Dr. Jackson and Partners

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	Requires improvement
Are services safe?	Requires improvement
Are services effective?	Requires improvement
Are services well-led?	Requires improvement

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Dr Jackson and Partners (previously known as Dr Walters and Partners and also known as Mayford House Surgery) on 24 January 2017. The overall rating for the practice was requires improvement. The full comprehensive report on the 10 May 2016 inspection can be found by selecting the link below on our website at www.cqc.org.uk. http://www.cqc.org.uk/location/1-577985237

This inspection was an announced focused inspection carried out on 24 January 2017. The inspection was 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 at our previous inspection on 10 May 2016. This report covers our findings in relation to those requirements and also additional improvements made since our last inspection.

Overall the practice is rated as requires improvement.

Our key findings were as follows:

- The system and processes in place for reporting, recording and reviewing significant events had improved in some but not all areas. Despite this we identified that significant events were still not always being recorded and actioned and in some cases there was insufficient information recorded to allow adequate investigation.
- There were still gaps in the safeguarding children and adults training completed by staff.
- The practice had addressed some of the issues relating to medicines management.
- All staff had a Disclosure and Barring Service (DBS) check in place. Despite this there remained some concern in respect of the management of the recruitment process.
- The practice had made some improvement in the management of health and safety. We saw evidence to show that recommendations by external agencies had been acted on. However, there remained gaps in staff training in this area. For example fire safety, health and safety and cardio pulmonary resuscitation (CPR).
- The practice had in the last two weeks put a system in place to ensure patients with a learning disability were recalled to the practice for a review.

Summary of findings

- The practice could not demonstrate how they ensured role-specific training and updating for relevant staff. Whilst some recent steps had been taken by the practice management to review the systems for managing training there remained significant gaps in the completion of mandatory training. There was a lack of understanding as to the frequency of the requirements of such training.
- Since our last inspection there had been significant changes in the partnership arrangements. There was a new partnership arrangement and a new CQC registered manager in place. There was a clear commitment from the new partnership to deliver improvements.
- Evidence showed the partners had started to take steps towards improving the governance arrangements at the practice. Whilst there was clear evidence of improvement there were still areas that required improvement or further improvement.

Importantly, the provider must:

- Ensure that all significant events are reported, reviewed, investigated and that measures are in place to see whether the changes introduced have been effective and embedded into practice.
- Ensure that all vaccines are stored, managed and disposed of properly so that immunisations are carried out safely and efficiently in line with Public Health England guidance.
- Review the effectiveness of the management of training so that persons employed by the practice receive appropriate training as is necessary to enable them to carry out the duties they are employed to perform.
- Review the effectiveness of the governance systems and processes in place to enable the practice to assess, monitor and mitigate risks to the health, safety and welfare of their patients and staff.

At our previous inspection on 10 May 2016, we rated the practice as inadequate for providing safe services and requiring improvement for providing effective and well led services. Whilst improvement had been made at this inspection and there was evidence of an improvement pathway we still found issues that required improvement or further improvement. Consequently, the practice has been rated as requires improvement for safe which is reflective of some of the improvement we saw; requires improvement for effective as little improvement had been made in respect of training, and well led rated as requires improvement. It should be noted that there has been improvement in this area with the new partnership arrangement and some of the new governance arrangements and engagement with staff. However there are still a wide range of areas that need improvement. Consequently the rating for well led remains as requires improvement.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

At our previous inspection on 10 May 2016, we rated the practice as inadequate for providing safe services. We issued the provider with a warning notice and a requirement notice in respect of these issues. When we undertook a follow up inspection on 24 January 2017 these arrangements had improved in some but not all areas. The practice is rated as requires improvement.

At this inspection we found:

- The system and processes in place for reporting, recording and reviewing significant events had improved in some but not all areas. The practice had taken action to raise the profile and importance of significant events and complaint reporting within the practice and had introduced a structured review process. Despite this we identified that significant events were still not always being recorded and actioned, and in some cases there was insufficient information recorded to allow adequate investigation.
- There were still gaps in the safeguarding adults and children training completed by clinical and non-clinical staff.
- The practice had put a system in place to respond to national patient safety alerts and staff kept records of the action they took in response to these.
- Blank prescriptions were now stored securely and a system was in place to track their movement, which was in accordance with national guidance.
- We looked at the recruitment records for two of the most recently recruited clinical staff and the DBS status for all staff (clinical and non-clinical). All staff had a DBS check in place. Despite this the overall recruitment process was unstructured.
- The practice had made some improvement in the management of health and safety. We saw evidence to show that recommendations by external agencies had been acted on. However, there remained gaps in the completion of staff training in areas such as fire safety, health and safety and cardio pulmonary resuscitation (CPR).

Are services effective?

Requires improvement

At our previous inspection on 10 May 2016, we rated the practice as requires improvement for providing effective services. We issued the

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provider with a requirement notice in respect of these issues. When we undertook a follow up inspection on 24 January 2017 these arrangements had improved in some but not all areas. The practice remains at being rated as requires improvement.

At this inspection we found:

- The practice had in the last two weeks put a system in place to ensure patients with a learning disability were recalled to the practice for a review. All of the 40 patients had now been invited for an annual review.
- The practice could not demonstrate how they ensured role-specific training and updating for relevant staff. Staff did not always have access to appropriate training to meet their learning needs and to cover the scope of their work. Whilst some recent steps had been taken by the practice management to review the systems for managing training, there remained significant gaps in the completion of mandatory training and a lack of understanding as to the frequency of the requirements of this. For example, the health care assistants were not trained to the required safeguarding children level, three staff had not completed CPR training, eight staff had not completed fire safety training, ten staff had not completed health and safety training and no staff had completed information governance training.
- The practice now had a system for identifying patients that had not attended for cervical screening and had started to contact patients via telephone to remind them of this. They also continued to remind patients opportunistically when they attended the practice.

Are services well-led?

Requires improvement

At our previous inspection on 10 May 2016, we rated the practice as requires improvement for being well-led. We issued the provider with a requirement notice in respect of these issues. When we undertook a follow up inspection on 24 January 2017 these arrangements had improved in some but not all areas. The practice remains at being rated as requires improvement.

At this inspection we found:

- Evidence showed the partners had started to take steps towards improving the governance arrangements at the practice. Whilst there was clear evidence of some improvement, there were still areas that required improvement or further improvement. Specifically issues relating to reporting, recording, actioning and reviewing significant events over a

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period of time, ensuring recruitment arrangements were understood and followed, having an understanding and oversight of the training requirements and completion of training for staff.

- Since our last inspection there had been significant changes in the partnership arrangements. There was a new partnership arrangement and a new CQC registered manager in place. There was a clear commitment from the new partnership to deliver improvement. The partners had started to take action to address the range of issues we previously identified, particularly around the culture, reporting of significant events and complaints, support for staff and addressing poor performance and sickness absence. Whilst we identified a wide range of areas that still required improvement, it was evident the practice was on an improvement pathway.

Summary of findings

Areas for improvement

Action the service MUST take to improve

- Ensure that all significant events are reported, reviewed, investigated and that measures are in place to see whether the changes introduced have been effective and embedded into practice.
- Ensure that all vaccines are stored, managed and disposed of properly so that immunisations are carried out safely and efficiently in line with Public Health England guidance.
- Review the effectiveness of the management of training so that persons employed by the practice receive appropriate training as is necessary to enable them to carry out the duties they are employed to perform.
- Review the effectiveness of the governance systems and processes in place to enable the practice to assess, monitor and mitigate risks to the health, safety and welfare of their patients and staff.

Dr. Jackson and Partners

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector and a CQC Pharmacist Specialist.

Background to Dr. Jackson and Partners

Dr Jackson and Partners (also known as Mayford House Surgery), Boroughbridge Road, Northallerton, North Yorkshire, DL7 8AW is situated in Northallerton serving patients in Northallerton and the outlying smaller villages. The registered list size is 9,845 and predominantly of white British background. The practice is ranked in the eighth least deprived decile, below the national average. The practice age profile is comparable to the England average, the largest percentage above the England average being 65 years plus. The practice is a dispensing practice and dispenses to approximately a 3,400 patients of the patients. There has been a change in the partnership arrangement and clinical staffing since the last inspection. The practice is now managed by four partners (three female and one male) and two salaried GPs (one male and one female). The practice is a training practice for qualified doctors who are progressing to their chosen speciality both in primary and secondary care. The practice occasionally has medical students attached to the practice. The practice is part of the 'Heartbeat Alliance' a federation of other practices in the Hambleton, Richmondshire and Whitby Clinical Commissioning Group (CCG).

There have been changes to the nursing team since the last inspection. The practice employs an advanced nurse practitioner (ANP), a practice nurse manager, two practice nurses and two health care assistants. They also employ a pharmacist, a dispensary manager and two dispensers. The team is supported by a full time practice manager and a range of secretaries, IT staff and a reception team.

The practice is open between 8.30am and 6.30pm Monday to Friday. Extended hours are offered one evening a week from 6.30pm to 8pm. General appointment times for GPs are from 8.40am to 11.30am, 2pm until 4pm and either 3pm to 5pm or 4pm to 6pm. There is a sit and wait clinic at 11.30am daily for urgent and non-urgent appointments.

Standard appointments are 10 minutes for face to face and five minutes for telephone calls.

The practice has opted out of providing out-of-hours services to its own patients. When the practice is closed, patients are directed to Harrogate District Foundation Trust (the contracted out-of-hours provider) via the 111 service.

The practice holds a General Medical Services (GMS) contract to provide GP services which is commissioned by NHS England.

Why we carried out this inspection

We undertook a comprehensive inspection of Dr Walters and Partners (now known as Dr Jackson and Partners) on 10 May 2016 under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The practice was rated as requires improvement. The full comprehensive report following the inspection on 10 May 2016 can be found by selecting the 'all reports' link for Dr Jackson and Partners on our website at www.cqc.org.uk.

We undertook a follow up focused inspection of Dr Jackson and Partners on 24 January 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. We inspected the practice against three of the five key questions we ask about services: Is this service safe? Is this service effective? Is this service well led?

How we carried out this inspection

Before visiting Dr Jackson and Partners, we reviewed a range of information we held about the practice and asked other organisations to share what they knew including Hambleton, Richmondshire and Whitby CCG. We carried out a focused inspection on 24 January 2017.

During our visit we:

Spoke with the CQC registered manager GP partner and the practice manager.

Asked other clinical and non-clinical staff to complete a questionnaire after the inspection.

Observed the way the service was delivered but did not observe any aspects of patient care or treatment.

Requires improvement

Are services safe?

Our findings

At our previous inspection on 10 May 2016, we rated the practice as inadequate for providing safe services. We issued the provider with a warning notice and a requirement notice in respect of these issues. When we undertook a follow up inspection on 24 January 2017 these arrangements had improved in some but not all areas. The practice is rated as requires improvement.

Safe track record and learning

At the previous inspection we found the practice had a system in place for reporting, recording and reviewing significant events. However, this was not effective. Where significant events and complaints were recorded, the practice could not demonstrate that these were thoroughly investigated to prevent further occurrences and to make sure improvements were made as a result. There was no system in place for analysing significant events over a period of time. We also found that not all issues that should have been recorded as significant events were being recorded and actioned. For example, we identified issues with the vaccine fridge temperatures going outside the required range had not been reported as a significant event and actioned appropriately. Outcomes of investigations were not always shared with the people concerned.

At this inspection we found:

The system and processes in place for reporting, recording and reviewing significant events had improved in some but not all areas. The significant event records viewed showed some improvement in the way such events were managed.

Action had been taken to raise awareness of significant events and complaint recording with staff, with a training session planned shortly after this inspection. An audit had been carried out on the level of reporting within the practice and action was being taken to try and address this. A new recording tool had been put in place. However we noted this was not being used consistently. There was evidence of discussion at practice meetings shortly after an event had been raised and quarterly significant event analysis meetings where significant events were reviewed. The individual significant event record showed evidence of action taken and involvement of the people concerned; such as staff and the patient. However, due to the timing of the quarterly review some patients may not be contacted until three months later. All significant events were now recorded in one place and a summary record maintained for the quarterly review meeting. The recording tool and minutes from this meeting were brief. It was not always clear from the minutes of these meetings what action was to be taken to prevent reoccurrence, who was responsible for the action, or the date it should be completed. There was no date for review and no evidence of following up any of the measures put in place to see whether the changes had been effective and embedded into practice. One record did state 'follow up in one month' but there was no date to indicate when this was and no evidence of any follow up.

We identified that significant events were still not always being recorded and actioned. We looked specifically at the vaccine fridges following the issues identified at the previous inspection. We checked vaccines in three medicine refrigerators and found they were stored securely with access restricted to authorised staff. Temperature records were maintained in accordance with national guidance. However, temperatures outside of the recommended range for storing vaccines had been recorded on three days in December 2016 for the downstairs vaccine fridge, and no action had been taken or recorded. We discussed this with the lead nurse and practice manager who were unaware this fridge had been out of range. Temperatures for the other two vaccines fridges upstairs were within recommended limits. Staff in the dispensary showed us records of 'near misses' (errors that have been identified before medicines have left the dispensary) which were now discussed at regular meetings to identify trends and patterns in frequent errors, and implement mitigating actions. A number of significant incidents involving medicines had been reported. However, in some cases there was insufficient information recorded to allow adequate investigation.

Overview of safety systems and process

At the last inspection we identified gaps in the safeguarding training completed by staff, with not all staff having completed the required level of training.

The practice did not have a system in place to demonstrate they acted on national patient safety alerts.

The practice did not have systems in place to monitor the use of blank prescription forms in line with national guidance.

Requires improvement

Are services safe?

At the last inspection we looked at staff recruitment records. We identified that that not all clinical staff and staff that acted as a chaperone had a DBS check in place. Shortly after the inspection we received confirmation that all clinical staff and those staff who acted as a chaperone now had a DBS check. We found that recruitment files were poorly organised.

At this inspection we found:

Whilst some training had been completed there were still gaps in the safeguarding training completed by staff. For example health care assistants were not trained to the required level and there was limited evidence to demonstrate that clinical staff were completing regular safeguarding updates as required.

There were systems in place to respond to national patient safety alerts and staff kept records of the action they took in response to these.

Blank prescriptions were stored securely and a system was in place to track their movement, which was in accordance with national guidance.

We looked at the recruitment records for two of the most recently recruited clinical staff and the DBS status for all staff. We found all required staff had a DBS check in place. We noted that a recent nurse and GP had commenced work a short time before a DBS check had been received. We were provided with some evidence to indicate at least one of the staff members was on induction during this time. Some improvement to the organisation of the recruitment files had been made however we found a continued lack of structure as to what recruitment checks had and had not been carried out. For example, the practice manager was uncertain as to whether references had been sent for, for one member of clinical staff as they were on a temporary contract and not needed. It transpired that references had been obtained. There was also no evidence on file of professional registration checks being carried out. These were produced later in the inspection. The process of recruitment was unstructured. The practice told us they were planning to introduce a checklist to ensure appropriate checks were undertaken but this had not yet been implemented.

Monitoring risks to patients

At the previous inspection the practice did not have well managed systems in place to manage health and safety.

Where risks were identified, the practice did not always introduce measures to reduce or remove the risks within a timescale that reflected the level of risk and impact on people using the service. Records showed a fire safety risk assessment completed in 2009 and a legionella risk assessment completed in 2014 which were both completed by external professionals and identified areas of high and medium risk had not been fully acted on. For example the inspection and testing of the electrical circuit, relocation of the photocopier, training of staff and carrying out of fire drills had not been actioned.

Risk assessments relating to the health, safety and welfare of people using services were not completed or poorly completed. We found no health and safety risk assessments for the environment apart from one basic COSHH record.

At this inspection we found:

Action had been taken to address some of the issues relating to fire safety. Following our inspection in May 2016 we referred our findings to the fire service. An inspection and re-inspection by the local fire service had been carried out. Records showed the practice had acted on the recommendations they made. For example fire wardens had been trained, a risk assessment put in place and a fire drill carried out. We noted one area that had not been actioned until three months after the re-inspection and that eight staff had not completed fire safety training.

The practice had taken action to address the issues relating to legionella. They had commissioned an assessment by an external company and demonstrated they had acted on the recommendations. For example by identifying and training a legionella lead and testing water temperatures on a regular basis.

A range of risk assessments relating to the health, safety and welfare of people using services had been put in place. For example risk assessments had been completed for areas such as COSHH, first aid and manual handling.

Arrangements to deal with emergencies and major incidents

At the previous inspection not all staff had completed training in fire safety, health and safety and CPR.

At this inspection we found:

Requires improvement

Are services safe?

Training records provided showed the shortfalls in training in relation to fire safety, health and safety and CPR had not been addressed.

Requires improvement

Are services effective?

(for example, treatment is effective)

Our findings

At our previous inspection on 10 May 2016, we rated the practice as requires improvement for providing effective services. We issued the provider with a requirement notice in respect of these issues. When we undertook a follow up inspection on 24 January 2017 these arrangements had improved in some but not all areas. The practice remains at being rated as requires improvement.

Management, monitoring and improving outcomes for people

At the previous inspection the practice did not have an effective system in place to recall patients with a learning disability to the practice for annual reviews. Records showed only seven out of

36 patients on the learning disability register had received an annual review.

At this inspection we found:

The practice had in the last two weeks put a system in place to ensure patients with a learning disability were recalled to the practice for a review. All of the 40 patients (increased from 36 at the previous inspection) had now been invited for an annual review. Of these, eight reviews had been completed. Records showed GP partners at the practice had agreed that such patients would be divided between them and they would take the lead to follow up any patients that had not attended in the next four weeks. The practice had employed a clinical pharmacist who carried out medicines review clinics and reviews of patients with some long term conditions, and also managed repeat prescription reauthorisations. A system was in place to manage the repeat prescribing of high risk medicines, and we saw how this worked to keep patients safe.

Effective staffing

At the previous inspection the practice could not demonstrate how they ensured role-specific training and updating for relevant staff. They could not easily provide a detailed record and supporting documentation to confirm what training staff had completed.

At this inspection we found:

Staff still did not have access to appropriate training to meet their learning needs and to cover the scope of their work. The practice could not demonstrate how they ensured role-specific training and updating for relevant staff. Whilst some recent steps had been taken by the practice management to review the systems for managing training there remained significant gaps in the completion of mandatory training and a lack of understanding as to the frequency of the requirements of this training.

Very little progress had been made to action the shortfalls in the training we identified at the inspection in May 2016. It was unclear from the records whether clinical staff had completed the required number of hours training in respect of safeguarding children and adults, the health care assistants were not trained to the required safeguarding children level, three staff had not completed CPR training, eight staff had not completed fire safety training, ten staff had not completed health and safety training, no staff had completed information governance training, the lead for infection control had only, days before the inspection been booked on an infection control course. We also found there was no management oversight of the training for nursing staff in respect of ensuring their cervical screening, vaccination and immunisation and yellow fever training was up to date. We found all the nurses and one health care assistants vaccination and immunisation training was overdue an update and no training was planned.

Supporting patients to live healthier lives

At the previous inspection the practice did not have a policy to offer telephone reminders for patients who did not attend for their cervical screening test. This was managed opportunistically.

At this inspection we found:

The practice now had a system for identifying patients that had not attended for screening and had started to contact patients via telephone to remind them of this. They also continued to remind patients opportunistically when they attended the practice.

Are services well-led?

Requires improvement

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

Our findings

At our previous inspection on 10 May 2016, we rated the practice as requires improvement for being well-led. We issued the provider with a requirement notice in respect of these issues. When we undertook a follow up inspection on 24 January 2017 these arrangements had improved in some but not all areas. The practice remains at being rated as requires improvement.

Vision and strategy

At our previous inspection the practice did not have a publicised mission statement.

At this inspection we found:

A statement has now been added to the practice website and we saw evidence that partners were planning on obtaining feedback from staff in terms of the statement.

Governance arrangements

At our previous inspection the arrangements for governance did not always operate effectively and risks and issues were not always dealt with appropriately or in a timely way.

At this inspection we found:

Evidence showed the partners had taken steps to improve the governance arrangements at the practice. Whilst there was clear evidence of improvement there was still areas that required improvement or further improvement. Specifically recording, actioning and reviewing significant events over a period of time, ensuring recruitment arrangements were understood and followed, having an understanding and oversight of the training requirements and completion of training for staff.

The practice had a planned programme of clinical audit in place which identified leads and dates for the audit to take place. The programme of non-clinical audit did not identify target dates for completion.

The CQC registered manager demonstrated a clear understanding of the issues that needed addressing and along with the other partners at the practice, was committed to doing this. There was evidence to demonstrate the partners had started to do this.

Leadership and culture

At our previous inspection we identified concern in respect of the leadership and culture at the practice.

At this inspection we found:

Since our last inspection there had been significant changes in the partnership arrangements. There was a new partnership arrangement and a new CQC registered manager in place. There was a clear commitment from the new partnership to deliver improvement. The partners had started to take action to address the range of issues we previously identified particularly around the culture, reporting of significant events and complaints, support for staff and addressing poor performance and sickness absence. Whilst we identified a wide range of areas that still required improvement, it was evident the practice was on an improvement pathway and had started to put measures in place to deliver that improvement.

We asked for feedback from staff. We received two completed questionnaires post inspection. Feedback was positive and referred to changes that had taken place in the practice. For example the management of significant events, changes that had been introduced following feedback given to the partners and of a more inclusive team.

Seeking and acting on feedback from patients, the public and staff

At our previous inspection some staff said they did not always feel they were listened to or understood.

The Patient Participation Group did not have a chair or vice chair and there was minimal engagement with patients.

At this inspection we found:

The practice demonstrated a commitment to seeking and responding to the views of staff. The partners had requested that staff complete a questionnaire in order that they could fully understand the issues raised at our previous inspection. The practice provided evidence to demonstrate they had acted on feedback from staff. For example GPs had been allocated to teams (clinical and non-clinical) so they could better understand the issues and attend team meetings. They had also recently begun to actively manage poor performance and sickness absence and was putting measures in place to address low staff morale and inclusion such as monthly team meetings and being able to correspond with the practice manager electronically.

Are services well-led?

Requires improvement

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

The PPG did not have a chair or vice-chair. We were told the practice was hopeful they would be able to recruit a chair for the PPG in the near future. There had been some engagement with the PPG and patients during a recent consultation exercise at the practice. The practice continued to meet with the PPG on a quarterly basis supported by the practice manager.

Continuous improvement

The partners at the practice recognised their shortfalls and were working to address these. The partners demonstrated their commitment to continuous improvement. They demonstrated they had begun responding to the issues identified at our previous inspection but also in the wider context of general practice. They held regular strategy meetings which evidenced the practice was planning for the future. Recent changes involved the clinical staffing structure following the retirement of two partners last year. Two GP's had been replaced with two salaried GPs, an existing nurse trained to be a nurse practitioner and the employment of a pharmacist.

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 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: The registered person did not do all that was reasonably practicable to assess, monitor, manage and mitigate risks to the health and safety of service users. The practice must ensure that all significant events are reported, reviewed, investigated and that measures are in place to see whether the changes introduced have been effective and embedded into practice. The practice must ensure that all vaccines are stored, managed and disposed of properly so that immunisations are carried out safely and efficiently in line with Public Health England guidance. This was in breach of regulation 12 of the Health and Social Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: The provider did not have established systems and processes in place to enable the practice to assess monitor and mitigate risks to the health, safety and welfare of their patients and staff.

This section is primarily information for the provider

Requirement notices

Specifically issues relating to reporting, recording, actioning and reviewing significant events over a period of time, ensuring recruitment arrangements were understood and followed, having an understanding and oversight of the training requirements and completion of training for staff.

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

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing How the regulation was not being met: The practice did not always ensure that staff received such appropriate training as is necessary to enable them to carry out the duties they are employed to perform. The practice could not demonstrate how they ensured role-specific training and updated training for relevant staff. The practice could not demonstrate that all staff who required it had completed training in areas such as safeguarding adults and children, fire safety, health and safety, emergency resuscitation, infection control and information governance. This was in breach of regulation 18(2) of the Health and Social Act 2008 (Regulated Activities) Regulations 2014.