Nork Clinic

Quality Report

63 Nork Way
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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?	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

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection of Nork Clinic on 14 April 2015. We visited the practice location at 63 Nork Way, Banstead, Surrey SM7 1HL.

Overall the practice is rated as good. Specifically, we found the practice to be good for providing effective, caring, responsive and well-led 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 children at a level appropriate to their role.
- 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.

Summary of findings

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

Importantly, the provider must:

- Ensure that all staff are trained in safeguarding of children at a level appropriate to their role and that contact details for local authority safeguarding teams are accessible to all staff within the practice.
- Ensure risk assessment and monitoring processes effectively identify, assess and manage risks relating to fire safety arrangements.
- Ensure the actions identified as a result of auditing of infection control processes are documented and reviewed so that progress and completion can be monitored.
- Ensure all remedial works and ongoing monitoring recommendations are implemented in order to reduce the risk of exposure of staff and patients to legionella bacteria.

In addition the provider should:

- Ensure that used and sealed sharps bins are stored securely, away from patient treatment areas.

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. Information about safety was recorded, monitored, appropriately reviewed and addressed. Lessons were learned and communicated widely to support improvement. Staff had some understanding of procedures relating to the safeguarding of children and vulnerable adults. However, not all staff had received training in child safeguarding at a level appropriate to their role. Risks to patients and staff were not always assessed and well managed. For example, the practice had not assessed the risks associated with fire safety and evacuation procedures. The practice had not conducted a rehearsal of their fire evacuation procedures. Fire alarms had not been tested until the day prior to our inspection. The practice had not responded to the risks identified in relation to potential exposure to legionella bacteria which is found in some water systems.

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 capacity and promoting good health. Staff had in the main, received training appropriate to their specific roles and any further training needs had been identified and planned to meet those needs. Staff worked closely with multidisciplinary teams and external services.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice higher than others for several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information to help patients understand the services available was easy to understand. We also saw that staff treated patients with kindness and respect, and maintained confidentiality. The practice advertised local support groups so that patients could access additional support if required. Staff within the practice felt well supported by management and the wider team.

Summary of findings

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. The practice had recognised the needs of the vulnerable patients within the local population and provided services to meet those needs. Patients were generally satisfied with their ability to access the practice by phone. Patients told us they could usually obtain an appointment on the same day. Urgent appointments were also available on the same day. The practice provided a system of GP-led triage for patients requesting urgent appointments. 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. Recruitment processes were well documented and induction arrangements were in place for staff. The practice had developed a comprehensive information and induction pack to support locum GPs. The practice had a number of policies and procedures to govern activity and held regular governance meetings. Incidents were recorded and there was evidence of lessons learned. Governance arrangements were formalised to ensure learning was disseminated to the whole practice team. The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group (PPG) was active.

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 people. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in dementia and end of life care. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs. The practice had a dedicated telephone line for those patients who were over the age of 75 years and were considered to be most vulnerable. All patients over the age of 75 years had a named GP. The practice ensured early referral to services for memory assessment. Older patients were able to request that prescriptions were sent directly to their choice of pharmacy to avoid the need for collection from the practice.

People with long term conditions

Good

The practice is rated as good for the care of people 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 people 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. However, not all practice staff had received training in the safeguarding of children at a level appropriate to their role. 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. We saw good examples of joint working with midwives and health visitors.

Summary of findings

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 on one evening each week to meet the needs of people 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 35-74 years.

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 teams in the case management of people experiencing poor mental health, including those with dementia. GPs in the practice worked closely with community mental health teams to refer patients for counselling or cognitive behavioural therapy. One community mental health service provided counselling and support to patients from the practice on one day each week. The practice liaised closely with a local mental health consultant to manage the care 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 eight comment cards all of which contained positive comments about the practice. We also spoke with eight 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. One comment card and two patients we spoke with indicated that they felt a newly installed screen in front of the reception desk restricted the level of privacy and was a barrier to communication between patients and practice staff. 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 83% 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 80% of practice respondents saying the GP was good at treating them with care and concern. We also noted that 94% 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 children at a level appropriate to their role and that contact details for local authority safeguarding teams are accessible to all staff within the practice.
- Ensure risk assessment and monitoring processes effectively identify, assess and manage risks relating to fire safety arrangements.
- Ensure the actions identified as a result of auditing of infection control processes are documented and reviewed so that progress and completion can be monitored.
- Ensure all remedial works and ongoing monitoring recommendations are implemented in order to reduce the risk of exposure of staff and patients to legionella bacteria.

Action the service SHOULD take to improve

- Ensure that used and sealed sharps bins are stored securely, away from patient treatment areas.

Nork Clinic

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a GP specialist advisor and a practice manager specialist advisor.

Background to Nork Clinic

Nork Clinic provides general medical services to approximately 7,200 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 two nursing home facilities, two care homes and one local hospice. Data available to the Care Quality Commission (CQC) shows the number of registered patients suffering income deprivation is lower than the national average.

Care and treatment is delivered by four GP partners and two associate GPs. Three of the GPs are female and three are male. The practice employs a team of three practice nurses and one healthcare assistant. 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 practice is open from 8.30am to 6.30pm on weekdays. Extended hours consultations are available one evening per week from 6:30pm until 8:15pm. The practice operates a flexible appointment system to ensure all patients who needed to be seen the same day were accommodated.

Services are provided from:

63 Nork Way, Banstead, Surrey SM7 1HL.

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 Surrey Downs Clinical Commissioning Group (CCG). We carried out an announced visit on 14 April 2015. During our visit we spoke with a range of staff, including GPs, practice nurses and administration staff.

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

Detailed findings

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 regular team 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.

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, the practice had reviewed its procedures for the processing of blood test results following an administrative error and a subsequent delay in contacting a patient. We saw that extensive review and learning from this and other incidents had been recorded.

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 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 another GP partner was the lead for safeguarding vulnerable adults. Safeguarding policies and procedures were consistent with local authority guidelines and included local authority reporting processes and contact details.

The GP partners had undertaken training appropriate to their role. However, not all staff had received training in the safeguarding of children at a level appropriate to their role. Staff 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. However, not all staff knew how to access the contact details for local authority safeguarding teams. Those details were not easily accessible within the practice.

Some staff we spoke with described recent incidents in which they had reported safeguarding concerns to the safeguarding lead or external services. 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 record. This included information so staff were 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.

A chaperone policy was in use within the practice and this was clearly advertised to patients in the consulting rooms. 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. All nursing staff, including health care assistants, could be asked to be a chaperone. We were told that some reception and administration staff had also been trained to undertake chaperone duties. Those staff had all been subject to a criminal records check via the Disclosure and Barring Service.

Requires improvement

Are services safe?

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. The lead GP for safeguarding children met regularly with the health visitor to ensure the timely sharing of information and to discuss children of concern.

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 which confirmed 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 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.

Cleanliness and infection control

We observed the premises to be clean and tidy. We saw there were cleaning schedules in place and that cleaning records were kept. 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. Disposable curtains were in place in clinical and consulting rooms. Spillage kits were available within the practice.

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 practice had carried out a comprehensive and ongoing audit of all infection control processes in December 2014. However, we found that the practice had not developed an action plan to address the findings of the audit. As a result, areas identified as requiring action had not been followed up or reviewed. For example, GPs and nurses had not received hand hygiene awareness update training within the last 12 months.

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. However, we noted that a large number of used and sealed sharps bins were stored in one treatment room instead of being transferred to the practice's secure outside storage container.

The practice had undertaken an assessment of the risks associated with potential exposure to legionella bacteria

which is found in some water systems in February 2014. However, the practice manager confirmed that the required actions resulting from the findings of the risk assessment had not yet been responded to.

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. A schedule of testing was recorded. We saw evidence that testing and calibration of relevant equipment had been carried out in February 2015. For example, digital blood pressure machines and weighing scales.

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 noted that servicing of firefighting equipment had last been carried out in June 2014.

Staffing and recruitment

Records we examined contained all the evidence required to show that comprehensive 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.

We were told that some reception and administration staff had been trained to undertake chaperone duties. Those staff had been subject to a criminal records check via the Disclosure and Barring Service. Some staff undertaking only administrative duties had not been subject to a criminal records check via the Disclosure and Barring Service but the practice had 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. Although staff turnover was low, there had been several new staff appointed to the reception team recently. The practice had also experienced recent challenges in maintaining staffing levels due to the long term sickness of one staff member and the unplanned absence of one GP partner.

Monitoring safety and responding to risk

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. However, the practice had not assessed the risks associated with fire safety and evacuation procedures. The practice had not conducted a rehearsal of their fire evacuation procedures. Fire alarms had not been tested until the day prior to our inspection. The practice had undertaken an assessment of the risks associated with potential exposure to legionella bacteria which is found in some water systems, in February 2014. However, the practice manager confirmed that the required actions resulting from the findings of the risk assessment had not yet been responded to.

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 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.

Requires improvement

Are services safe?

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.

Testing of the practice fire alarms had been carried out on the day prior to our inspection but the practice manager confirmed that the alarms had not been tested previously. The practice had not carried out a rehearsal of their fire evacuation procedures.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Care and treatment was delivered in line with recognised best practice standards and guidelines. The practice ensured they kept up to date with new guidance, legislation and regulations.

The GPs and nursing staff we spoke with could clearly outline the rationale for their treatment approaches. They were familiar with current best practice guidance accessing guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We saw minutes of practice meetings where new guidelines were disseminated. The implications for the practice's performance and for patients were discussed and required actions agreed. 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 thorough assessments of patients' needs, in line with NICE guidelines and these were reviewed when appropriate.

The practice had appointed both GP and nurse leads for specialist clinical areas such as diabetes 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 lead nurse for diabetes told us they had undertaken advanced training in diabetes. They worked closely in conjunction with a specialist diabetic nurse who regularly attended the practice to support the management of complex cases. The practice nurse described the value of this arrangement in ensuring that patient care and support reflected current best practice guidance and in the dissemination and sharing of information.

The practice managed patients with a range of long term conditions in line with evidence based practice. For example, we saw the practice nurses managed the care of a number of patients with leg ulcers. The nurses worked closely with the local tissue viability nurse in the ongoing assessment and management of those patients.

The practice referred patients appropriately to secondary and other community care services. The GP partners told us that referrals were regularly reviewed in conjunction with the clinical commissioning group.

We saw no evidence of discrimination when making care and treatment decisions. Interviews with GPs showed the culture in the practice meant patients were referred to other services based upon need and that age, sex and race was not taken into account in this decision-making.

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 patients with suspected cancers, who required urgent referral to secondary care, in order to ensure they were referred and seen within two weeks. Findings of the audit resulted in GPs being provided with training in dermatology and the raising of awareness of the importance of prompt and appropriate referral. Other clinical audits undertaken included the review of patients undergoing cervical cytology and a review of patients prescribed anticoagulant medicines which reduced the risk of blood clots forming.

The practice achieved 81.8% of the maximum Quality and Outcomes Framework (QOF) results 2013/14. 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 practice performed similarly to the regional and national average in most QOF clinical targets. For example, the number of patients with diabetes who had received an influenza immunisation was recorded as 82.6%, with the national average being 93.5%. The percentage of patients with diabetes whose last measured total cholesterol was five mmol/l or less was 75.2% compared with a national average of 81.6%. The practice had however, been an outlier for some QOF clinical targets in 2013/14. The

Good

Are services effective?

(for example, treatment is effective)

practice had monitored those targets within 2014/15 and told us that their records indicated that improvements had been achieved. The percentage of patients with diabetes who had a record of an albumin:creatinine ratio test in the preceding 12 months had been 47.13% compared with a national average of 85.97%. The practice records indicated they had achieved an increase to 82% in 2014/15. The percentage of patients with diabetes in whom the last blood pressure reading had been 140/80 mmHg or less had been 55.21% compared with a national average of 78.55%. The practice records indicated they had achieved an increase to 71% in 2014/15. In 2013/14, 51.85% of patients with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive, agreed care plan documented in their records. This was compared with a national average of 86.09%. The practice told us that this had increased to 100% in 2014/15.

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

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that some staff were not up to date with all mandatory training courses. Some nursing and administration/ reception staff had not received training in the safeguarding of children at a level appropriate to their role. GPs and nurses had not received hand hygiene awareness update training within the last 12 months. A number of reception and administrative staff were required to act as chaperones within the practice and had received appropriate training to support this role. Administrative staff had been supported by the practice to undertake a national vocational qualification (NVQ) relevant to their role.

Staff interviews confirmed that the practice was proactive in providing training and funding for relevant courses. We spoke with practice nurses who told us the practice supported education and ongoing professional development. 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. One practice nurse told us they had recently undertaken training in sexual health. Staff told us they attended regular external training events supported by the local clinical commissioning group and designated time was identified on a monthly basis to support internal training and meetings.

The practice had developed a comprehensive information and induction pack to support locum GPs. We spoke to one locum GP who told us how valuable that resource had been. They told us they felt well supported in their role. Induction schedules were in place to support administration and reception staff.

All GPs were up to date with their yearly continuing professional development requirements and all either had been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

Staff we spoke with told us they had received regular appraisals which gave them the opportunity to discuss their performance and to identify future training needs. Personnel files we examined confirmed this.

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 and care homes and a local hospice. A named GP carried out regular visits to the homes. The practice 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. Those meetings were attended by district

Good

Are services effective?

(for example, treatment is effective)

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. One community mental health service attended the practice on one day each week to provide counselling and support to patients.

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.

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 35 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 all new patients.

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.

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 91.2% of children aged up to 24 months had received their mumps, measles and rubella vaccination. This was higher than the regional

Good

Are services effective?

(for example, treatment is effective)

average of 84.7%. Data we reviewed showed that 94.3% of children aged up to 12 months had received their meningitis C vaccination, compared with a regional average of 86.7%.

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 completed CQC comment cards to tell us what they thought about the practice. We received eight completed cards and all 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 83% 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 80% of practice respondents saying the GP was good at treating them with care and concern. We also noted that 94% 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. Some 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 and asking patients if they wished to discuss private matters away from the reception desk. However, the practice had recently installed a clear screen in front of the reception desk. Some patients told us they felt the screen reduced the level of privacy afforded to them as staff and patients needed to raise their voices to be heard through the screen. The practice manager told us they were aware of this feedback and would continue to review patient comments in this regard.

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 77% of practice respondents said the GP was good at involving them in decisions about their care and 89% 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 80% of patients said the last GP they saw or spoke to was good at treating them with care and concern and that 94% 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 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. We saw written information

Good

Are services caring?

was available for carers to 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 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 vulnerable patients within the local population. The practice told us they provided care and support to patients experiencing 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. One community mental health service provided counselling and support to patients from the practice on one day each week. The practice liaised closely with a local mental health consultant to manage the care of patients with poor mental health.

The practice held a register of all patients with a learning disability. They offered them annual health checks and longer appointments as required. The practice worked closely with community services if additional support needs were determined following a review.

The practice supported patients with complex needs and those who were at risk of unplanned hospital admission. Personalised care plans were produced and were used to support patients to remain healthy and in their own homes. Patients with palliative care needs were supported. The practice had a palliative care register and had regular multidisciplinary meetings to discuss patient and their families' care and support needs.

Patients with long term conditions had their health reviewed at regular intervals. The practice provided care plans for asthma, chronic obstructive pulmonary disorder (COPD), diabetes, dementia and mental health conditions.

The practice had gathered feedback from patients via a patient survey which had last been published in February 2015 and via comments and complaints received. The practice had a small patient participation group (PPG) which had been established since 2012 and met on a quarterly basis. The practice manager showed us the analysis of the last patient survey, which was considered in conjunction with the PPG. We noted that a total of 135 patients had responded to this survey. The results and actions agreed from these surveys and the minutes of meetings held by the PPG, were available on the practice website.

In response to feedback gathered from patients the practice had increased the number of phone lines into the practice and introduced a system of GP-led triage for patients requesting an urgent appointment with their GP. Online appointment bookings had also been introduced. Members of the PPG had been involved in improving parking arrangements outside of the practice.

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 provided care and support to patients with a learning disability and worked closely with community services to support their needs. The practice told us that patients without a permanent address could register and be treated at the practice. The practice provided care and support to patients from within a local traveller community.

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

The practice premises and services had been adapted to meet the needs of patients with disabilities. However, access to the premises was by a single manual door. Patient services were provided on the ground and first floor levels. Lift services were available to the first floor. The waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the front reception desk, treatment and consultation rooms. 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.

Access to the service

The practice was open from 8.30am until 6.30pm on weekdays. Extended hours were also available on one

Good

Are services responsive to people's needs?

(for example, to feedback?)

evening each week until 8.15pm. Patients could call to make appointments from 8.30am. Appointments could be booked on the day or up to six weeks in advance. The practice manager told us that approximately 70% of appointments were booked on the day of the appointment. A number of urgent appointments were available on the day. The practice provided a system of GP-led triage for patients requesting urgent appointments. This ensured patients received a call back from a GP in order to assess their needs. Telephone consultations were also available at the beginning and end of every day.

Results of a recent GP patient survey showed that 87.11% of respondents found it easy to get through to the practice by phone. The survey found that 83.73% of respondents were satisfied with the practice's opening hours.

Information was available to patients about appointments on the practice website. This included how to arrange home visits, how to book appointments and the number to call outside of practice hours. There were arrangements in place to ensure patients received urgent medical assistance when the practice was closed. Patients were advised to call the out of hours' service.

Patients spoken with and comments left on CQC comment cards confirmed that patients were mainly happy with the appointment system. Several patients told us they were happy with the GP led triage system and always received a timely call back from the GP. Other patients told us they were usually able to obtain an appointment on the same day. Two patients told us they sometimes found it difficult to access the practice by telephone at peak times during the day but this was not reflected in other comments we received.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Their complaints policy was in line with recognised guidance and contractual obligations for GPs in England. The practice manager and the complaints administrator handled all complaints and managed them in conjunction with the GP partners.

Complaints information was made available to patients in the practice and on the practice website. The practice had a complaints leaflet and a complaints form which was available to patients. A Friends and Family test suggestions box was available within the patient waiting area and reception which invited patients to provide feedback on services provided. The patients we spoke with said they had never had cause to complain.

We reviewed the practice complaints log for those received in the last twelve months and found these were all discussed, reviewed and learning points were noted. 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 eleven members of staff and they all knew and understood the vision and values and were clear about what their responsibilities were in relation to these.

The practice had a clear strategy to support the increasing numbers of patients registered with the practice and the increasing demand for appointments. The practice manager told us of the intention to recruit an additional GP to the practice and to undertake expansion of the premises in order to accommodate two additional consulting rooms.

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.

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 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 incidents 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. Staff told us that meetings had been less frequent of late because of pressures upon staffing levels. This was due to the long term sickness of one staff member and the unplanned absence of one GP partner. We noted that the last clinical review meeting had been held in February 2015. The practice manager told us that the next meeting was scheduled for the end of April 2015.

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 patients with suspected cancers, who required urgent referral to secondary care, in order to ensure they were referred and seen within two weeks. Findings of the audit resulted in GPs being provided with training in dermatology and the raising of awareness of the importance of prompt and appropriate referral. Other clinical audits undertaken included the review of patients undergoing cervical cytology and a review of patients prescribed anticoagulant medicines which reduced the risk of blood clots forming.

The practice had systems and processes to manage and monitor risks to patients, staff and visitors to the practice. 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. However, the practice had not assessed the risks associated with fire safety and evacuation procedures. The practice had undertaken an assessment of the risks associated with potential exposure to legionella bacteria which is found in some water systems, in February 2014. However, the practice manager confirmed that the required actions resulting from the findings of the risk assessment had not yet been responded to.

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 lead for adult and child safeguarding. We spoke with eleven 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.

We saw evidence that the practice held regular clinical team meetings, staff meetings and partners meetings. We

Are services well-led?

Good

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

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 a patient survey which had last been published in February 2015 and via comments and complaints received. The practice had a small patient participation group (PPG) which had been established since 2012 and met on a quarterly basis. The practice manager showed us the analysis of the last patient survey, which was considered in conjunction with the PPG. We noted that a total of 135 patients had responded to this survey. The results and actions agreed from these surveys and the minutes of meetings held by the PPG, were available on the practice website.

In response to feedback gathered from patients the practice had increased the number of phone lines into the practice and introduced a system of GP-led triage for patients requesting an urgent appointment with their GP. Online appointment bookings had also been introduced. Members of the PPG had been involved in improving parking arrangements outside of the practice.

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 mostly told us they felt involved and engaged within the practice to improve outcomes for both staff and patients. Staff were able to give an example of how they had provided feedback which had resulted in a change in processes within the practice. Changes had been made to the allocation of duties surrounding the processing of repeat prescriptions. Staff felt this had improved the service provided by reception staff and levels of confidentiality. Staff told us they felt they had been listened to in this regard.

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

The practice had systems in place for reporting, recording and monitoring significant events, incidents and accidents. The practice kept records of significant events that had occurred and these were made available to us. Significant events were discussed at regular 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 reviewed the system used to manage and monitor incidents. We saw records of incidents were completed in a comprehensive and timely manner. We saw evidence of action taken as a result. For example, the practice had reviewed its procedures for the processing of blood test results following an administrative error and a subsequent delay in contacting a patient. We saw that extensive review and learning from this and other incidents had been recorded.

All of the GPs within the practice had undergone training relevant to their lead roles and areas of special interest such as gynaecology and child safeguarding. All of the GPs had undergone annual appraisal and had been revalidated or had a date for revalidation.

Staff we spoke with told us they had undergone regular appraisals which gave them the opportunity to discuss their performance and to identify future training needs. Personnel files we examined confirmed this.

We reviewed staff training records and saw staff were up to date with attending mandatory training courses such as the safeguarding of children and vulnerable adults and infection control. The practice nurses had been provided with appropriate and relevant training to fulfil their roles. For example, the practice had appointed a lead nurse for diabetes and a lead nurse for respiratory conditions. Both

Are services well-led?

Good

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

lead nurses had undertaken appropriate training to fulfil these roles. The nurses attended internal and external clinical meetings and had the opportunity to regularly partake in review of their clinical practice. For example, the lead nurse for diabetes within the practice worked closely with a specialist diabetic nurse to ensure complex cases were managed in line with best practice guidance.

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 did not have suitable arrangements in place to prevent abuse of service users by means of providing appropriate training for staff.** **This was in breach of 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 12 HSCA (RA) Regulations 2014 Safe care and treatment **We found that the registered provider did not ensure that effective systems were in place to assess the risk of, and prevent, detect and control the spread of infections, including those that are healthcare associated.** **This was in breach of regulation 12 (1) (2) (h) 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 17 HSCA (RA) Regulations 2014 Good governance **We found that the registered person had not always assessed, monitored and mitigated the risks relating to the health safety and welfare of service users and others who may be at risk from the carrying on of the regulated activity.**

This section is primarily information for the provider

Requirement notices

This was in breach of regulation 17 (1) (2) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.