

# South Meadow Surgery

## Quality Report

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

### Ratings

#### Overall rating for this service

Good



Are services safe?

Requires improvement



Are services effective?

Good



Are services caring?

Good



Are services responsive to people's needs?

Good



Are services well-led?

Good



# Summary of findings

## Contents

### Summary of this inspection

	Page
Overall summary	2
The five questions we ask and what we found	4
The six population groups and what we found	6
What people who use the service say	9
Areas for improvement	9

### Detailed findings from this inspection

Our inspection team	10
Background to South Meadow Surgery	10
Why we carried out this inspection	10
How we carried out this inspection	10
Detailed findings	12
Action we have told the provider to take	26

## Overall summary

### Letter from the Chief Inspector of General Practice

We undertook a comprehensive inspection of the South Meadow Surgery Centre on 19 March 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing well-led, effective, caring and responsive services. It was good at providing services for all the population groups including older people; people with long term conditions; mothers, babies, children and young people; the working age populations and those recently retired; people in vulnerable circumstances and people experiencing poor mental health. It required improvement for providing safe services.

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.

- 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.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.
- Risks to patients were assessed and well managed.

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

Importantly the provider must:

# Summary of findings

- Ensure medicine management systems are reviewed and reflect national guidelines.

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

# Summary of findings

## The five questions we ask and what we found

We always ask the following five questions of services.

### Are services safe?

The practice is rated as requires improvement for providing safe services as there are areas where it should make improvements. This was because the practice medicine management systems did not always reflect national guidelines. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. There were enough staff to keep patients safe.

Requires improvement



### Are services effective?

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. Patient needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. There was evidence of appraisals and personal development plans for all staff. Staff worked with multidisciplinary teams.

Good



### Are services caring?

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.

Good



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

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients we spoke with said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day. The practice had good facilities and was well equipped to treat patients and meet

Good



# Summary of findings

their needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised and shared learning from complaints with staff.

## Are services well-led?

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 supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings. There were systems in place to monitor and improve quality and identify risk. The practice sought feedback from staff and patients, which it acted on. The practice had a patient participation group (PPG) in place. Staff had received inductions, regular performance reviews and attended staff meetings and events.

**Good**



# Summary of findings

## The six population groups and what we found

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

### Older people

The practice is rated as good for the care of older 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. Clinical risk meetings, to discuss older patients with complex needs, were held with other healthcare providers including district nurses to coordinate patient care. The practice also offered vaccinations to older patients in line with current national guidelines. The practice catered to residential care homes and the practice nurse holds a flu clinic at the care homes.

Good



### People with long term conditions

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. Longer appointments and home visits were available when needed. All 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. The practice also conducted clinical audits on the management of patients with long-term conditions. The practice had system in place to identify patients with potential long term condition, and advised the patient step by step on how to minimise risk.

Good



### Families, children and young people

The practice is rated as good for the care of families, children and young people. 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, and we saw evidence to confirm this. 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, health visitors and school nurses. Systems were in place for identifying and following-up children who were at risk, and these cases were reviewed with the

Good



# Summary of findings

health visitor regularly. A good skill mix was noted amongst the GPs with some having additional diplomas and specialist interests in areas relevant to the needs of the local population, such as geriatric medicine.

## **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 was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group. Cervical smear tests were offered to patients in line with national guidelines. Travel vaccinations were administered at the practice, and health promotion material was available to patients in the practice and on the website. The practice also registered students from a local college, who had a named GP.

## **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 and mental health problems. It had carried out annual health checks for patients with learning disabilities and these patients were offered longer appointments. The practice provided medical services to intensive supported housing and to army families who lived in Windsor

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. It had told vulnerable patients about how to access various support groups and voluntary organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

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

Good



The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. The practice offered in-house counselling to patients.

## Summary of findings

The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations. Leaflets about local support groups were available and referrals to the memory clinic for patients with dementia were made.



# Summary of findings

## What people who use the service say

We spoke with seven patients which also included members of the patient participation group (PPG). A PPG is made up of a group of volunteer patients and practice staff who meet regularly to discuss the services on offer and how improvements can be made.

Patients we spoke with were positive about the service they received from the practice. Patients told us the staff were courteous, kind and treated them with dignity and respect. They said the staff were understanding and helpful; it was a good practice and it was relatively easy to make an appointment. They felt involved and supported in decisions about their care and were given a caring service. Patients said they were given a wide range of information about their medical condition by the GP or the nurse.

We received further feedback from five patients via comment cards. The comments cards reviewed were generally positive. Patients appreciated the service

provided and told us they had no complaints. Patients were satisfied with the facilities at the practice. Patients commented on the building being clean and tidy. Patients commented GPs and nurses explained procedures in great detail and were always available for follow up help and advice.

The practice results for the national GP patient survey 2014 were within the clinical commissioning group (CCG) and national average. Eighty seven per cent of patients said the reception staff were helpful and 85% of patients said they were able to get an appointment to see or speak to someone the last time they tried. Ninety two per cent of patients said the last appointment they got was convenient and 98% of patients said they had confidence and trust in the last GP they saw. Eighty seven per cent of patients described their overall experience of this surgery as good.

## Areas for improvement

### Action the service MUST take to improve

- Ensure medicine management systems are reviewed and reflect national guidelines.

# South Meadow Surgery

## Detailed findings

### Our inspection team

#### Our inspection team was led by:

Our inspection team was led by a CQC lead inspector, and a GP specialist advisor. The team included a second CQC inspector, practice nurse, a practice manager and expert by experience.

### Background to South Meadow Surgery

The South Meadow surgery provides general medical services to over 12,500 registered patients. The practice is split at two sites, South Meadow surgery and Dedworth Medical Centre. This inspection was carried out at both sites.

The South Meadow Surgery moved to its current premises in 1991 and took over the Dedworth Medical Centre in September 2005. Although the practice is split over two sites, staff worked as one practice with one set off staff, one computer system and one patient list. The South Meadow Surgery has a high number of patients registered who are under 18 years of age.

All consulting and treatment rooms are located on the ground floor, on both sites. Care and treatment is delivered by ten GPs, five practice nurses, a respiratory nurse, three health care assistants and phlebotomists. The practice also works closely with midwives, district nurses and health visitors.

The practice has a General Medical Services (GMS) contract. GMS contracts are subject to direct national negotiations between the Department of Health and the General Practitioners Committee of the British Medical Association.

There were no previous performance issues or concerns about this practice prior to our inspection.

The practice is a GP training practice. This was a comprehensive inspection.

The practice provides services from the following two sites:

#### **South Meadow Surgery**

3 Church Close

High Street

Eton, Windsor

Berkshire

SL4 6AP

#### **Dedworth Medical Centre**

80 Vale Road

Windsor

Berkshire

SL4 5JL

### 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 is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This provider had not been inspected before and that was why we included them.

# Detailed findings

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

## How we carried out this inspection

Before visiting we checked information about the practice such as clinical performance data and patient feedback. This included information from the clinical commissioning group (CCG), Reading Healthwatch, NHS England and Public Health England. We visited South Meadow Surgery on 19 March 2015. During the inspection we spoke with GPs, nurses, the practice manager, reception and administrative staff. We obtained patient feedback by speaking with patients, from comment cards, the practice's surveys and the GP national survey. We looked at the outcomes from investigations into significant events and audits to determine how the practice monitored and improved its performance. We checked to see if complaints were acted on and responded to. We looked at the

premises to check the practice was a safe and accessible environment. We looked at documentation including relevant monitoring tools for training, recruitment, maintenance and cleaning of the premises.

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

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

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

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

People experiencing poor mental health (including people with dementia)

# Are services safe?

## Our findings

### Safe track record

The practice used a range of information to identify risks and improve patient safety. For example,

For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. National Institute of Health and Care Excellence (NICE) guidance and reminders were cascaded by the GPs to relevant staff. These were also discussed at clinical governance meetings to ensure consistent information was given to patients. Patient safety alerts were received by the practice manager, and disseminated by email to clinical staff.

Records were kept of significant events that had occurred and these were made available to us. Staff we spoke to were aware of their responsibilities to raise concerns, and the procedures for reporting incidents and significant events.

### 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 during the last three years. We reviewed a summary of significant events, which showed there were seven incidents reported within the last three years. All incidents were logged with a summary of the event, learning achieved, actions agreed, and a review following the event. We saw evidence of action taken as a result, for example when there was a delay in issuing death certificate and cremation form. The practice put in place a new policy and protocol for all reception staff to follow. The issue was also discussed with the GPs to ensure they communicated clearly and quickly with the relatives of the deceased.

Significant events and complaints were reviewed regularly during clinical meetings. There was evidence that the practice had learned from these and that the findings were shared with all 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.

Multi-disciplinary practice meetings took place where attendance included clinicians from other disciplines such

as palliative care nurses, community midwives or health visitors. Minutes from the meetings identified sharing information and reflective practice to reduce risk and improve services going forward.

### Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed that all staff had received relevant role specific training on safeguarding. We asked members of medical, nursing and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details were easily accessible.

The practice had appointed dedicated GPs as leads in safeguarding vulnerable adults and children. They had been trained and could demonstrate they had the necessary training to enable them to fulfil this role. All staff we spoke with were aware who these leads were and who to speak with in the practice if they had a safeguarding concern.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments; for example children subject to child protection plans.

The practice had a chaperone policy in place. This provided staff with information about when a chaperone should be considered, the role of a chaperone, and who should carry out chaperone duties. The nurses and health care assistant (HCA) acted as a chaperone, and they had received appropriate chaperone training. We saw notices in the waiting area and next to examination couches in the surgeries informing patients that they could request a chaperone.

### Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff, at both

## Are services safe?

surgeries. There was a clear policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. The practice staff followed the policy.

All prescriptions were reviewed and signed by a GP before they were given to the patient. We found blank prescriptions were left in the printers overnight and were not locked away, at both sites. We found batch numbers were not recorded. This meant the practice did not have adequate security systems in place for prescriptions.

The nurses administered vaccines using directions that had been produced in line with legal requirements and national guidance. We saw up-to-date copies of both sets of directions, and evidence that nurses had received appropriate training to administer vaccines. We found there were no up to date directions for travel immunisations. The practice manager told us the local CCG had not produced any recently, and had been advised by the CCG to use the core directions and follow the national guidelines.

The practice held stocks of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse) and had in place standard operating procedures that set out how they were managed. At the South Meadow surgery, a controlled drugs register was kept which detailed the stock level of several injectable medicines. We found the controlled drugs were stored in a controlled drugs cupboard and access to them was restricted. At the time of the inspection the key was kept offsite and thus controlled drugs store could not be checked. The key were not stored in accordance with the Misuse of Drugs (Safe Custody) Regulations.

The GPs held controlled drugs in their drug bags. At the South Meadow surgery we found one GP had kept one ampoule in a plastic carry case. This carry case was not stored in accordance with the Misuse of Drugs (Safe Custody) Regulations. We also found an expired ampoule (July 2014), in the GP's carry case. The GP told us the last expired ampoule was taken to the local chemist for disposal. However, the destruction of controlled drugs should be carried out by the Controlled Drug Local Intelligence Network (CD LIN) in line with local guidance and not at the local pharmacist.

At the Dedworth Medical Centre, staff showed us a blue metal container, which contained controlled drugs. The container was locked and the key was not kept securely.

The container and the key were not stored in accordance with the Misuse of Drugs (Safe Custody) Regulations. This meant the practice did not have appropriate systems for the storage and security of the controlled drugs.

Following the inspection, the practice immediately reviewed its security around controlled drugs at both surgeries. The practice confirmed to us they had risk assessed whether the GPs needed controlled drugs and had decided controlled drugs were not needed by GPs during normal working hours. Subsequently the GPs had returned the controlled drugs in line with national guidance, and these were logged and stored in a locked controlled drugs cabinet. Only GPs potentially on call over evenings and weekends may require access to controlled drugs and would be accessed in accordance with national guidelines. The controlled drug policy was also reviewed and updated to reflect these changes.

### Cleanliness and infection control

We observed the premises to be clean and tidy at the South Meadow Surgery. We saw there were cleaning schedules in place and 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.

At the Dedworth Medical Centre we found the cleaning of the premises was inconsistent. For example, the waiting and reception area and patient toilet facilities were clean and tidy. However, we found not all the treatment rooms and consultation rooms were clean. For example, we saw in one of the treatment rooms there was dirt and dust on the curtain rails, on the arm of the lamp used for examination and on the couch. We saw in one of the consultation rooms the curtain rail and couch were dirty. We saw in another consultation room there was thick dirt on a cabinet that had been placed under the couch. We found in two of the GP consultation rooms sharp bins had not been labelled or dated.

At the time of the inspection, evidence related to the cleaning and monitoring arrangements at the Dedworth Medical Centre was not reviewed as this information had been kept at South Meadow Surgery. Following the inspection, this evidence was made available to us. This included, evidence of risk assessment, Health and Safety guidelines, cleaners specification and book and monthly monitoring sheets. The practice had identified issues with the standards of the cleaning in February 2015 and

# Are services safe?

subsequently a meeting had taken place to discuss the expectations with the cleaning company. The practice had also recently introduced monthly checklist sheets, to ensure cleaning was monitored and all areas of the practice were cleaned.

The practice had a lead for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. The infection lead was due to provide all practice staff training on infection control by April 2015, and confirmed this had been set for the next protected learning time.

We saw evidence that the lead had carried out an infection control audit in March 2015. This audit had identified the GPs needed to clear the surfaces in their room to allow effective cleaning. However, the audit did not state when the improvements identified were to be actioned by and when the next audit was due. This had been identified by the practice, who were aware audit cycles are not always completed and a plan had been put in place to ensure second audits were undertaken.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these to comply with the practice's infection control policy. There was also a policy for needle stick injury and staff knew the procedure to follow in the event of an injury.

Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms.

The practice had a policy for the management, testing and investigation of legionella (a bacterium that can grow in contaminated water and can be potentially fatal). We saw records that confirmed the practice was carrying out regular checks in line with this policy to reduce the risk of infection to staff and patients.

## Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. We saw evidence of calibration of relevant

equipment; for example weighing scales, spirometers, blood pressure measuring devices and the fridge thermometer. We saw equipment had been checked and calibrated on February 2015. We found equipment PAT testing was overdue. The practice manager confirmed that arrangements had been made for testing to place in April 2015.

## Staffing and recruitment

We reviewed six personnel files for staff who had been employed in the last two years. Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, health checks, registration with the appropriate professional body and criminal records checks through the Disclosure and Barring Service (DBS). The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff.

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

## Monitoring safety and responding to risk

The practice had a system in place for reporting, recording and monitoring significant events. There were procedures in place to assess, manage and monitor risks to patient and staff safety. The practice ensured the appropriate checks and risk assessments had been carried out. For example, the practice had carried out a fire risk assessment, and this had been incorporated into the practice fire policy. The building landlord carried out regular fire drill, and the practice confirmed the last fire drill was carried out on March 2015. We saw fire drill procedures were in place and displayed in all staff areas.

The practice also had a health and safety policy. Health and safety information was displayed for staff to see and there was an identified health and safety representative. Staff had access to panic buttons and keys on the computer in the event of an emergency.

## Arrangements to deal with emergencies and major incidents

## Are services safe?

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). We saw at the Dedworth Medical Centre staff had access to a defibrillator, oxygen and emergency drugs and this was kept in the reception area. All emergency equipment and medicine we checked was in date and fit for use

At the South Meadow Surgery we saw the resuscitation equipment was kept in an office drawer unit and the bag and oxygen masks were kept separately on the wall opposite. We found this provision was not appropriate, as the storage system was immobile and the equipment was not kept in one place for easy access. Following the inspection, the practice confirmed they had reviewed this provision and had made changes. An emergency grab bag was purchased, to ensure all the emergency drugs, oxygen and defibrillators were kept in one bag.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. Processes were 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. Records showed that all staff had received training in basic life support.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, full loss of computer system (both short term and long term), adverse weather, infection, loss of GP partner and equipment failure. The document also contained relevant contact details for staff to refer to. For example, contact details of the electricity and gas company to contact if the electricity and gas system failed.



# Are services effective?

(for example, treatment is effective)

## Our findings

### Effective needs assessment

We found care and treatment was delivered in line with CCG and recognised national guidance, standards and best practice. For example, the clinicians used National Institute for Health and Care Excellence (NICE) quality standards and best practice in the management of conditions such as diabetes and for ovarian cancer diagnosis. Clinical staff told us any updates were circulated and reviewed by the clinicians, changes made as required and these were discussed at the team meetings as appropriate. 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 GPs told us they lead in specialist clinical areas such as diabetes, medication, cardiology and substance and misuse. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support. GPs told us this supported all staff to continually review and discuss new best practice guidelines for the management of respiratory disorders.

The practice held multiple clinic appointments where appropriate, such as for those patients who had more than one long term condition. Other clinics included: sexual health, contraception and INR clinics.

The practice had registers for patients needing palliative care, hypertension, cancer, epilepsy, mental health, asthma and heart failure. This helped to ensure each patient's condition was monitored and that their care was regularly reviewed. Monthly multi-disciplinary team meetings were held and they included other professionals involved in the individual patient's care.

All GPs we spoke with used national standards for urgent referrals seen within two weeks, and we saw national templates were saved on the shared drive for easy access. Discrimination was avoided when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were cared for and treated based on need and the practice took account of patient's age, gender, race and culture as appropriate.

### Management, monitoring and improving outcomes for people

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, and managing child protection alerts and medicines management. The information staff collected was then collated by the practice manager to support the practice to carry out clinical audits.

The practice had a system in place for completing a wide range of completed clinical audit cycles. These included audits for prescribing, minor operations, diabetes, contraceptive services, dermoscopy outcomes and diagnosis of ovarian cancer. For example we reviewed the 'Transcervical Resection of Endometrium and Contraception audit' dated January 2015. The aim of the audit was to ensure all patients who had a Transcervical Resection of Endometrium (TCRE) procedure, were advised of the risk of an ectopic pregnancy and were provided with appropriate advice on their contraceptive needs. Awareness was raised on the importance of checking that any patient who had had received procedure was provided with adequate advice on all complications and risks. We saw evidence that key points had been summarised and learning was shared with all GPs in a clinical meeting.

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, we saw an audit regarding the practice prescribing rates of antibiotics. The results showed that the practice were high prescribers of antibiotics, in comparison to national average. The results were shared with all GPs via email and had been put on the clinical meeting agenda to discuss how the practice could reduce their prescribing in this area.

We found there were mechanisms in place to monitor the performance of the practice and the clinician's adherence with best practice to improve outcomes for people. We saw the practice had a system in place for monitoring patients with long term conditions (LTC) and this included asthma, hypertension, Chronic Obstructive Pulmonary Disease (COPD), diabetes and learning disabilities. Care plans had been developed and they had incorporated NICE and other expert guidance.



# Are services effective?

## (for example, treatment is effective)

The practice routinely collects information about patients care and outcomes. The practice used the Quality and Outcomes Framework (QOF) which is a voluntary system for the performance management and payment of GPs in the National Health Service. This enabled GP practices to monitor their performance across a range of indicators including how they manage medical conditions. The practice achieved 94.6% on their QOF 2014 score, which was slightly better than the national average of 94.2%. Data from the QOF showed how the practice had performed well on areas including heart failure and rheumatoid arthritis.

### Effective staffing

All GPs had undertaken regular annual appraisals and either been revalidated or had a date for revalidation. (Every GP is appraised annually and every five years undertakes a fuller assessment called revalidation. Only when revalidation has been confirmed by the General Medical Council (GMC) GP continue to practice and remain on the performers list with NHS England). The nursing team had been appraised annually. We saw learning needs had been identified and documented action plans were in place to address these. Staff told us the practice was proactive and supportive in providing training that been identified. For example, one staff member had identified a course in allergy testing and told us their appraiser was supportive of this suggestion. Another staff member told us they had identified training in compression therapy and this had been funded by the practice. This enabled the staff member to provide appropriate care to patients with leg ulcers.

All staff undertook annual appraisals that identified learning needs from which action plans were documented. Our discussions with staff confirmed that the practice was proactive in providing training and funding for relevant courses. There were systems in place to disseminate relevant learning through a structure of team meetings. For example, updates in clinical treatments and protocols were shared with the GPs and nurses on the internal computer system.

Staff told us the practice had good staffing levels as staff retention was high. The GPs covered each other internally, where possible. When required cover was provided by salaried GPs, who worked additional sessions, thus locum GPs were rarely used. If a locum GP is required, they interviewed by the practice manager, to ensure they are

suitably qualified and have appropriate skills and expertise before working for the practice. Staffing levels were frequently reviewed by the practice manager, to ensure they had enough staff members with appropriate skills.

### Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and manage those of patients with complex needs. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from communications with other care providers on the day they were received. The GP who saw these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well. There were no instances identified within the last year of any results or discharge summaries that were not followed up appropriately.

The practice held monthly multidisciplinary team meetings to discuss the needs of complex patients, for example those with end of life care needs or children on the at risk register. These meetings were attended by district nurses, health visitors, palliative care nurses and decisions about care planning were documented in a shared care record. Staff felt this system worked well and remarked on the usefulness of the forum as a means of sharing important information.

### 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 had made most of their referrals through the Choose and Book system. Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital). Staff reported that this system was easy to use. The practice had follow up system in place for all two week referrals, as this information was kept in a

# Are services effective?

## (for example, treatment is effective)

folder where designated member of staff checked this on a daily basis. Due to the practice based services such as dermoscopy, cardiology, audiograms, patients were screened effectively onsite, before a referral was made.

The practice had also signed up to the electronic Summary Care Record (Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours). There was information in the practice and on the website informing patients of this.

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

### Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. All the GPs and nursing staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice. When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision.

Nursing staff explained how they gave patients verbal information about treatment and choices and they were able to show they had recorded a summary of the issues discussed. They were able to give examples and talked knowledgably about the challenges, considerations and process required. For example, a nurse told us they had a patient who was usually accompanied by their relative, but had expressed to the nurse they did not wish for them to attend with them. The nurse reviewed this and organised an independent signer for this patient, to ensure they had an appropriate person with them.

The practice catered to a unique population of teenage boys at the local school. The practice had systems in place to ensure consent was sought appropriately for these patients. For example, parents had signed a consent form which was valid for one year and this was regularly reviewed. This covered consent to immunisations. For any acute health problems, parents were contacted or alternatively the school teachers acted on behalf of the

parent or child. The clinical staff spoke with confidence about Gillick competency assessments of children and young people, which were used to check whether these patients had the maturity to make decisions about their treatment. All staff we spoke with understood the principles of gaining consent including issues relating to capacity.

Patients felt involved in planning their care and those we spoke with confirmed the GP had explained treatment options so they understood them.

### Health promotion and prevention

There was health promotion material available in the waiting area. This included information on, cancer, diabetes, memory loss, and sexual transmitted diseases. There was also information about services to support them in, for instance, smoking cessation schemes. Patients were encouraged to take an interest in their health and to take action to improve and maintain it.

The practice with the support of the PPG sent out regular newsletters to share information about relevant health topics and what was happening in the practice. For example, the Spring edition newsletter, included information on loneliness and isolation, how to access health information on practice website, electronic prescriptions and booking online appointments.

In 2013/14 the number of patients with a smoking status recorded in their records was 84.31% which was slightly lower than the CCG and England average. Of these patients 96.28% of patients had received advice and support to stop smoking which was higher than the national and CCG average.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance for all childhood immunisations was approximately 95% and was above average for the CCG. There was a clear policy for following up non-attenders by the practice nurse. In 2013/14 the practice vaccinated 70% of patients over 65 years old with the flu vaccine. This was lower than the national average of 72.99%. For patients within the at risk groups, 53.85% of patients were vaccinated in the same period. This was slightly better than the national average of 53.22%.

## Are services effective?

(for example, treatment is effective)

The practice offered screening services for patients. The data for chlamydia screening league table October 2014, showed South Meadow surgery was in the top 12 of 50 practices for achieving over one test a week.

# Are services caring?

## Our findings

### **Respect, dignity, compassion and empathy**

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the 2014 national patient survey and the friends and family test. The evidence from these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, the 2014 national GP survey showed, that 83% of patients said that the GP they saw was good at treating them with care and concern. Ninety eight per cent of patients said they had trust and confidence in the GP they saw and 91% of patients said the nurse they saw was good at treating them with care and concern.

Patients completed CQC comment cards to tell us what they thought about the practice. We received five completed cards and the majority were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. We also spoke with seven patients on the day of our inspection. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. Some patients told us the reception staff we always polite, courteous and helpful.

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

During our visit we observed that conversations between reception staff and patients at the reception desk could be heard in the waiting area. The reception desk was situated near the waiting room, which limited privacy for patients. Staff told us, only minimal information was obtained in the reception area, and that if patients wished to discuss issues in privacy they would use one of the consultation rooms.

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. For

example, the nursing team told us all confidential information was discussed when the patient had entered the room and when the door was closed. They told us they always used the curtains when examining a patient and locked the door to ensure their dignity was preserved.

### **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 2014 GP national patient survey showed 87% of practice respondents said the GP involved them in care decisions and 86% felt the GP was good at explaining treatment and results. Ninety six per cent of patients stated the nurse they saw was good at giving them enough time and 93% patients said was good at listening to them. Both these results were above average compared to national average.

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. The practice website carried a facility to translate information into 80 different languages.

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

The survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. For example, in the 2014 GP national survey 91% of patients considered they were treated with care and concern during their consultation with the clinical team. The patients we spoke with on the day of our inspection and the comment cards we received were also consistent with this survey information. For example, these highlighted that staff responded compassionately when they needed help and provided support when required.

## Are services caring?

Notices in the patient waiting room, on the TV screen and patient website also told patients how to access a number of support groups and organisations. We were shown the written information available for carers to ensure they understood the various avenues of support available to them. We saw evidence that patients were referred to

counselling services, including bereavement counselling, when this was appropriate. We saw information about carers support was available at the both surgeries and practice website. The practice offered an additional appointment to patients during bereavement so support and advice could be discussed.

# 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 patient's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered. For example, the GP partners we spoke with had identified and discussed access issues for patients. In order to meet patient's needs, the practice had plans in place to increase consultation space at the branch site and were in a process to recruit a new salaried GP. This would then enable the practice to offer more appointments to patients.

The practice had appointed a new health care assistant, and had assigned specific responsibilities to them. These included, monitoring the over 75 checks, 24 hour blood pressure monitoring and phlebotomy. This ensured better accessibility to patients for these services and also freed up the nursing team to concentrate and deal with patients who had complex health issues.

GP and nurses added more consultations to their normal working day if patient demand was high or when required by patients. For example, a nurse told us they had treated a patient who did not like a lot of people around them when they came to the surgery. In order to meet the patient's needs, the nurse had arranged to see them at the end of their lunch break and before the afternoon clinic. This ensured the patient felt comfortable when receiving treatment and minimised the patient's anxiety. The patient had complimented the nurse's unique approach.

The practice had systems in place to measure patient demand and provide services accordingly. For example, the practice had carried audits to establish the best way to utilise the skills of the phlebotomy staff, by ensuring they were at the right site and at the right time based on patient's needs. The audit results were analysed and discussed with the clinical team, and the phlebotomy service for both sites was reviewed and adjusted to meet patient needs.

The practice provided medical care to three residential care homes. All three care homes had regular ward rounds, with a final visit on a Friday to address any medical needs and

issues before the weekend. Regular reviews were carried out by the patients named GP. The GP worked closely with the patient's relatives and care home staff, to ensure patients' needs were met appropriately.

A range of clinics and services were offered to patients across the two sites, which included cervical screening, minor surgery, cancer and palliative care, mental health, chronic kidney disease and obesity. These included asthma, diabetes and coronary heart disease. The practice also offered enhanced services, such as counselling, depot injections, drug and alcohol additional support and smoking cessations.

One of the GP partners was a board member of the Windsor and Maidenhead clinical commissioning group (CCG). The practice engaged regularly with the CCG and other practices to discuss local needs and service improvements that needed to be prioritised.

### Tackling inequity and promoting equality

The South Meadow surgery occupied a historical building, which was leased to the practice. The practice did not have control over the building maintenance or management, as this was managed by another organisation. This had limited the practice in what they could provide to patients. The corridors at the surgery were narrow, and there were several internal doors to access each area. Disabled parking was available and a hearing loop was in place. There was disabled toilet access and baby changing facilities were available.

At the South Meadow surgery we observed three patients with limited mobility, struggle with doors when entering and leaving the practice. The weight and height of the ring handle on the door made access difficult for these patients.

The Dedworth Medical Centre was purpose built. The doorways were wide and there was space for wheelchairs and mobility scooters to turn. The surgery had large consultation rooms spread over the ground and first floor. The practice had access to a lift which enabled patients with limited mobility easier access to consultation rooms on first floor. The practice had reserved car spaces for patients with disabilities. Adapted toilet and washroom facilities were available for patients with disabilities.

Staff had received equality and diversity training and one of the GP's was an equality and diversity lead for the practice.

### Access to the service

# Are services responsive to people's needs?

(for example, to feedback?)

The practice offered a range of appointments to patients every weekday between the hours of 8am and 6.30pm. The practice opened for extended hour's appointments on Thursday evenings and offered early morning appointments on Saturday from 9am to 12pm, where pre-bookable appointments could be made. This benefitted patients who worked full time.

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

Patients could access a male or female GP. All patients with long-term conditions and those over the age of 75 years had a named GP who had overall responsibility for their care and support. The practice offered longer appointments for patients who might require them, including patients with learning disabilities, mental health conditions, and multiple long-term conditions. Home visits and telephone consultations were available to patients who required them, including housebound patients and older patients.

## Listening and learning from concerns and complaints

Patient's comments and complaints were listened to and acted upon. Information on how to make a complaint was provided on the practice website and leaflet. The complaints procedure provided further information on how to make complaint on someone's behalf and who at the practice would deal with the complaint. The practice had a clear complaints procedure and this was displayed in the waiting area. This allowed patients to make an anonymous complaint as they were able to provide the information discreetly.

The practice kept a record of all written complaints received. We reviewed a sample of complaints, which included a mixture of clinical and non-clinical complaints. We saw the complaints had been investigated and responded to, where possible, to the patient's satisfaction. The outcomes of complaints, actions required and lessons learned were shared with the staff during team meetings.

Staff told us complaints were openly discussed to ensure all staff were able to learn and contribute to any improvement action that might be required; and this was reflected in some of the records we looked at.

The patients we spoke with told us they would be comfortable making a complaint if required. They said they were confident a complaint would be fairly dealt with and changes to practice would be made if this was appropriate.



# 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. We found details of the vision were part of the practice's strategy and business development plan. The staff we spoke with were clear about their roles and responsibilities and the vision of the practice, and were committed to the delivery of a high standard of service and patient care.

The practice had a business development plan in place, which had been regularly reviewed in the last two years. The business development focused on areas such as, appropriate staffing levels, regular staff training, and improved interaction with the patient participation group. The practice regularly discussed and monitored the development plan to ensure objectives were being achieved.

Staff spoke positively about communication, team work and their employment at the practice. They told us they were actively supported in their employment and described the practice as having an open, supportive culture and being a good place to work. There was a stable staff group and were positive about the open culture within the practice.

The GP partners understood the challenges the practice faced in terms of delivering good quality care, and actions needed to address them. These included, dealing with four GP's going on maternity leave at the same time in 2013, and the practice was able to arrange appropriately. The practice had recognised the premises in the branch site was not suitable to meet patient demand, an action plan was in place to include additional clinical space.

### Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the practice. All policies and procedures we looked at had been reviewed annually and were up to date.

The practice carried out a rolling programme of clinical audits which were used to monitor quality and systems to identify where action should be taken. These included audits in, prescribing, minor operations, diabetes, Contraceptive services, dermoscopy outcomes and

diagnosis of ovarian cancer. Audits were conducted based on the needs of the practice population, and in response to feedback and performance. For example, we reviewed the 'Ovarian Cancer diagnosis' audit dated September 2014. In response to the results, the clinical team discussed and agreed NICE guidelines would be used for diagnosis and the guidance was made available to all clinical staff. We saw the results of audits had been shared with the clinical team within regular clinical meetings.

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. Significant events and complaints were shared with the practice team to ensure they learned from them and received advice on how to avoid similar incidents in the future

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed it was performing in line with national standards. We saw that QOF data was regularly discussed at GP meetings and action plans were produced to maintain or improve outcomes.

We found the practice had not taken measures to always identify, assess and manage risks. For example, the practice infection control audits did not always include when improvement actions were to be completed and when the next audit was due. The storage system for emergency equipment was not appropriate. Monitoring systems had not identified these issues.

### Leadership, openness and transparency

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead nurse for infection control and one of the GP partners was the lead for safeguarding. The GPs had clinical lead roles in family planning, diabetes, child health, cardiology and dermatology. The nursing team had expertise and lead roles in sexual health, asthma, contraception and minor illness. All staff we spoke with were clear about their own roles and responsibilities. They told us they felt valued, well supported and knew who to go to in the practice with any concerns.

We saw from minutes that GPs and nurses meetings were held weekly, and the administration team meetings were held monthly. We reviewed various meeting minutes and saw there was clear flow of information being discussed



# Are services well-led?

Good 

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

and shared. For example, we saw in the reception meeting minute dated February 2015, areas of discussion included child and adult safeguarding, child protection reports, online training and the telephone system. 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. All meeting minutes were stored on the internal computer system, which all staff had access to. This ensured staff who were unable to attend meetings were provided with minutes so that they were kept up to date with any changes that may have been implemented.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, such as recruitment and induction policies which were in place to support staff. We were shown the electronic staff handbook that was available to all staff, which included sections on health and safety, medical records and patient confidentiality at work. Staff we spoke with knew where to find these policies if required.

Staff also spoke positively about the practice and how they worked collaboratively with colleagues and health care professionals; for example, midwives and health visitors.

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

The practice gathered feedback from patients through the NHS patient survey; family and friends test survey, suggestion box and complaints received. We reviewed the results of the February 2015 family and friend test survey, and saw 88% feedback from patients was very positive. Some patients raised concerns they had experienced difficulty in obtaining an appointment. In response to these comments, the practice reviewed these comments and made changes to their systems. For example, a new GP, a practice nurse and a health care assistant were appointed, to ensure more appointments could be made available to patients.

The practice had also reviewed their telephone system in Autumn 2014. The practice had worked with the telephone provider to establish how many calls were being connected and disconnected. The practice reviewed the demand on the telephone system at both sites, to ensure staffing levels were adequate. The results were reviewed and changes were made accordingly.

The practice had an active patient participation group (PPG), with six members. The group met every three

months, and these meetings were attended by the practice manager and by a GP partner. The practice was seeking to include more PPG members to ensure that the group was fully representative of the practice population. The PPG members were engaged in the cancer screening program, family and friend test survey and patient survey.

The practice had gathered feedback from staff through staff meetings, appraisals and discussions. Staff told us they felt valued as part of the practice team and were encouraged to give feedback and felt listened to. For example, one staff member told us they suggested the possibility of the practice offering an enhanced service for skin testing. This idea was listened to and the team had discussion about this proposition. There were opportunities for formal and informal communication for staff, to ensure issues were raised and managed promptly and appropriately. Staff were aware there was a whistleblowing policy. They knew who they should approach if they had any concerns.

## **Management lead through learning and improvement**

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at five staff files and saw that regular appraisals took place which included a personal development plan. Staff we spoke with told us they felt supported to complete training and could request additional training which would benefit their role.

Staff were enabled to acquire further qualifications that were relevant to the work they performed and patient health needs. For example, practice nurses had completed Diplomas in travel medicine and sexual health. The new health care assistants were supported by practice to complete training in undertaking phlebotomy and completing NHS Health checks.

We saw there was a system in place for staff appraisals and staff had mandatory training and additional training to meet their role, specific needs. Mandatory training included: safeguarding vulnerable adults and children, moving and handling, equality and diversity, infection control and basic life support training. A nurse told us they had identified a training course on allergy testing and had discussed this during their appraisal. The appraiser welcomed this suggestion and agreed to make arrangements for this course. The practice had clear expectations of staff attending refresher training and this was completed in line with national expectations.

This section is primarily information for the provider

## Requirement notices

### Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment  Care and treatment must be provided in a safe way for service users. The registered person must comply with the proper and safe management of medicines. Regulation 12 (2) (g).
Family planning services	
Maternity and midwifery services	
Surgical procedures	
Treatment of disease, disorder or injury	