Dr A R Bridge and Partners

Quality Report

Martock Surgery
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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 responsive to people's needs?	Good
Are services well-led?	Good

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Dr A R Bridge and Partners, which at that time was known as Dr J R Buckle and Partners, on 18 February 2016. The practice is also known as Martock Surgery. The overall rating for the practice was requires improvement. The full comprehensive report on the February 2016 inspection was published on 13 October 2016 and can be found by selecting the 'all reports' link for Dr A R Bridge and Partners on our website at www.cqc.org.uk.

This inspection was an announced focused inspection carried out on 29 June 2017 to confirm that the practice had carried out their plan to meet the legal requirements in relation to the breaches in regulations that we identified in our previous inspection on 18 February 2016. This report covers our findings in relation to those requirements and also additional improvements made since our last inspection.

Overall the practice is now rated as good. At this Inspection the practice was rated as good for providing safe, responsive and well-led services and requires improvement for providing effective services.

Our key findings were as follows:

- There was an open and transparent approach to safety and an effective system in place for reporting and recording significant events.
- The practice had safe systems of infection prevention and control and staff had received appropriate infection prevention and control training.
- Staff assessed patients' needs and delivered care in line with current evidence based guidance. The practice demonstrated that staff understood their roles and responsibilities according to policies and procedures. The practice had now embedded systems of good governance to monitor and improve the quality of services provided to patients.
- The practice had completed a Disclosure and Barring Service (DBS) check for all staff. Staff that acted as chaperones had completed relevant training to support them in this role.
- An overarching governance framework supported the delivery of the strategy and good quality care. This included arrangements to monitor and improve quality and identify risk.
- Staff had received inductions, annual performance reviews and attended staff meetings and training opportunities.

Summary of findings

- The partners encouraged a culture of openness and honesty. The practice had systems for being aware of notifiable safety incidents and sharing the information with staff and ensuring appropriate action was taken.
- The practice proactively sought feedback from staff and patients and we saw examples where feedback had been acted on. The practice engaged with the patient participation group.

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

Importantly, the provider must:

- Ensure there are systems in place for staff training relevant to each role. For example, to ensure staff are trained in safeguarding adults, safeguarding children and fire safety.

In addition the provider should:

- Review administrative systems to improve telephone access to non-urgent appointments.

At our previous inspection on 18 February 2016, we rated the practice as requires improvement for providing effective services as not all staff had received training necessary to undertake their roles and responsibilities. At this inspection we found that not all staff had completed training in safeguarding adults, safeguarding children and fire safety, consequently the practice is still rated as requires improvement for providing effective services.

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?

Good

The practice is rated as good for providing safe services.

- There was an effective system in place for reporting and recording significant events.
- Lessons were shared to make sure action was taken to improve safety in the practice.
- When things went wrong patients received reasonable support, truthful information, and a written apology. They were told about any actions to improve processes to prevent the same thing happening again.
- All staff had been recruited safely; all clinical staff had a Disclosure and Barring check including staff who acted as chaperones.
- The practice had safe systems of Infection prevention and control and staff had received appropriate Infection prevention and control training.
- The practice had clearly defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from abuse.
- Risks to patients were assessed and well managed.

Are services effective?

Requires improvement

The practice was rated as requires improvement for effective services.

- Staff were aware of current evidence based guidance.
- Clinical audits demonstrated quality improvement.
- Staff had the skills and knowledge to deliver effective care and treatment. However, not all staff had completed training appropriate to their responsibilities, including in relation to safeguarding adults and children; and fire safety.
- There was evidence of appraisals and personal development plans for all staff.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services.

- The practice had introduced a new appointment system to improve access to appointments; and had recruited a second nurse practitioner, a clinical pharmacist and five health coaches to provide additional clinical capacity.
- Patient Survey data from July 2016 showed improvements in patients' experience when accessing appointments.

Summary of findings

- 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. All verbal complaints were recorded appropriately and discussed during team meetings. Learning from complaints was shared with staff and other stakeholders.

Are services well-led?

Good

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

- The practice had a clear vision and strategy to deliver high quality care and promote good outcomes for patients. Staff were clear about the vision and their responsibilities in relation to it.
- There was a clear leadership structure and staff felt supported by management. The practice had policies and procedures to govern activity and held regular governance meetings.
- An overarching governance framework supported the delivery of the strategy and good quality care. This included arrangements to monitor and improve quality and identify risk.
- Staff had received inductions, annual performance reviews and attended staff meetings and training opportunities. However, not all staff had completed training appropriate to their responsibilities.
- The partners encouraged a culture of openness and honesty. The practice had systems for being aware of notifiable safety incidents and sharing the information with staff and ensuring appropriate action was taken.
- The practice proactively sought feedback from staff and patients and we saw examples where feedback had been acted on. The practice engaged with the patient participation group.

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
We did not inspect the population groups as part of this inspection. However, the outcomes we found when inspecting the Safe, Effective, Responsive and Well-led domains means this population group is now rated as Good.

Good

People with long term conditions
We did not inspect the population groups as part of this inspection. However, the outcomes we found when inspecting the Safe, Effective, Responsive and Well-led domains means this population group is now rated as Good.

Good

Families, children and young people
We did not inspect the population groups as part of this inspection. However, the outcomes we found when inspecting the Safe, Effective, Responsive and Well-led domains means this population group is now rated as Good.

Good

Working age people (including those recently retired and students)
We did not inspect the population groups as part of this inspection. However, the outcomes we found when inspecting the Safe, Effective, Responsive and Well-led domains means this population group is now rated as Good.

Good

People whose circumstances may make them vulnerable
We did not inspect the population groups as part of this inspection. However, the outcomes we found when inspecting the Safe, Effective, Responsive and Well-led domains means this population group is now rated as Good.

Good

People experiencing poor mental health (including people with dementia)
We did not inspect the population groups as part of this inspection. However, the outcomes we found when inspecting the Safe, Effective, Responsive and Well-led domains means this population group is now rated as Good.

Good

Summary of findings

Dr A R Bridge and Partners

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector, supported by an Assistant Inspector.

Background to Dr A R Bridge and Partners

Dr A R Bridge and Partners supports 11,085 patients in a largely rural area of South Somerset. Services are provided from the main location of Martock Surgery, Church Street Martock, Somerset, TA12 6JL and a branch surgery; South Petherton Medical Centre located at Bernard Way, South Petherton, Somerset TA13 5EG. The branch surgery was not visited during the follow up inspection in June 2017. Martock Surgery was purpose built in 1991 in the centre of Martock. South Petherton Medical Centre was purpose built in 2012 on the outskirts of South Petherton adjacent to the community hospital. There is full access for people with disabilities including a lift. There is an independent pharmacy attached to South Petherton medical centre.

There are six GPs, five of whom are partners. Three are male and three are female. Between them they provide 42 GP sessions each week. The GPs are supported by five practice nurses, whose working hours are equivalent to 3.7 WTEs (whole time equivalents), two nurse practitioners who are non-medical prescribers, two health care assistants and a clinical pharmacist. The GPs and nurses are supported by thirty-four management and administrative staff including a business manager, operations manager, finance officer, IT Lead and five health coaches who were appointed in April 2017.

The practice's patient population is expanding and has lower than average numbers of patients, both male and female, between the age of 20 and 39 years than the national average. There are more than average numbers of patients, both male and female, over the age of 60.

Average male and female life expectancy for the area is two years above the national average of 79 and 83 years respectively and one year above clinical commissioning group (CCG) averages for each gender. Approximately 29% of the patients are over the age of 65 years compared to a national average of 17%. Approximately 61% of patients have a long standing health condition compared to a national average of 54% which can result in a higher demand for GP and nurse appointments.

National GP patient survey results (Jan 2016) were lower than average with 76% of patients describing their overall experience at the practice as good compared to a national average of 85%.

The general Index of Multiple Deprivation (IMD) population profile for the geographic area of the practice is in the eighth least deprivation decile. (An area itself is not deprived: it is the circumstances and lifestyles of the people living there that affect its deprivation score. Not everyone living in a deprived area is deprived and that not all deprived people live in deprived areas).

Martock Surgery is open between 8.30am and 6.30pm every Monday, Tuesday, Thursday and Friday, and between 8.30am and 1pm every Wednesday. Appointments are available from 9am until 11.30 am and 3.30pm until 6pm; with extended hours, pre-booked appointments available from 6.30pm until 7pm every Tuesday and Thursday.

The branch surgery, South Petherton Medical Centre, is open between 8.30am and 6.30pm every Tuesday, Wednesday and Friday; between 8.30am and 6pm every Monday; and between 8.30am and 5pm every Thursday.

Detailed findings

Appointments are available between 9am and 11.30 am; and 3.30pm and 6pm. Extended hours appointments are available between 6.30pm and 7pm every Tuesday and Thursday; and between 8.30am and 11am on alternate Saturdays.

GPs offered patients telephone consultations, appointments and performed home visits where appropriate. The practice offers online booking facilities for non-urgent appointments and an online repeat prescription service.

During evenings and weekends, when the practice is closed, patients are directed to dial NHS 111 to access an Out of Hours service delivered by another provider.

The practice is taking part in the Primary Care Improvement Scheme in collaboration with other practices in the South Somerset area, which involves providing a total of 45 hours each week, with opening hours until 8pm Monday to Friday and Saturdays between 8.30am and 12noon on a rota basis.

The practice has a Personal Medical Services contract to deliver health care services; the contract includes enhanced services such as health screening, antenatal and postnatal care, immunisations, contraceptive services, chronic disease management, care and treatment of mental health and social related illnesses, drug and alcohol problems and the management of smoking cessation. These contracts act as the basis for arrangements between the NHS Commissioning Board and providers of general medical services in England.

Why we carried out this inspection

We carried out an announced comprehensive inspection at Dr A R Bridge and Partners, which at that time was known as Dr J R Buckle and Partners, on 18 February 2016 under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The overall rating for the practice was requires improvement. The full comprehensive report on the Month Year inspection can be found by selecting the 'all reports' link for Dr A R Bridge and Partners on our website at www.cqc.org.uk. The report of the February 2016 inspection was published on 13 October 2016.

We undertook an announced focused inspection carried out on 29 June 2017. This inspection was carried out to review in detail the actions taken by the practice to improve the quality of care and to confirm that the practice was now meeting legal requirements.

How we carried out this inspection

During our visit we:

- Spoke with a range of staff including two GPs, a practice nurse, the Practice Manager, a Health Coach and several administrative staff.
- Reviewed meeting minutes including those relating to clinical issues, significant events, audits, the patient participation group (PPG); and those held by management and practice staff.
- Reviewed five staff files and the staff training matrix.
- Reviewed Friends and Family Test data gathered by the practice since April 2017.
- Looked at information the practice used to deliver infection prevention and control (IPC) including policies and procedures, cleaning schedules, audits and IPC training for staff.

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

Good

Are services safe?

Our findings

At our previous inspection on 18 February 2016, we rated the practice as requires improvement for providing safe services as the arrangements in respect of infection prevention and control, significant event analysis and requirements relating to staff who acted as chaperones were not adequate.

These arrangements had significantly improved when we undertook a follow up inspection on 29 June 2017. The practice is now rated as good for providing safe services.

Safe track record and learning

At our last Inspection we found that the practice had carried out a thorough analysis of significant events. However, significant events were not consistently and accurately recorded to enable review.

At this inspection we found there was an effective system in place for reporting and recording significant events.

- Staff told us they would inform the practice manager of any incidents and there was a recording form available on the practice's computer system. The incident recording form supported the recording of notifiable incidents under the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).
- We saw evidence that when things went wrong with care and treatment, patients were informed of the incident, received reasonable support, truthful information, a written apology and were told about any actions to improve processes to prevent the same thing happening again.
- The practice carried out a thorough analysis of the significant events. We saw evidence that the practice was consistently recording significant events on the appropriate form. A significant event audit spreadsheet had been implemented to monitor any required action and dates of completion; and to record discussion with staff, lessons learnt and improvements made.
- Analysis of significant events had been undertaken to identify trends; and we saw minutes from meetings that lessons learned and improvements made had been discussed with staff at quarterly meetings. All significant events were available to all relevant staff via the practice's intranet.

Overview of safety systems and process

At our last Inspection we found some processes and practices were not in place to keep patients safe which included:

- Staff who acted as chaperones had not received training for the role, although clinical staff had received a Disclosure and Barring Service (DBS) check. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable). Non-clinical staff had not received training and had not had a DBS check or been subject to a risk assessment.
- The practice maintained appropriate standards of cleanliness and hygiene. We observed the premises to be clean and tidy, however, we did not see evidence of cleaning schedules for specific equipment such as spirometers. This presented potential risk of cross infection.
- The practice nurse was the infection control clinical lead but had not received specific training in infection prevention and control. Whilst a policy was in place, annual infection control audits had not been undertaken and it was not clear that adequate non-clinical time was in place to ensure this function was effective. We spoke to the practice who provided evidence that an audit had been carried out within 48 hours of the inspection. However, this did not include an action plan to address any improvements identified as a result.

At this inspection in June 2017 we found the practice had clearly defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from abuse, which included:

- A chaperone policy document was available in the waiting room and we saw notices to advise patients that chaperones were available if required. All staff who acted as a chaperone had been trained for the role and had received a Disclosure and Barring Service (DBS) check.
- Clinical staff had protected time each day to clean the clinical rooms and specific equipment including spirometers. We saw that staff recorded cleaning tasks electronically each day upon completion. Cleaning schedules and clinical rooms were checked each month

and were saw completed monthly audits from March, April and May 2017. An annual infection control audit, which included an action plan, had been completed in February 2017.

- Patient toilets now included a signature sheet for staff to sign to evidence daily cleaning. We saw the cleaning schedule for all areas of the practice which included daily cleaning tasks as well as deep cleaning tasks which were undertaken weekly or monthly.
- The practice nurse was the infection prevention and control (IPC) clinical lead and had received IPC training specific to the role. Two practice nurses had also received specific IPC training so that they were also able to oversee the new system which had been implemented, should the IPC lead be absent. Clinical staff had attended IPC meetings in November 2016 and February 2017 to discuss the new procedures and receive relevant training. All staff had received training in hand hygiene and spillage and contamination in February 2017.

Requires improvement

Are services effective?

(for example, treatment is effective)

Our findings

At our previous inspection on 18 February 2016, we rated the practice as requires improvement for providing effective services as the arrangements in respect of quality improvement, including clinical audits; and staff appraisal needed improving.

These arrangements had significantly improved when we undertook a follow up inspection on 29 June 2017, however, the practice is still rated as requires improvement for providing effective services.

Management, monitoring and improving outcomes for people

At our last Inspection we found there was limited evidence of quality improvement, including clinical audit:

- We saw evidence of three clinical audits completed in the last two years. However, we did not see evidence that these were completed audits where the improvements made were implemented, monitored and reviewed. There was no evidence that findings were shared with management staff; were used by the practice to improve services; or that audit was driving improvement in patient outcomes.

At this inspection we saw evidence that clinical audit had improved quality and outcomes for patients. For example:

- We saw evidence of three full cycle audits that were completed in February 2017, including audits of frailty and osteoporosis, as well as several other audits that were being undertaken. Each full cycle audit that we reviewed indicated that changes had been implemented and evidenced improved outcomes for patients.
- We saw evidence from minutes of staff meetings and clinical audit meetings that improvements had been implemented, monitored, scheduled for review and findings were shared with staff. We found that all clinical audits were now managed via a spreadsheet and findings were accessible to relevant staff via the practice intranet.

Effective staffing

At our last inspection in February 2016 we found that staff had the skills, knowledge and experience to deliver effective care and treatment. The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. Staff had access to appropriate training to meet their learning needs and to cover the scope of their work. This included ongoing support, one-to-one meetings, coaching and mentoring, and facilitation and support for revalidating GPs. However, we did not see evidence that:

- All staff had received an appraisal within the last 12 months and it was unclear that key staff had the sufficient non-clinical time to ensure appropriate clinical supervision.
- Some staff training was not up to date, for example training in infection prevention and control; for acting as a chaperone; and in the Mental Capacity Act (2005) and associated guidance.

At this inspection in June 2017 we saw evidence that there had been improvement in how staff received appropriate support, training, professional development, supervision and appraisal to enable them to carry out their roles. For example:

- We reviewed five staff files and the staff training matrix and found that all staff had received an appraisal within the last 12 months except for two staff members who worked at the practice on an irregular basis. We spoke to the practice manager who scheduled appraisals for those staff to be completed in the near future.
- The practice now held a range of regular meetings including quarterly staff meetings, monthly clinical meetings and fortnightly management meetings. There was also an informal daily meeting to discuss clinical cover and review patients who were experiencing complex health issues. Staff told us they found these meetings beneficial and had been receiving clinical updates, training and time to discuss clinical issues.
- The practice had implemented a new training team which consisted of administrators and clinicians who had lead roles in scheduling, organising and delivering training as well as having an overview of the new staff training matrix.
- The practice had implemented a staff training matrix in November 2016 that recorded training requirements for all staff, when training had been completed and when staff were due to complete refresher training. We saw evidence that all relevant staff had completed training in chaperoning, infection control and the Mental Capacity Act (2015). However, we found that there were still gaps

Requires improvement

Are services effective?

(for example, treatment is effective)

in training. For example, six administrative staff had not completed training in safeguarding adults and four administrative staff had not completed training in safeguarding children. We found that 11 staff had not undertaken fire safety training, however, this training had been scheduled for July 2017.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

At our previous inspection on 18 February 2016, we rated the practice as requires improvement for providing responsive services. We identified that the provider should make improvements through a review of clinical capacity and administrative systems to improve the availability of and telephone access to non-urgent appointments.

These arrangements had significantly improved when we undertook a follow up inspection on 29 June 2017. The practice is now rated as good for providing responsive services.

Access to the service

At our last inspection feedback from patients reported that access to appointments, a named GP and continuity of care was not always available quickly, although urgent appointments were usually available the same day. GP patient survey data (January 2016) showed that patient's satisfaction with how they could access care and treatment was significantly lower than local and national averages. For example:

- 60% of patients were satisfied with the practice's opening hours compared with the clinical commissioning group (CCG) average of 78% and national average of 75%.
- 40% of patients said they could get through easily to the practice by phone compared with the CCG average of 78% and national average of 73%.
- People told us on the day of the inspection that they had difficulty in getting through to the practice by phone to book appointments when they needed them.

At this inspection in June 2017 we saw evidence that:

- The practice had introduced a new system in March 2017 to improve access to appointments. Patients who required a same day appointment had an initial telephone consultation with a GP and were offered an appointment to meet their needs. The practice told us that this had provided greater capacity to manage incoming calls.
- A second nurse practitioner had been recruited and the practice had also appointed a clinical pharmacist in June 2016 who offered additional appointments for medicines queries.
- The practice was taking part in the Primary Care Improvement Scheme in collaboration with other practices in the South Somerset area, which involves providing a total of 45 additional hours each a week, with opening hours until 8pm Monday to Friday; and Saturdays between 8.30am and 12noon on a rota basis.
- The practice had secured funding to appoint five health coaches who supported patients to improve their health and wellbeing, sign post patients to other services and supported patients who were vulnerable or at risk of recurring hospital admissions.

GP patient survey data (July 2016) showed that patient's satisfaction with how they could access care and treatment was lower than local and national averages. However, results showed improvements in patient satisfaction since January 2016. For example:

- 62% of patients were satisfied with the practice's opening hours compared with the clinical commissioning group (CCG) average of 79% and the national average of 76%. This was an improvement of 2% since January 2016.
- 51% of patients said they could get through easily to the practice by phone compared with the CCG average of 79% and the national average of 73%. This was an improvement of 11% since January 2016.
- 84% of patients were able to get an appointment to see or speak to someone the last time they tried, compared with the CCG average of 88% and the national average of 85%. This was an improvement of 12% since January 2016.
- 83% of patients described their overall experience of the surgery as good, compared with the CCG average of 89% and the national average of 85%. This was an improvement of 7% since January 2016.
- 82% of patients would recommend this surgery to someone new to the area, compared with the CCG average of 83% and the national average of 78%. This was an improvement of 8% since January 2016.

We discussed the results of the GP patient surveys with the practice who showed us evidence that further work was underway to support patients to understand the new appointment system. For example, the patient participation group (PPG) had been relaunched in 2017;

Good

Are services responsive to people's needs?

(for example, to feedback?)

and the practice had also regularly attended local 'Making the most of Martock' Community Partnership meetings in order to engage with patients and improve understanding of the new appointment system.

We reviewed recent 'Family and Friends test' data, collated by the practice since April 2017. There were 30 responses from patients during this period, with three referring to the phone system, of which two related to the new initial telephone consultations. Two patients had reviewed the practice on the NHS Choices website in 2017 and both gave a rating of five out of five stars.

Are services well-led?

Good

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

Our findings

At our previous inspection on 18 February 2016, we rated the practice as requires improvement for providing well-led services as there was no overarching governance structure.

We found arrangements had significantly improved when we undertook a follow up inspection of the service on 29 June 2017. The practice is now rated as good for being well-led.

Governance arrangements

At our last Inspection in February 2016 we found:

- Models of clinical care used were not consistently; decision making was not timely or robust; and a strong working relationship between clinicians and management was not felt to be in place.
- There were gaps in implementation and updating of infection prevention and control; and training records.
- We did not see evidence that key leadership staff had sufficient time in place to effectively deliver their responsibilities. For example, the practice arrangements for recording and review of significant events and quality improvement were not effective.
- Practice meetings were not held frequently in order to provide a regular opportunity for staff to learn about the performance of the practice. Staff told us they were not always informed of new developments.
- A limited programme of clinical and internal audit was used to monitor quality, however, we saw little evidence that this was used to make improvements.

At this inspection in June 2017 we found:

- The practice had implemented a staff structure system that identified lead roles. Staff told us there was a strong working relationship between clinicians and management; and that communication and support had improved through frequent meetings, supervision and appraisals. Staff confirmed that they were receiving procedural updates in a timely and accessible way.
- Systems to ensure safe infection prevention and control (IPC) had been implemented, monitored and reviewed. All staff had received updates regarding these changes during meetings and all staff had received appropriate IPC training. However, we found that not all staff had completed training for safeguarding adults and safeguarding children; and fire safety.
- Leadership staff had protected time to deliver their responsibilities; including quality improvement, significant event analysis and infection prevention and control.
- We saw evidence from minutes of staff meetings and clinical audit meetings that improvements had been implemented, monitored, scheduled for review; and findings were shared with staff. We found that all clinical audits were now managed via a spreadsheet and findings were accessible to relevant staff via the practice intranet.
- The practice had recruited a clinical pharmacist, a second nurse practitioner and five health coaches which enabled the GP to focus on implementing good governance systems.

Leadership and culture

At our last inspection we found:

- Practice meetings were not held frequently in order to provide a regular opportunity for staff to learn about the performance of the practice. Staff told us they were not always informed of new developments.
- Staff told us the partners were approachable and took time to listen to members of staff. However, we did not see evidence of robust and reliable communication systems to ensure all staff were made aware of or involved in developments.

At this inspection we found:

- The practice now held a range of regular meetings including; quarterly staff meetings, monthly clinical meetings, fortnightly management meetings; as well as an informal daily meeting during the coffee break to discuss clinical issues and cover. Staff told us that they felt supported and management were open, transparent and responsive.

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 18 HSCA (RA) Regulations 2014 Staffing **How the regulation was not being met:** The service provider had failed to ensure that persons employed in the provision of a regulated activity received such appropriate support, training, professional development, supervision and appraisal as was necessary to enable them to carry out the duties they were employed to perform. In particular: • not all persons employed received appropriate training, relevant to their role, in safeguarding adults, safeguarding children and fire safety. This was in breach of regulation 18(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.