Belmont Medical Centre

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 caring?	Good
Are services responsive to people's needs?	Requires improvement
Are services well-led?	Inadequate

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Belmont Medical Centre on 25 January 2017. Overall the practice is rated as requires improvement.

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

- There was a system in place for reporting and recording significant events.
- We found that some patients were at risk of harm because systems and processes were not sufficiently in place to keep them safe. For example, monitoring of patients taking high risk medicines, action of patient safety alerts such as Medicines and Healthcare products Regulatory Agency (MHRA) and recruitment checks.
- Staff had access to guidelines from the National Institute for Health and Care Excellence.
- Whilst there was evidence of some quality monitoring to improve patient care, the practice had not implemented a structured programme of activity.
- Feedback from patients showed 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. Improvements were made to the quality of care as a result of complaints and concerns.
- Data showed that whilst patients found accessing appointments could be difficult, they were able to see a preferred GP if required. 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 their needs.
- There was a leadership structure and staff felt supported by management. The practice reviewed feedback received, and took action to implement improvements.
- The provider was aware of and complied with the requirements of the duty of candour.

The areas where the provider must make improvement are:

Summary of findings

- Implement a co-ordinated approach for the review and action of patient safety alerts received within the practice; to ensure risks are effectively managed.
- Implement an effective system to ensure all patients prescribed with high risk medicines are regularly monitored.
- Ensure that all staff undertaking chaperone duties have received training. The provider must ensure compliance with its own assessment of risk, that all staff undertaking chaperone duties are subject to a DBS check.
- Ensures that it assesses and manages the risk of legionella.
- Ensure recruitment arrangements include all necessary employment checks for employees and locum staff working within the practice.
- Implement formal governance arrangements including systems for assessing and monitoring risks and the quality of the service provision.
- Ensure that a process for undertaking regular staff appraisals is implemented.
- Ensure that all nurses have undertaken training in the Mental Capacity Act 2005.

The areas where the provider should make improvement are:

- Review significant incidents recorded and investigated to ensure measures taken to improve systems and processes have been effective. Review should include whether staff learning has become embedded within the practice.
- Ensure that the remaining controlled drugs are disposed of in line with regulations and that the records are reviewed and updated.
- Assess whether children's pads are required to be held with the defibrillator in the event of a patient emergency.
- To continue to identify carers as a low number of the practice list size had been identified.
- Continue to strive to improve the patient experience around access to appointments.
- To make contact with patients who have volunteered interest in joining the patient participation group. (PPG)

Where, as in this instance, a provider is rated as inadequate for one of the five key questions or one of the six population groups it will be re-inspected no longer than six months after the initial rating is confirmed. If, after re-inspection, it has failed to make sufficient improvement, and is still rated as inadequate for any key question or population group, we will place it into special measures. Being placed into special measures represents a decision by CQC that a service has to improve within six months to avoid CQC taking steps to cancel the provider's registration.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

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

- There was a system in place for reporting and recording significant events. Eleven incidents had been reported within the previous twelve months. The practice carried out investigations as a result and lessons were shared to make sure action was taken to improve processes within the practice.
- The practice had not undertaken a subsequent review of incidents investigated to ensure that corrective measures had been effective or to ensure staff learning was embedded. Following our inspection, the practice told us they would strengthen their systems and undertake reviews.
- When things went wrong, patients received information, support and an apology.
- Patients were at risk of harm because some of the systems and processes were not sufficiently in place to keep them safe. These included the management of patient safety alerts, ensuring all patients prescribed with high risk medicines received regular monitoring, staff recruitment processes and managing risks relating to staff chaperoning and legionella.
- Staff were trained to an appropriate level in safeguarding and we saw evidence that child and adult safeguarding issues were managed.

Are services effective?

Requires improvement

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

- Data from the Quality and Outcomes Framework (QOF) showed patient outcomes were at or above average compared to the national average. The practice had achieved 100% of available QOF points in 2015/16. This was above the CCG average of 98%. The practice's overall exception reporting rate was 13.5%.The CCG average rate was 9.2% and national average was 9.8%
- Staff had access to guidelines from the National Institute for Health and Care Excellence.
- Clinical audits demonstrated some quality improvement. This included a one cycle audit of a particular medicine which

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resulted in 23 patients being prescribed with an alternative treatment because of risks identified. The practice had not implemented a structured programme for quality monitoring activities.
- There was evidence of staff training and operational management, but appraisals were overdue review as these were last undertaken in 2014.
- Staff worked with other health care professionals to understand and meet the range and complexity of patients' needs.

Are services caring?

Good

The practice is rated as good for providing caring services.

- Data from the national GP patient survey showed patients rated the practice positively for several aspects of care. This included 94% of patients said the GP was good at listening to them compared to the clinical commissioning group (CCG) average of 93% and the national average of 89%.
- Data also showed that 88% of patients said they found the receptionists at the practice helpful compared to the CCG average of 89% and the national average of 87%.
- Feedback from CQC comment cards completed showed that patients were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.
- Information for patients about the services available was easy to understand and accessible. This included information for carers and the practice website.
- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.

Are services responsive to people's needs?

Requires improvement

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

- Practice staff reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group to secure improvements to services where these were identified. A range of services were offered which included: phlebotomy, (taking blood); 24 hour blood pressure monitoring; ECGs to test the heart's rhythm; travel vaccinations and minor surgery including the removal of lesions and joint injections.
- Data from the national GP survey was mixed. For example, 61% of patients usually got to see or speak to their preferred GP, which was the same as the CCG average and above the national

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average of 59%. However, 40% of patients usually waited 15 minutes or less after their appointment time to be seen compared to the CCG average of 68% and national average of 65%.

- The practice told us they had responded to the data findings and were planning to make adjustments to its appointment system. This included extending appointment times from 10 to 15 minutes to reduce them overrunning, and impacting upon the next patient waiting to be seen.
- We found there was continuity of care, with urgent appointments available the same day if patients were identified as requiring a face to face appointment.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- Information about how to complain was available and easy to understand and evidence showed the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.

Are services well-led?

Inadequate

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

- The practice had a vision to deliver high quality care and promote good outcomes for patients. The practice had implemented a business plan. The partnership met regularly and attended meetings within the locality where potential plans for the future were discussed.
- The practice had a governance framework, although this required strengthening. The practice had a number of policies and procedures to govern activity. There was limited evidence however, that audit drove quality improvement.
- Whilst some risks to patients had been identified such as infection control, other material risks had not been identified. These included assurance that patients taking high risk medicines had received regular monitoring and patient safety alerts were actioned.
- There was a leadership structure and staff felt supported by management. Regular staff meetings were held and documented.
- The provider was aware of and complied with the requirements of the duty of candour. The partners encouraged a culture of openness and honesty. The practice had systems in place for notifiable safety incidents and ensured this information was shared with staff to ensure appropriate action was taken.

Summary of findings

- The practice did not have a patient participation group (PPG). The practice had however, reviewed feedback from the national survey, Friends and Family test, Healthwatch report findings and from complaints received.

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

Requires improvement

The practice is rated as requires improvement for the care of older people. The issues identified as requires improvement overall affected all the patients including this population group.

- The practice offered proactive, personalised care to meet the needs of the older people in its population. All patients had a named GP.
- The practice provided care to patients residing in two local nursing homes. We received feedback from care homes staff which was positive about the effectiveness and responsiveness of the practice service. In one of the homes, a nurse practitioner from the practice undertook weekly routine visits. We were informed that this had improved the overall patient care experience and helped build positive relationships between practice and care home staff.
- The practice was responsive to the needs of older people, and offered home visits and urgent appointments for those with enhanced needs.
- National data showed the practice was performing marginally below the CCG and national averages for its achievement within stroke and transient ischaemic attack (TIA) related indicators. Data showed that 85% of patients with a history of stroke or TIA had received a blood pressure reading within the previous 12 months. The CCG average was 89% and national average was 88%.

People with long term conditions

Requires improvement

The practice is rated as requires improvement for the care of people with long-term conditions. The issues identified as requires improvement overall affected all the patients including this population group.

- Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority.
- National data showed the practice was performing above the local CCG average for its achievement within 11 diabetes indicators. The practice achieved 100% of available QOF points compared with the CCG average of 95% and national average of 90%.

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- Data also showed that 96% of patients with chronic obstructive pulmonary disease (COPD) had received a confirmed diagnosis. This was above the CCG average of 91% and national average of 89%. Exception reporting was 1.3% which was lower than CCG average of 5.4% and national average of 9.2%.
- Longer appointments and home visits were available when needed.
- All these patients had a named GP and a structured annual review to check their health and medicines needs were being met. For those patients with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Requires improvement

The practice is rated as requires improvement for the care of families, children and young people. The issues identified as requires improvement overall affected all the patients including this population group.

- There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances.
- Childhood immunisation rates for the vaccinations given to under two year olds exceeded national expectations of 90% achievement. Five year old vaccinations ranged from 94% to 98% within the practice whereas the CCG average ranged from 88% to 94%.
- Our conversations with staff supported that children and young people were treated in an age-appropriate way and were recognised as individuals.
- A full range of contraceptive services were available for patients who requested these. This included coil fittings and implant insertion and removal. The practice also promoted the use of a downloadable app for patient convenience. The app prompted the user about when contraceptive appointments / procedures were due.
- The practice offered counselling to patients who were considering vasectomy and referrals were made to a local provider for procedures to be performed.
- Appointments were available outside of school hours and the premises were suitable for children and babies.

Summary of findings

Working age people (including those recently retired and students)

Requires improvement

The practice is rated as requires improvement for the care of working-age people (including those recently retired and students). The issues identified as requires improvement overall affected all the patients including this population group.

- 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 worked as part of a federation that offered appointments to patients outside of usual working hours. Patients could access services from 6pm to 8pm on weekdays and from 8am to 8pm on weekends and bank holidays at a local surgery one mile away.
- The practice was proactive in offering online services. The practice participated in the electronic prescription service, enabling patients to collect their medicines from their preferred pharmacy without having to collect the prescription from the practice.
- Data showed that 80% of women aged over 25 but under 65 had received a cervical screening test in the previous 5 years. The practice was performing the same as the CCG average and similar to the national average of 81%.

People whose circumstances may make them vulnerable

Requires improvement

The practice is rated as requires improvement for the care of people whose circumstances may make them vulnerable. The issues identified as requires improvement overall affected all the patients including this population group.

- The practice held a register of patients living in vulnerable circumstances including those with a learning disability. The practice had 41 patients on the learning disability register. The practice did not offer learning disability annual health checks. We were informed that one of the practice nurses who was trained to undertake the reviews had left the practice. We were told that funding for training was no longer provided by the CCG and therefore they were unable to provide a nurse to deliver the training. Following our inspection, the practice told us they would source alternate training and they acknowledged these patients would benefit from regular review.
- The practice offered longer appointments for patients with a learning disability and other patients who requested these.
- The practice regularly worked with other health care professionals in the case management of vulnerable patients.

Summary of findings

- 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)

Requires improvement

The practice is rated as requires improvement for the care of people experiencing poor mental health (including people with dementia). The issues identified as requires improvement overall affected all the patients including this population group.

- 100% of patients with a mental health condition had a documented care plan in place in the previous 12 months. This was above the CCG average of 90% and above the national average of 89%. Exception reporting was 15.6% which was above the CCG average of 12.7% and above national average of 12.7%.
- 82% of patients diagnosed with dementia had had their care reviewed in a face to face meeting in the last 12 months. This was slightly below the CCG average of 83% and national average of 84%. The practice had not exception reported any patients.
- A dementia nurse was attached to the practice and held clinics when required and undertook home visits to see patients and carers. The nurse acted as a link between primary and secondary care and signposted patients to holistic services including a singing group.
- The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those with dementia.

Summary of findings

What people who use the service say

The national GP patient survey results were published in July 2016. The results showed the practice performance was mixed when compared with local and national averages. 274 survey forms were distributed and 104 were returned. This represented 38% response rate.

- 63% of patients found it easy to get through to this practice by phone compared to the Clinical Commissioning Group average (CCG) of 80% and national average of 73%.
- 85% of patients were able to get an appointment to see or speak to someone the last time they tried compared to the CCG average of 89% and national average of 85%.
- 83% of patients described the overall experience of this GP practice as good compared to the CCG average of 91% and national average of 85%.
- 89% of patients said the last GP they saw or spoke to was good at involving them in decisions about their care compared to the CCG average of 87% and national average of 82%.
- 70% of patients said they would recommend this GP practice to someone who has just moved to the local area compared to the CCG average of 84% and national average of 78%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 38 comment cards, 37 of which were positive about the standard of care received. Comments included that staff were friendly, helpful and accommodating and patients felt that their needs were met. A number of comments referred to an excellent service being provided. We noted that 10 comment cards contained mixed feedback however in relation to waiting times to obtain an appointment. One comment card contained negative feedback about the waiting time spent in the practice after arrival for an appointment.

The practice's results from the NHS Friends and Family test showed that in September and October 2016, 140 patients would recommend the practice to their friends and family and 18 were unlikely to recommend the practice.

Areas for improvement

Action the service MUST take to improve

- Implement a co-ordinated approach for the review and action of patient safety alerts received within the practice; to ensure risks are effectively managed.
- Implement an effective system to ensure all patients prescribed with high risk medicines are regularly monitored.
- Ensure that all staff undertaking chaperone duties have received training. The provider must ensure compliance with its own assessment of risk, that all staff undertaking chaperone duties are subject to a DBS check.
- Ensure it assesses and manages the risk of legionella.
- Ensure recruitment arrangements include all necessary employment checks for employees and locum staff working within the practice.
- Implement formal governance arrangements including systems for assessing and monitoring risks and the quality of the service provision.
- Ensure that a process for undertaking regular staff appraisals is implemented.
- Ensure that all nurses have undertaken training in the Mental Capacity Act 2005.

Action the service SHOULD take to improve

- Review significant incidents recorded and investigated to ensure measures taken to improve systems and processes have been effective. Review should include whether staff learning has become embedded within the practice.

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- Ensure that the remaining controlled drugs are disposed of in line with regulations and that the records are reviewed and updated.
- Assess whether children's pads are required to be held with the defibrillator in the event of a patient emergency.
- To continue to identify carers as a low number of the practice list size had been identified.
- Continue to strive to improve the patient experience around access to appointments.
- To make contact with patients who have volunteered interest in joining the patient participation group. (PPG)

Belmont Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector**.** The team included a GP specialist adviser.

Background to Belmont Medical Centre

Belmont Medical Centre is located in Hereford, a cathedral city and county town of Herefordshire. It is approximately 16 miles east of the border with Wales, 24 miles southwest of Worcester and 23 miles northwest of Gloucester.

There is access to the practice by public transport from surrounding areas. There are also parking facilities on site.

The practice currently has a list size of 7946 patients.

The practice holds a General Medical Services (GMS) contract with NHS England. The GMS contract is held between general practices and NHS England for delivering primary care services to the local communities. The practice provides GP services commissioned by NHS Herefordshire Clinical Commissioning Group (CCG). A CCG is an organisation that brings together local GPs and experienced health professionals to take on commissioning responsibilities for local health services.

The practice is situated in an area with mid average levels of deprivation (level 5, Indices of Multiple Deprivation decile, IMD). Level 1 IMD represents a most deprived area and level 10, the least deprived. A higher number of patients registered at the practice are unemployed (11%) compared with the local CCG average (4%) and national average (5%).

The practice has a slightly higher than national average number of babies, young children, teenagers and adults in their 20's, 30's and 40's.

The premises are modern and purpose built. Patient services are all available on the ground level of the building. The practice premises form part of a complex which includes a pharmacy, physiotherapy and rehabilitation centre, a centre for natural health and a library.

The practice is currently managed by two GP partners. (both male). The partners also employ three salaried GPs (all female). Two regular sessional locums (male and female) also work in the practice. They are supported by five practice nurses, one Healthcare Assistant, a practice manager, assistant practice manager, reception manager and a team of administrative and clerical staff.

One of the GP partners also works as the CCG primary care prescribing lead.

On weekdays, the practice opens at 8am and closes at 6pm. The practice has a local arrangement with the CCG to close at 6pm. GP consultations generally commence at 8.10am to 11.30am, 2pm to 3pm and 4.30pm to 6pm on weekdays. The practice is part of a federation of 24 practices which offers extended hours GP appointments. Practice patients could therefore pre-book appointments and attend a surgery approximately 1 mile away from the practice. Appointments are available between 6pm and 8pm on weekdays and 8am to 8pm on weekends and bank holidays.

The practice has opted out of providing out-of-hours services to its own patients. When the practice is closed, patients are directed to Primecare via the 111 service.

Detailed findings

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. The 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.

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 25 January 2017. During our visit we:

- Spoke with a range of staff (GPs, nurses, practice manager, administrative and reception staff).
- Reviewed a sample of the personal care or treatment records of patients.
- Reviewed comment cards where patients shared their views and experiences of the service.
- Reviewed practice protocols and procedures and other supporting documentation including staff files and audit reports.

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 were provided for specific groups of people and what good care looked 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).

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.

Requires improvement

Are services safe?

Our findings

Safe track record and learning

There was a system in place for reporting and recording significant events.

- Staff told us they would inform the practice manager of any incidents and there was a recording form available on the practice's computer system. The incident recording form supported the recording of notifiable incidents under the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).
- We saw evidence that when things went wrong with care and treatment, patients were informed of the incident, received information, support and a verbal or written apology. They were told about any actions to improve processes to prevent the same thing happening again.
- Information we were provided supported that the practice carried out an analyses of the significant events. We noted 11 incidents were reported within 2016/17.

Practice management told us that staff discussed issues raised from significant events in protected learning time meetings held every three months. Whilst the practice held minutes of these meetings, they did not make reference to discussion of incidents. We were informed that incident reporting forms were updated when these meetings were held. We reviewed a sample of incident recording forms. They supported that lessons were shared and action was taken to improve processes within the practice. For example, an incident resulted in the patient death procedure being updated. This acted as a prompt for reception staff to follow when obtaining information for administrative purposes. The practice had not undertaken a subsequent review of significant events to assess if measures taken were effective or to ensure that staff learning was embedded within the practice.

We looked at the system for how patient safety alerts including Medicines and Healthcare Products Regulatory Agency (MHRA) were disseminated and acted upon. The practice manager received these alerts and passed them on to practice clinicians for review and subsequent action. A log was maintained of alerts received and issued to staff. The log did not include information to show whether alerts had been actioned by a nominated member of staff. We asked GPs about what action the practice had taken in relation to a particular alert issued. We were subsequently informed that they had not taken action in response. Following our inspection, the practice management informed us they had strengthened the existing process in place and one named GP would take responsibility for the action of alerts. We were also informed that a search had been undertaken in respect of the patients potentially affected by the alert that we had discussed with the practice.

Overview of safety systems and processes

The practice had some systems, processes and practices in place to keep patients safe and safeguarded from abuse, which included:

- Arrangements were in place to safeguard children and vulnerable adults from abuse. These arrangements reflected relevant legislation and local requirements. Policies were accessible to all staff. The policies outlined who to contact for further guidance if staff had concerns about a patient's welfare. There were two lead members of staff for safeguarding, the GP partners. The GPs attended safeguarding meetings when possible and provided reports where necessary for other agencies. Staff demonstrated they understood their responsibilities and all had received training on safeguarding children and vulnerable adults relevant to their role. GPs were trained to child protection or child safeguarding level 3. All nurses were trained to either level 2 or 3.
- A notice in the waiting room advised patients that chaperones were available if required. We were informed by practice management that only clinical staff and two members of the reception team were nominated to undertake chaperoning and they had received training to undertake this role. We were told that staff who acted as chaperones had received a Disclosure and Barring Service (DBS) check. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable). We spoke with a member of the reception team who advised us that any staff could undertake chaperoning duties if requested to do so, by one of the GPs. Our discussions with another member of

staff supported this. Not all these staff had received a DBS check to undertake this role, although a risk assessment by the practice had identified that staff undertaking chaperoning must receive a DBS check. Our review of training records showed that three out of six reception staff had undertaken chaperone training. We discussed our findings with practice management who advised us that immediate action would be taken to ensure all staff were trained for the role and DBS checked prior to undertaking further chaperone duties.

- The practice maintained appropriate standards of cleanliness and hygiene. We observed the premises to be clean and tidy. One of the practice nurses was the infection control clinical lead who liaised with the local infection prevention teams to keep up to date with best practice. There was an infection control protocol in place and staff had received up to date training. Annual infection control audits were undertaken and we saw evidence that action was taken to address any improvements identified as a result. One of the actions taken included the decluttering of items within clinical treatment rooms to ensure effective cleaning in all areas.
- We found there were some arrangements for managing medicines, including emergency medicines and vaccines (including obtaining, recording, handling, storing, security and disposal). We noted exceptions however in relation to some patients who were prescribed with high risk medicines. Our review of a small sample of records included those patients prescribed lithium and leflunomide. Documentation showed that not all patients prescribed these medicines had received regular blood test monitoring. For example, out of seven records we examined, all patients had received monitoring but six had monitoring overdue by between one to five months. Following our inspection, we asked the practice to provide us with additional information about other patients prescribed high risk medicines. Analyses of this information showed that the practice had adequate monitoring in place for those patients.
- The practice carried out medicines audits, with the support of the local CCG pharmacy teams, to ensure prescribing was in line with best practice guidelines for safe prescribing. Blank prescription forms and pads were securely stored and there were systems in place to monitor their use. Two of the nurses had qualified as independent prescribers and could therefore prescribe medicines for specific clinical conditions. They received mentorship and support from the medical staff for this extended role. Patient Group Directions (PGDs) had been adopted by the practice to allow nurses to administer medicines in line with legislation. PGDs are documents which permit the supply of prescription-only medicines to groups of patients without individual prescriptions. The Health Care Assistant was trained to administer vaccines and medicines against a patient specific prescription or direction from a prescriber. Patient specific directions are instructions to administer medicines to individually named patients.
- The practice partners told us that a historical decision was made not to hold supplies of controlled drugs (medicines that require extra checks and special storage because of their potential misuse). We were informed by practice staff that they had found two controlled drugs prior to our inspection taking place. These had been held securely but had expired. We noted monitoring documentation contained inaccurate information regarding the quantities held. We noted there were extra quantities of the medicines when checked against the monitoring document. We discussed the issue with the practice partners who told us that the holding of the controlled drugs was an oversight and they had already made appropriate arrangements for the items to be destroyed. The practice had also consulted with the controlled drugs accountable officer prior to our visit.
- We reviewed four personnel files. We found that most of the appropriate recruitment checks had been undertaken prior to employment. For example, qualifications, registration with the appropriate professional body, references and the appropriate checks through the Disclosure and Barring Service for those staff who required DBS checks. We found that the practice had not obtained proof of identity including a photograph in all of the files we examined. The practice's recruitment policy included the requirement to obtain this evidence.
- We reviewed two locum GP files. In one of the locum files, we found the practice had not obtained evidence of satisfactory conduct in previous employment or evidence of staff identity including a photograph. We were told by practice management that the locum was known by one of the GP partners.

Monitoring risks to patients

Requires improvement

Are services safe?

There was assessment of most of the risks to patients, although we noted an exception.

- There were some procedures in place for monitoring and managing risks to patient and staff safety. There was a health and safety policy available. The practice had up to date fire risk assessments and had carried out fire drills.
- All electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly. This was last tested in June 2016. The practice told us that staff had undertaken a legionella risk assessment of the premises and we were provided with documentation about the assessment after our inspection had taken place. (Legionella is a term for a particular bacterium which can contaminate water systems in buildings). We discussed the requirement for the risk assessment to be undertaken by a competent person. After our inspection, we were informed that a second independent assessment by a competent person had taken place.
- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. Administrative and reception staff worked fixed hours and provided cover for each other when required. Two regular locum doctors were utilised within the practice to ensure there were enough GPs to provide patient care. The practice employed five nurses and staffing was co-ordinated.

Arrangements to deal with emergencies and major incidents

The practice had adequate arrangements in place to respond to emergencies and major incidents.

- There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency.
- All staff received basic life support training and there were emergency medicines available in the treatment room.
- The practice had a defibrillator available on the premises with adult pads available. We noted that children's pads were not held. Oxygen was available with adult and children's masks. A first aid kit and accident book were available.
- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and stored securely.
- The practice had a comprehensive business continuity plan in place for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff and copies were held off site by management.

Requires improvement

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice had systems in place to keep all clinical staff up to date. Staff had access to guidelines from National Institute for Health and Care Excellence (NICE).

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent published results were 100% of the total number of points available. The CCG average was 98% and national average was 95%. The practice overall exception reporting rate was 13.5%. The CCG average rate was 9.2% and national average was 9.8%. (Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects).

Data from 2015/16 showed:

- Performance for overall diabetes related indicators was 100% which was above the CCG average of 95% and national average of 90%. Overall exception reporting was 19.1% which was above the CCG average of 11.2% and above the national average of 11.6%.
- 100% of patients newly diagnosed with diabetes were referred to a structured education programme, which was above the CCG average of 96% and national average of 92%. Exception reporting was 31.6% however, which was above the CCG average of 13.7% and national average of 23%.
- 96% of patients with chronic obstructive pulmonary disease (COPD) had received a confirmed diagnosis. This was above the CCG average of 91% and national average of 89%. Exception reporting was 1.3%, which was below the CCG average of 5.4% and national average of 9.2%.
- 81% of patients with a diagnosis of depression had received a review after their diagnosis. Performance was below the CCG average of 87% and national average of 83%. Exception reporting was 23.6%, which was similar to the CCG average of 22.8% and the national average of 22.1%.
- 100% of patients with a mental health condition had a documented care plan in place in the previous 12 months. This was above the CCG average of 90% and national average of 89%. Exception reporting was 15.6% which was above the CCG and national averages of 12.7%.

Whilst we noted high QOF achievement and low exception reporting within some clinical indicators such as COPD, we discussed reasons for higher exception reporting in areas such as diabetes. We were informed that efforts had been made to encourage patients to attend a structured education programme, but a number of patients were not compliant. Our review of the practice's exception reporting processes showed that the practice followed guidance.

The practice did not offer learning disability annual health checks. We were informed that one of the practice nurses who was trained to undertake the reviews had left the practice. We were also told that funding for training was no longer provided by the CCG and therefore they were unable to provide a nurse to deliver the training. Following our inspection, the practice told us they would source alternate training and they acknowledged these patients would benefit from regular review.

There was some evidence of quality improvement including clinical audit.

There were six one cycle clinical audits undertaken in the last two years. We reviewed a hydroxyzine audit (April 2015) which was undertaken following the release of guidance about associated risks for elderly patients and those with particular health conditions taking the medicine. Hydroxyzine is a medicine used to treat itching caused by allergies and it may also be used to treat anxiety. The audit involved a review of patients prescribed with the medicine to identify if it was appropriate for their continued use. The audit identified 23 patients who required alternative medicine and action was taken to review these patients. The audit contained recommendations for clinical practice. The practice had not completed the full cycle audit to demonstrate whether quality improvement had been achieved. We were however, provided with the full cycle audit which was completed and provided to us on the day of our inspection.

Requires improvement

Are services effective?

(for example, treatment is effective)

The practice provided us with information about quality improvements in the service provided to a local nursing home where some patients were resident. The practice manager and one of the partners had met with care homes staff to provide awareness about appropriateness for requesting urgent home visits. The practice made a decision to deploy one of their nurse practitioners on a weekly basis to review patients at the home. We were informed that this measure was successful as requests for urgent visits had decreased and care homes staff reported that this had enhanced the healthcare provided to its residents. We reviewed feedback provided by the home which identified that a positive and supportive relationship had been formed between care homes staff and the practice.

The practice provided minor surgical procedures and provided us with a one year audit undertaken in 2016. The data showed positive outcomes from procedures performed. However, there was no evidence of analysis, discussion amongst colleagues or reflections as a result.

Practice GPs had special interests in diabetes, gynaecology, musculoskeletal disorders and minor operations.

Effective staffing

- The practice had an induction programme for all newly appointed staff. This covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality.
- The practice could demonstrate how they ensured role-specific training and updating for relevant staff. For example, for those reviewing patients with long-term conditions. We spoke with two nurses who had updated their skills in asthma, family planning and ill child examination.
- Staff administering vaccines and taking samples for the cervical screening programme had received specific training which had included an assessment of competence. Staff who administered vaccines could demonstrate how they stayed up to date with changes to the immunisation programmes, for example by access to on line resources and discussion at practice meetings.
- We were informed that the learning needs of staff were identified through a system of daily management monitoring and reviews of practice development needs. We were advised that appraisals were overdue review however as they were last undertaken in 2014. Practice management advised us that they would plan to hold appraisals this year.
- Staff had access to training to meet their learning needs and to cover the scope of their work. This included ongoing support, one-to-one meetings, coaching and mentoring, clinical supervision and facilitation and support for revalidating GPs.
- Staff received training that included: safeguarding, fire safety awareness, basic life support and information governance. Staff had access to and made use of e-learning training modules and in-house training.

Coordinating patient care and information sharing

We found information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practice's patient record system and their intranet system. This included care and risk assessments, medical records and investigation and test results.

The practice shared relevant information with other services in a timely way, for example when referring patients to other services.

Staff worked together and with other health and social care professionals to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. This included when patients moved between services, including when they were referred, or after they were discharged from hospital. Meetings took place with other health care professionals on a regular basis.

Consent to care and treatment

GPs sought patients' consent to care and treatment in line with legislation and guidance, but we noted some exceptions in relation to nursing staff.

- GP staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005. We spoke with two nurses who were unable to demonstrate their knowledge of the Act and how it applied to patients who may lack capacity to consent. Our review of training records showed that these staff had not yet completed the training. One of the nurses we spoke with

also undertook weekly care home visits where patients with dementia were residing. Following our inspection, we were told that all nurses would complete this training.

- When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance.
- The practice sought consent and this was recorded accordingly on patient records when procedures such as minor surgery were performed and contraceptive devices were fitted.

Supporting patients to live healthier lives

The practice identified patients who may be in need of extra support. For example:

Patients receiving end of life care, carers and those at risk of developing a long-term condition were signposted to the relevant service. The practice promoted a diabetes prevention programme and an Expert Patients Programme for those with long term health conditions. Those requiring smoking cessation advice were invited to attend an in house clinic.

The practice's uptake for the cervical screening programme was 80%, which was the same the CCG average and similar to the national average of 81%. There was a policy to offer reminders for patients who did not attend for their cervical screening test. Alerts were also placed on patient records for opportunistic testing if they attended the practice but had not responded to reminders.

The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening. Data showed that uptake for bowel cancer screening in the previous 30 months was 54% which was lower than the CCG average of 62%. Data from 2015 showed that uptake for breast cancer screening in the previous 36 months was 66% which was lower than the CCG average of 73%.

Childhood immunisation rates for the vaccinations given to under two year olds exceeded national expectations of 90% achievement. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 95% to 98%. Five year old vaccinations ranged from 94% to 98% within the practice whereas the CCG average ranged from 88% to 94%.

Patients had access to appropriate health assessments and checks. These included health checks for new patients and NHS health checks for patients aged 40–74. Appropriate follow-ups for the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.

Good

Are services caring?

Our findings

Kindness, dignity, respect and compassion

Consultation and treatment room doors were closed during consultations and conversations taking place in these rooms could not be overheard. Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations and treatments.

During our inspection, we observed that members of staff were courteous and helpful to patients and treated them with dignity and respect. Reception staff knew they could offer patients a private area to discuss any sensitive issues.

Feedback received from patients in Care Quality Commission comment cards were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect. Results from the national GP patient survey in July 2016 showed patients felt they were treated with compassion, dignity and respect. The practice was above average or in line with local and national averages for its satisfaction scores on consultations with doctors and nurses. For example:

- 94% of patients said the GP was good at listening to them compared to the clinical commissioning group (CCG) average of 93% and the national average of 89%.
- 91% of patients said the GP gave them enough time compared to the CCG average of 91% and the national average of 87%.
- 95% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 98% and the national average of 95%.
- 92% of patients said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 90% and national average of 85%.
- 91% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 93% and national average of 91%.

Data was also positive in relation to feedback regarding receptionists.

- 88% of patients said they found the receptionists at the practice helpful compared to the CCG average of 89% and the national average of 87%.

The practice management told us they had reviewed the survey feedback along with findings from a draft Healthwatch report which they received in August 2016.

Care planning and involvement in decisions about care and treatment

Feedback received from CQC comment cards showed that patients felt involved in decision making about the care and treatment they received.

Results from the national GP patient survey showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. Results were in line with local and national averages. For example:

- 91% of patients said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 91% and the national average of 86%.
- 89% of patients said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 87% and national average of 82%.
- 84% of patients said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average of 88% and national average of 85%.

Patient and carer support to cope emotionally with care and treatment

Patient information leaflets and notices were available in the patient waiting area which told patients how to access a number of support groups and organisations. Information about support groups was also available on the practice website.

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 52 patients as carers (0.6% of the practice list). Carers were referred to a local support group. The practice had nominated a member of staff as the carers lead. They attended quarterly carers leads meetings organised by the Herefordshire carers support group. The group provided information to the leads on how to identify carers and the variety of support and help available. We saw information for carers displayed in the practice reception area. Carers were also offered the flu vaccination.

Good

Are services caring?

Staff told us that if families had suffered bereavement, their usual GP contacted them. This contact was either followed by the offer of a patient consultation or by giving them advice on how to find a support service.

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified.

- The practice provided a range of services that ensured these were easily accessible for their patients. This included phlebotomy (taking blood); 24 hour blood pressure monitoring; ECGs to test the heart's rhythm; spirometry (test that can diagnose various lung conditions and monitor severity), travel vaccinations and minor surgery including the removal of lesions and joint injections.
- The practice offered near patient testing for patients prescribed with warfarin. This meant patients could have results from tests undertaken available immediately.
- Near patient testing was also available for brain natriuretic peptide (BNP) testing. BNP testing measures the amount of the BNP hormone in a patient's blood. The level of BNP increases when heart failure symptoms worsen.
- Weekly nurse led clinics were provided for patients with long term conditions such as diabetes, heart disease, hypertension and peripheral vascular disease.
- Patients had access to an in-house physiotherapist who worked in the premises two days a week. Patients experiencing musculoskeletal injuries and disorders (muscles, tendons, ligaments, nerves, discs etc) were referred to the physiotherapist to help manage their conditions.
- Patients experiencing depression and low level mental health problems were referred to an in-house primary care mental health worker who was based in the premises one day a week.
- Full contraceptive services including coil, implant insertion and removal were offered to patients who would benefit.
- There were longer appointments available for patients with a learning disability and other vulnerable patients who requested them.
- The practice offered same day appointments for patients with urgent needs. Requests for these appointments were assessed using a clinician led triage system. Patients were contacted by telephone by a nurse practitioner or GP and a same day appointment was given to those who were identified as needing to attend a face to face appointment.
- Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice.
- Patients could book appointments and order repeat prescriptions on line. The practice participated in the electronic prescription service, enabling patients to collect their medicines from their preferred pharmacy without having to collect the prescription from the practice.
- There were disabled facilities, a hearing loop and translation services available.

Access to the service

On weekdays, the practice opened at 8am and closed at 6pm. The practice informed us they had a local agreement with the CCG to close at 6pm. After 6pm an arrangement was in place whereby calls were diverted to the out of hours provider. GP consultations generally commenced at 8.10am to 11.30am, 2pm to 3pm and 4.30pm to 6pm on weekdays. The practice was part of a federation of 24 practices which offered extended hours GP appointments. Practice patients could therefore pre-book appointments and attend a surgery approximately 1 mile away from the practice. Appointments were available between 6pm and 8pm on weekdays and 8am to 8pm on weekends and bank holidays.

In addition to pre-bookable appointments that could be booked up to two weeks in advance, urgent appointments were also available for people that needed them.

The practice partners informed us that they had implemented a policy whereby patients who had moved out of the practice boundary area could still remain registered with the practice to receive care, if they chose to do so.

Results from the national GP patient survey showed that patients' satisfaction with how they could access care and treatment was mixed in comparison to local and national averages.

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

- 63% of patients found it easy to get through to this surgery by phone compared to the CCG average of 80% and national average of 73%.
- 85% of patients were able to get an appointment to see or speak to someone the last time they tried compared to the CCG average of 89% and national average of 85%.
- 68% of patients described their experience of making an appointment as good compared to the CCG average of 80% and national average of 73%.
- 68% of patients were satisfied with the practice's opening hours compared to the CCG average of 79% and national average of 76%.
- 40% of patients usually waited 15 minutes or less after their appointment time to be seen compared to the CCG average of 68% and national average of 65%.
- 61% of patients usually got to see or speak to their preferred GP, which was the same as the CCG average and above the national average of 59%.

We discussed the findings of the survey with practice management. They told us they were considering increasing appointment times from ten to 15 minutes per patient, which would help prevent appointments over-running and reduce the next patients waiting time after their arrival. They also told us they had made a decision to increase pre-bookable appointments from two to three weeks. The practice had introduced a rule whereby patients with prescription enquiries were required to call a dedicated line, to ensure the appointment phone line was used for this purpose only. An additional member of staff had been utilised to answer telephone lines at peak times of the week to increase the number of calls being answered.The practice management told us that they considered that these measures were proving to be effective.

We noted that ten CQC comment cards also identified difficulties in accessing appointments.

The practice had a system in place to assess:

- whether a home visit was clinically necessary; and
- the urgency of the need for medical attention.

The practice used its clinician led triage system to manage requests for home visits. In cases where the urgency of need was so great that it would be inappropriate for the patient to wait for a GP home visit, alternative emergency care arrangements were made. Clinical and non-clinical staff were aware of their responsibilities when managing requests for home visits.

Listening and learning from concerns and complaints

The practice had an effective system in place for handling complaints and concerns.

- Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England.
- The practice manager was the designated responsible person that co-ordinated the complaints process. Clinicians always reviewed any complaints of a clinical nature.
- We saw that information was available to help patients understand the complaints system.

We looked at five complaints received in the last 12 months and found these were satisfactorily handled and dealt with in a timely way with openness and transparency. The practice offered to meet with complainants to discuss their concerns whenever this was deemed appropriate. The practice undertook a review of complaints to identify any trends and consider the learning points and changes to practice. Lessons were learnt and shared with the team following a complaint, and action was taken to as a result to improve the quality of care. For example, following a complaint, a procedural change was implemented within the reception team regarding their disclosure of test results to patients.

Are services well-led?

Inadequate

(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 vision to deliver high quality care and promote good outcomes for its patients.

- The practice's statement of purpose included an objective to deliver safe, effective and empathetic care in a clean environment, by staff who had the skills, training and experience to carry out their duties. The objective included placing the patient as the focus of primary care rather then their condition. We found inconsistencies in the achievement of these strategic objectives. For example, the practice could not show that all staff had the full training necessary to carry out their duties.
- The practice had implemented a business plan for 2015-2018. We were also provided with documents which showed the partners met regularly to discuss practice matters. They also attended meetings with the Hereford City Locality Group where potential plans for the future were discussed. The practice was part of a federation of 24 local providers.

Governance arrangements

The practice had a governance framework, although this required strengthening.

- There was a staffing structure and staff were aware of their own roles and responsibilities.
- Practice specific policies were implemented and were available to all staff.
- An understanding of the performance of the practice was maintained. For example, this was demonstrated in high QOF achievement and the practice's response to the National GP survey data.
- We were provided with some limited evidence to show quality improvement as a result of clinical audit undertaken. We also noted a review was undertaken of the service provided to a local care home where practice patients were resident. This resulted in improved changes. However, there was an absence of a structured programme of audit activity to consistently drive quality improvement within the practice.
- There were arrangements for identifying, recording and managing some risks, issues and implementing mitigating actions. For example, safeguarding, staff resourcing and infection control processes. We identified systemic weaknesses in governance systems however, as there were risks to patients that had not been recognised. These included assurance that all patients receiving high risk medicines had been appropriately monitored and the absence of a managed approach for the review of action taken in relation to patient safety alerts received. In addition, the practice had not undertaken a risk assessment for legionella, ensured all staff recruitment processes were sufficiently in place and some staff undertaking chaperoning duties had not received training and DBS check or risk assessment.

Leadership and culture

The practice was led by two GP partners who were supported by other clinical staff, a practice manager and reception manager.

Areas were identified where strong leadership was required to ensure an effective and consistent approach to all issues was adopted by practice management.

The provider was aware of and had systems in place to ensure compliance with the requirements of the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).This included support training for all staff on communicating with patients about notifiable safety incidents. The partners encouraged a culture of openness and honesty. The practice had systems in place to ensure that when things went wrong with care and treatment:

- The practice gave affected people reasonable support, information and a verbal or written apology.
- The practice kept written records of verbal interactions as well as written correspondence.

There was a leadership structure in place and staff felt supported by management.

- The practice partners told us they did not adopt a hierarchical approach and they valued all their staff.

Are services well-led?

Inadequate

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

- Staff told us the practice held regular team meetings. We were provided with a sample of minutes taken from these meetings.
- Staff told us there was an open culture within the practice and they had the opportunity to raise any issues at team meetings.
- Staff said they felt respected and supported, particularly by the partners in the practice. We noted that two nurses had received support from the practice to qualify as nurse practitioners. The reception manager had also received promotion to take on this role. We did however note that staff appraisals were overdue for completion.

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

- The practice did not have a patient participation group (PPG). The PPG are a group of patients who work together with the practice staff to represent the interests and views of patients so as to improve the service provided to them. We were informed that the practice had advertised for a PPG but had not recruited any members. A recent visit by the Healthwatch team had identified a number of patients who stated they would be interested in joining the PPG and left their contact details. The practice had not yet made contact with the patients at the time of our inspection taking place.
- The practice had however, reviewed feedback from the national survey, Friends and Family test, Healthwatch report findings and from complaints received. As a result, improvements were implemented. For example, patients had complained about not being able to hear their names called clearly on the tannoy system. This led to the practice replacing the unit. The issue remained unresolved and the practice were seeking to change to a new system whereby names would be listed on screens.
- Staff told us they could informally provide feedback if necessary and discuss any concerns or issues with colleagues or management.

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 arrangements for assessing the risks to the health and safety of service users receiving care or treatment were not sufficiently in place. For example, we identified that not all patients prescribed with high risk medicines had been subject to regular monitoring to ensure their health needs and requirements were met. The system for the action of patient safety alerts did not ensure that all alerts were reviewed and action was taken to minimise the risks to patient safety. This was in breach of regulation 12 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **How the regulation was not being met:** The provider had not ensured that suitably competent and skilled persons were deployed. For example, staff had not received regular appraisal and not all nursing staff had undertaken Mental Capacity Act training. This was in breach of regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed

This section is primarily information for the provider

Requirement notices

Maternity and midwifery services

Surgical procedures

Treatment of disease, disorder or injury

How the regulation was not being met:

The provider had not ensured that all required documentation and information required was available in respect of staff members working within the service.

This was in breach of regulation 19 (1) and Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

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 arrangements in place to assess, monitor and improve the quality and safety of the services provided were not operating effectively enough. For example, the provider had not assessed the risk by a competent person and then mitigated any risk presented by legionella. The provider had assessed the risk of staff undertaking chaperone duties but had not ensured that all staff undertaking chaperone duties had received training and a Disclosure Barring Service check (DBS) as identified in their assessment. The provider had not ensured it had systems sufficiently in place for assessing and monitoring the safety and quality of the service provision. The provider had not established a system or process to improve the quality of the service for its patients with learning disabilities. This was in breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.