held six weekly multidisciplinary meetings to discuss patients and their families' care and support needs.

The practice held a register of those patients with a learning disability. These patients were offered an annual health check. Vulnerable patients, for example, patients who were carers were coded on the practice computer system to enable staff to identify them and ensure their needs were met (27.6% of the practices patient population were reported to have a caring responsibility as compared to a national average of 18.2%). The practice had taken steps to ensure all dementia patients were identified and all practice staff had attended dementia friends training.

The practice had a higher than national average number of patients over the age of 75 (9.9%) but ensured that all of these patients had a named GP and were offered an annual health check. This included the offer of a home visit if the patient was housebound.

The practice had ensured that patients in the 2% most likely to experience unplanned admission to hospital had fully comprehensive care plans which had been compiled with the involvement of family members/carers where appropriate. The practice computer system ensured patients with long term conditions were recalled for health and medication checks in a timely manner (58.6% of the practices patient population were reported to have a long standing health condition). The practice also offered chronic disease management clinics.

Nationally reported data for 2013/14 showed that the practice was in line with or above the local average for all standard childhood immunisations and that child

development checks were offered at intervals that were consistent with national guidelines. One of the GPs was a paediatric specialist and a Member of the Royal College of Paediatricians (MRCP).

The nationally reported data also showed that working age patients had access to healthcare opportunities to help them live healthier lives. For example, 85.6% of eligible women had received a cervical screening test during the last five years (national average 81.9%).

The practice could demonstrate that it had considered suggestions for improvement and changes to the way services were delivered as a consequence of feedback from patients. This had included ensuring that patients were notified of an anticipated delay to their appointment time if surgeries were running late. The practice had recently relaunched their Patient Participation Group (PPG) and were actively trying to recruit members through their website and in the surgery.

Tackling inequality and promoting equality

The practice had recognised the needs of different groups of people in the planning of its services. The practice had access to a telephone translation service if required for those patients for whom English was not their first language. The practice also maintained registers for patients with caring responsibilities, patients with learning disabilities and patients receiving palliative care. All of these measures helped to ensure that all patients had equal opportunities to access the care, treatment and support they needed.

The premises were situated in a single storey building which met the needs of people with disabilities. The reception area, treatment and consultation rooms were all accessible by those with mobility difficulties. Disabled parking spaces were available in the patient car park and there was step free and wheelchair access to the building through electrically operated sensor driven doors. The door to the practice itself was not electrically operated which could cause difficulties for patients with mobility issues.

The practice had a male and a female GP, which gave patients the ability to choose to see a doctor of a particular sex if preferred.

Access to the service

Surgery opening times were Monday to Friday 8am to 6pm. Appointment times were from 8.30am to 5.30pm with the

Are services responsive to people's needs?

(for example, to feedback?)

exception of Tuesday which was from 9.30am to 5.10pm. Pre bookable out of hours appointments were available at a nearby health centre as part of the practices involvement in the Riverview extended hours scheme.

Both of the patients we spoke with and those who completed Care Quality Commission (CQC) comment cards said they were satisfied with the appointment system operated by the practice. Of the patients who participated in the 2014 National GP Patient Survey published in January 2015: 84% said they could get an appointment to see or speak to someone last time they tried (national average 85%); 91% said the appointment was convenient (national average 92%) and 81% said their experience of making an appointment was good (national average 74%).

Appointments could be booked in the surgery, by telephone or on line. We looked at the practices' appointment system during our inspection and found that an appointment was available with a GP the following day. If a named GP was requested this could be several days later. Staff told us that the practice always held back 2-3 appointments per surgery which were then allocated for emergency same day appointments and released at 8am, 11am and 2pm. Children under the age of 5 requiring an emergency appointment were seen the same day at the end of surgery. Requests for home visits were considered by the GPs on a case by case basis and were carried out at the end of morning surgery. Although no formal telephone consultation process was in place the GPs would return patients calls to respond to queries regarding their condition or treatment. A facility was in place to remind patients of their appointment via a text messaging service.

There were arrangements in place to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed there was an answerphone message advising the called to ring the NHS 111 service for further advice and guidance.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Their complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. The practice manager was the designated responsible person for handling all complaints and would investigate complaints in conjunction with the GPs.

We saw that a leaflet detailing how to make a complaint was available to patients and that this was last reviewed in January 2015. This information was available on the practice website and also gave patients the information they needed on how to escalate their complaint to either the local Clinical Commissioning Group (CCG) or NHS England depending on the issue should they remain dissatisfied with the response received from the practice.

The practice had received five complaints for the period 1 April 2014 to 31 March 2015. Of these one related to a clinical matter, three related to communication and attitude and one related to administrative issues. We saw the complaints had been acknowledged, investigated, replied to and an apology given if appropriate. The practice had compiled an annual complaints report to share with staff with the purpose of determining and sharing learning outcomes.

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. This was clearly outlined in their mission statement which stated 'This practice aims to provide the highest quality health care available under the NHS to all of its patients' with a well-trained and motivated health team. Patients will be treated with consideration and respect by all members of staff. The practice will endeavour to educate patients on health care matters and provide them with appropriate information about their condition and treatment'. Staff told us they knew and understood what the practice was committed to providing and what their responsibilities were in relation to these.

The practice had developed a business plan which was reviewed annually by the GP partners and the practice manager. This identified possible threats to the practice and what could be done to mitigate these threats. This included addressing the GPs escalating workload by reducing additional commitments such as teaching students and ceasing to provide specialist disability advice to the Department of Works and Pensions (DWP).

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff via the shared drive on any computer within the practice. We looked at a sample of these policies and procedures which were up to date.

The practice used the Quality and Outcomes Framework (QOF) as a means to measure its performance. Where concerns were identified the practice actively sought to combat this. This included investigating issues when the practice had been identified as an outlier for the high number of patients with COPD for whom an unplanned hospital admission had been necessary and for the low number of patients who had been recorded by the practice as having dementia. Nationally reported data taken from the QOF for 2013/14 showed that the practice had received an overall score of 96.5% of the maximum points available to them for delivering care in line with the QOF clinical indicators. This achievement was 1.6% above the local CCG average and 2.5% above the England average. This confirmed the practice had delivered care and treatment in

line with expected national standards. The practice had also carried out a range of clinical audits aimed at improving the quality of care and treatment provided to patients.

The practice held regular staff, clinical and practice meetings. We looked at minutes from recent meetings and found that performance, quality, risks and issues outstanding from previous meetings had been discussed.

Leadership, openness and transparency

There was a clear leadership structure with named members of staff in leading roles. For example, there was a lead nurse for infection control, a member of the admin/reception team was the lead for carers, the assistant practice manager was the lead for the choose and book service and one of the GPs was the lead for safeguarding. We spoke with a range of staff and they were all clear about their roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

We found there were good levels of staff satisfaction which had resulted in a stable workforce and good staff retention rates. Staff we spoke with were proud of the practice and felt it was well led and a good place to work. They told us there was an open and honest culture within the practice and they were happy to raise issues both informally and during team meetings.

Staff were supported to work within expected guidelines by a range of policies and procedures. Staff we spoke with knew where to find the practices policies' if required.

Practice seeks and acts on feedback from users, public and staff

The practice had gathered feedback from patients through patient surveys, comments and complaints received.

NHS England guidance states that from 1 December 2014, all GP practices must implement the NHS Friends and Family Test (FFT). The FFT is a tool that supports the fundamental principle that people who use NHS services should have the opportunity to provide feedback on their experience that can be used to improve services and is a continuous feedback loop between patients and practices. The premise of the FFT is whether a patient would recommend the practice to a friend or family member. We saw the practice had introduced the FFT and were collating the results. The practice manager gave us an example

Are services well-led?

Good 

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

where they had acted upon patient feedback. They had committed to ensure appointments did not run late and where this did happen to make sure they informed patient on arrival of any late running surgeries. A poster in the reception area advised patients of this incentive.

The patient participation group (PPG) had been relaunched to try to improve the number of members but there had little interest from patients wanting to join the group. The practice had managed to recruit three members but were continuing to try to recruit additional members through their website and a poster displayed in the reception area.

The practice gathered feedback from staff through staff meetings and on a more informal day to day basis. Staff we spoke with told us they regularly attended staff meetings and felt these provided them with the opportunity to discuss the service being delivered, feedback from patients and raise any concerns they had. They said they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

The practice was able to demonstrate how staff, patients and stakeholders were involved in developing the vision of the practice in a number of ways. This included a 360degree appraisal system adopted by one of the GPs which gauges patient and colleague satisfaction with the service provided. The result of this survey identified that the mean scores for a set of standard 13 questions ranged

from 86% to 93%. For eight of the questions, the mean score fell slightly short of the upper quartile benchmark percentage in areas such as satisfaction with visit, warmth of greeting, ability to listen, explanations and respect shown. The practice demonstrated how it had considered the results and developed ways of increasing satisfaction. This had included joining the local GP alliance and Riverview extended hours schemes.

A whistle blowing policy was in place which was available to all staff electronically on any computer within the practice. Staff we spoke with were aware of the policy, how to access it and said they would not hesitate to raise any concerns they had.

Management lead through learning and improvement

The practice provided staff with opportunities to continuously learn and develop. Practice nursing staff told us they had opportunities for continuous learning to enable them to retain their professional registration and develop the skills and competencies required for chronic disease management.

The practice had completed an annual review of significant events and other incidents with a view to identifying any trends or themes and determine learning opportunities. These events were shared with relevant staff as and when appropriate rather than as a standard agenda item at staff meetings.

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	Regulation 18 HSCA (RA) Regulations 2014 Staffing The provider did not have suitable arrangements in place to ensure that staff employed within the practice were appropriately supported in relation to their responsibilities as staff were not receiving regular opportunities for appraisal.
Maternity and midwifery services	
Treatment of disease, disorder or injury	

This section is primarily information for the provider

Enforcement actions

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.