The Woottons Surgery

Quality Report

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Date of inspection visit: 23 March 2015
Date of publication: 16/07/2015

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?	Good
Are services well-led?	Requires improvement

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We inspected The Woottons Surgery on 23 March 2015 as part of our comprehensive inspection programme. Overall the practice is rated as requires improvement. Specifically, we found the practice to require improvement for providing safe, effective and well led services. It was good for providing a caring and responsive service. Due to the improvement required under the aforementioned domains it results in the practice being rated as requires improvement for the care to older patients, patients with long term conditions, patients in vulnerable circumstances, families, children and young patients, working age patients and patients experiencing poor mental health. Our key findings were as follows:

- Risks to patients were assessed and well managed with the exception of those relating to recruitment checks.
- Data showed patient outcomes were average for the locality. Although some audits had been carried out, we saw no evidence that audits were driving improvements in performance or patient outcomes.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- The practice had a number of policies and procedures to govern activity, but the practice did not hold regular governance meetings.

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

- Carry out staff Disclosure and Barring Service checks for staff caring for patients.
- Improve and align staff records to include evidence of qualifications and training.

And the provider should:

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- Take steps to improve the take up of annual health checks of people with a learning disability.
- Implement effective procedures to disseminate, and ascertain all relevant staff are familiar with, national patient safety alerts.
- Implement effective systems for all practice staff to record, review and learn from significant events.
- Carry out a risk assessment for the need to test for legionella.
- Ensure resuscitation training is up to date for all staff.
- Provide chaperone training for those staff that require this.
- Implement an effective clinical audit programme which demonstrates improved outcomes for patients.
- Improve performance reviews for staff and implement effective development plans for all staff.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

The practice is rated as requires improvement for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. However, when things went wrong, reviews and investigations were not thorough enough and lessons learned were not communicated widely enough to support improvement. Although risks to patients who used services were assessed, the systems and processes to address these risks were not implemented well enough to ensure patients were kept safe. There were enough staff to keep patients safe.

Are services effective?

Requires improvement

The practice is rated as requires improvement for providing effective services, as there are areas where improvements should be made. Care and treatment was delivered in line with recognised best practice standards and guidelines. There were no completed audits of patient outcomes. We saw no evidence that audit was driving improvement in performance to improve patient outcomes. Multidisciplinary working was taking place but record keeping was limited or absent.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients were overall satisfied with the care they received from the practice. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. We saw that the practice had taken steps to ensure information was accessible to patients. During our inspection we saw that staff treated patients with kindness and respect and maintained confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS England Area Team and clinical commissioning group (CCG) to secure improvements to services where these were identified. The practice had good facilities and was well equipped to treat patients and meet their needs. To those who required them, the practice offered onsite additional services therefore removing the need for patients to travel elsewhere. These services included phlebotomy and warfarin clinics. Learning from complaints with staff and other stakeholders took place.

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Are services well-led?

Requires improvement 

The practice is rated as requires improvement for well-led. Staff strived to achieve the common goal of patient focused quality care. The practice had a number of policies and procedures to govern activity but did not hold regular governance meetings. The practice proactively sought feedback from staff and patients, which it acted on. There was limited evidence that staff had received inductions and performance reviews. The practice offered no evidence of recent staff meetings and events other than standard multidisciplinary team meetings.

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 was rated as requires improvement in the domains of safe, effective and well-led. The concerns which led to these ratings apply to everyone using the practice, including this population group. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in end of life care. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs. Monthly multi-disciplinary meetings were held to identify the best ways to provide care to older people and, where appropriate, to avoid them going into hospital. Continued monitoring helped to ensure that older patients received the right treatment and care when they needed it. We spoke with a representative from five care homes where residents were patients at the practice. All of them told us that the practice offered effective care to their residents. A designated GP provided care to local care homes and held annual visits there in addition to the responsive visits. Older patients had a named GP and had the opportunity to take up the offer of a shingles vaccine.

People with long term conditions

Requires improvement

The practice was rated as requires improvement in the domains of safe, effective and well-led. The concerns which led to these ratings apply to everyone using the practice, including this population group. There were emergency processes in place and referrals were made for patients whose health deteriorated suddenly. The practice offered nurse led smoking cessation services. Longer appointments and home visits were available when needed. For those patients with the most complex needs, the practice worked with relevant health and care professionals to support patients. The practice supported patients to manage a range of long term conditions in line with best evidence based practice.

Families, children and young people

Requires improvement

The practice was rated as requires improvement in the domains of safe, effective and well-led. The concerns which led to these ratings apply to everyone using the practice, 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, vulnerable children. Immunisation rates were generally

Summary of findings

high for all standard childhood immunisations. Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this. Babies received six week post natal checks. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with health visitors, especially around safeguarding elements.

Working age people (including those recently retired and students)

Requires improvement

The practice was rated as requires improvement in the domains of safe, effective and well-led. The concerns which led to these ratings apply to everyone using the practice, including this population group. The needs of the working age population, those recently retired and students had been identified and the practice had previously provided extended hours, these were withdrawn following a low uptake of these appointments by this patient group. Telephone consultation had been made available instead. The practice provided the option of online booking for appointments. Health promotion and screening that reflected the needs for this age group was taking place.

People whose circumstances may make them vulnerable

Requires improvement

The practice was rated as requires improvement in the domains of safe, effective and well-led. The concerns which led to these ratings apply to everyone using the practice, including this population group. The practice held a register of patients living in vulnerable circumstances including those with a learning disability. It had carried out annual health checks and offered longer appointments for people that required this. However there was scope to better support patients with a learning disability to attend their review. 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. The practice had access to translation services and a hearing aid loop.

People experiencing poor mental health (including people with dementia)

Requires improvement

The practice was rated as requires improvement in the domains of safe, effective and well-led. The concerns which led to these ratings apply to everyone using the practice, including this population group. Clinicians provided empathetic and responsive care to patients with poor mental health. Patients experiencing poor mental health were invited to attend the practice for different physical health checks. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental

health, including those with dementia. It carried out advance care planning for patients with dementia. The practice had advised patients experiencing poor mental health about how to access various support groups and it had a system in place to follow up patients who had attended accident and emergency (A&E) where they may have been experiencing poor mental health.

Summary of findings

What people who use the service say

Prior to our inspection we arranged for a comment box to be left at the practice for patients to provide us with written feedback on their experience and views about the service provided. We received 46 completed comment cards of which 38 were positive, seven were generally positive with negative comments regarding access to appointments and one was negative around the care a patient received. We spoke with two patients during our inspection, including one member from the patient participation group (PPG). The PPG is a group of patients registered with the practice who have no medical training, but have an interest in the services provided. PPGs are a means for patients and GP practices to work together to improve the service and to promote and improve the quality of care. The patients we spoke with told us that they trusted staff at the practice and that they felt that they received a good level of care. One patient expressed their opinion that the practice provided a "sincere" service and that the GPs and nurses ensured that patients were seen and that their needs were met as conveniently and quickly as possible. The comment cards reflected these views, most with very positive comments around the staff and their professionalism, friendliness and helpfulness. Although the PPG was in existence it was at a reduced capacity due to a lack of engagement from patients to participate in the PPG. The PPG member told us that there was a plan to restart the PPG recruitment following the upcoming merger with Southgates Medical and Surgical Centre.

Areas for improvement

Action the service MUST take to improve

- Carry out staff Disclosure and Barring Service checks for staff caring for patients.
- Improve and align staff records to include evidence of qualifications and training.

Action the service SHOULD take to improve

- Take steps to improve the take up of annual health checks of people with a learning disability.
- Implement effective procedures to disseminate, and ascertain all relevant staff are familiar with, national patient safety alerts.
- Implement effective systems for all practice staff to record, review and learn from significant events.
- Carry out a risk assessment for the need to test for legionella.
- Ensure resuscitation training is up to date for all staff.
- Provide chaperone training for those staff that require this.
- Implement an effective clinical audit programme which demonstrates improved outcomes for patients.
- Improve performance reviews for staff and implement effective development plans for all staff.

The Woottons Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

a CQC lead inspector. The team included a GP specialist advisor and a second CQC inspector.

Background to The Woottons Surgery

The Woottons Surgery in Priory Lane, North Wootton provides services to patients living in North Wootton as well as the surrounding towns and villages, including Kings Lynn. The practice holds a Personal Medical Services (PMS) contract. The practice is managed by an individual GP who also holds the role of registered manager within the practice. The practice employs two salaried GPs, a long term locum GP, two nurse practitioners, two nurses, a nurse manager, a trainee phlebotomist/receptionist, a reception and administration team, two assistant practice managers and four housekeepers. The Woottons Surgery is located in a building which is used solely by the practice and serves a population of approximately 5,400. GP appointments are available every weekday between 8.30am and 12.30pm and 3pm and 5.30pm. The GP told us that they had tried extended opening but had stopped this service due to lack of interest from working age patients at whom this service was aimed. The practice operated a doctor call back service where a patient could request to speak with a doctor instead of attending in person. This service was available between 8.30am and 9.30am Monday to Friday. The practice website clearly details how patients may obtain services out-of-hours. The practice was going through the process of merging with another local practice: Southgates Medical and Surgical Centre. At the time of our inspection the merger had not yet occurred but was planned to take place on 01 April 2015. This meant that the merger will have taken place before this report is published. This report is reflective of our findings at The Woottons Surgery during our inspection. Representatives of Southgates Medical and Surgical Centre were present during our inspection and were informed of this report being written in relation to our findings on the day of inspection. There was a sincere interest from all parties present at the inspection to learn from the inspection and to take any findings forward post-merger.

Why we carried out this inspection

We inspected this service as part of our comprehensive inspection programme. We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014. Please note that when referring to information throughout this report, for example any reference to the Quality and Outcomes Framework data, this relates to the most recent information available to the CQC at that time.

How we carried out this inspection

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?

Detailed findings

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

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

- Older people
- People with long-term conditions
- Families, children and young people
- Working age people (including those recently retired and students)
- People living in vulnerable circumstances
- People experiencing poor mental health (including people with dementia)

Before inspecting, we reviewed a range of information we hold about the practice and asked other organisations such as the local Clinical Commissioning Group (CCG) and the NHS England Area Team. The CCG and NHS England are both commissioners of local healthcare services. We carried out an announced inspection on 23 March 2015. During our inspection we spoke with a range of staff: reception, administrative and clinical staff. We also spoke with patients who used the service, including one representative of the patient participation group (PPG). The PPG is a group of patients registered with the practice who have no medical training, but have an interest in the services provided. PPGs are an effective way for patients and GP practices to work together to improve the service and to promote and improve the quality of care. We reviewed comment cards which we had left for patients and members of the public to share their views and experiences of the service. We also reviewed a range of different records held by the practice.

Requires improvement

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents, national patient safety alerts and complaints. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. For example staff had reported a delay in referring a patient to an outpatient appointment and we saw that the practice had acted on this and improved its systems to make sure referrals were made in a timely manner. We reviewed safety records, incident reports and minutes of meetings where these were discussed. We saw that incidents and complaints were a standing agenda item in the monthly management meetings. However meeting minutes had not been taken since November 2013. The interim practice manager told us that they had recently completed a review of significant events for the past year and we saw records that confirmed this. They also told us that discussion at monthly management meetings had been recommenced and would be strengthened following the merger with Southgates Medical and Surgical Centre.

Learning and improvement from safety incidents

The practice had systems in place for reporting, recording and monitoring significant events. The practice kept records of significant events that had occurred and these were made available to us. A clinical meeting to review significant events (SE) was held once in the previous 18 months, two weeks prior to our inspection. We saw evidence that the practice had reviewed actions from past significant events and complaints. There was evidence that appropriate learning had taken place where necessary and that the findings were disseminated to relevant staff. For example, a recent incident involving a delay of referring a patient to secondary services due to an administrative error had led to an emphasis on diligence in following processes to reduce the risk of recurrence. All clinical and non-clinical staff we spoke with were aware of the system for raising issues and felt encouraged to do so. Staff used incident forms on the practice intranet and sent completed forms to the practice management. As only one meeting focussed on reviewing SE's had taken place in the last 18 months we found there was a lack of evidence on the cascading of learning from SEs. Staff told us that despite the lack of SE meetings, the SEs were dealt with in an appropriate manner, which we saw evidence of. For example, a patient had received instructions from an external health provider to follow up their care at the surgery but the provider had failed to inform the practice of the treatment the patient had received. As a result the practice filed a complaint against the other provider and gathered the information themselves. Staff told us that relevant staff were informed verbally about SE's. The practice acknowledged there was scope to improve the audit trail for this ongoing learning in order to ensure that issues had been cascaded to and discussed with all relevant staff. Where patients had been affected by something that had gone wrong, in line with practice policy, they were given an apology and informed of the actions taken. The practice did not have a robust system in place for the effective dissemination of national patient safety alerts to practice staff. We were informed by staff that they were provided with a paper copy of national patient safety alerts. All staff we spoke with were aware that safety alerts did get raised but not all clinical staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for. One member of staff told us that taking action following alerts was the responsibility of any registered individual to deal with appropriately. We were not shown a track record of alerts which had been disseminated. We were told by one of the GPs that action was being taken following information in a recent safety alert regarding Pregabalin (an anticonvulsant medicine) prescribing. We saw evidence of action being taken during our inspection.

Reliable safety systems and processes including safeguarding

Systems were in place to safeguard children and adults. A designated GP was the practice lead for safeguarding children and vulnerable adults. Safeguarding policies and procedures were consistent with local authority guidelines and included local authority reporting processes and contact details. The lead GP had undertaken training appropriate to their role. From the records we viewed we were not able to confirm that all staff had received training in the safeguarding of children and vulnerable adults at a level appropriate to their roles. Staff we spoke with demonstrated a good understanding of safeguarding children and vulnerable adults and the potential signs to indicate a person may be at risk. Staff described an open culture within the practice whereby they were encouraged and supported to share information within the team and to report their concerns. Information on safeguarding and

domestic abuse was displayed in the patient waiting room and other information areas. There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments; for example children subject to child protection plans. The lead safeguarding GP was aware of vulnerable children and adults records and demonstrated good liaison with partner agencies such as health visitors during monthly multidisciplinary meetings, of which we saw minutes. A chaperone policy was in place and information was displayed in the waiting room, at reception and in consulting and treatment rooms. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). Staff told us that no specific training had been undertaken by health care assistants who acted as chaperones when nursing staff were unavailable. Non-clinical staff confirmed they did not act as chaperones.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. We spoke with one of the nursing team who was designated as the lead for the management of medicines used at the practice. We saw that all medicines that were in general use were all securely stored in locked cupboards or fridges as appropriate. This included medicines used for managing pain, vaccines and local anaesthetics used during minor surgery. We saw records that showed that all medicines were subject to a monthly check to ensure they remained within their expiry dates and to monitor the stock levels of medicines that were regularly used. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations. The practice did not maintain a stock of controlled drugs. Temperature sensitive medicines, such as vaccines, were kept in locked fridges from the time they arrived and were checked in. We noted that there was a vaccine rotation system in place that ensured the vaccines were used in date order. The fridge temperatures were monitored to ensure the vaccines were stored safely and remained fit for use. However, when asked staff were not able to show us a written procedure that described the process for safe handling of temperature sensitive medicines. Vaccines were administered in accordance with directions that had been produced in line with legal requirements and national guidance. We saw up-to-date copies of these directions. All prescriptions were reviewed and signed by a GP before they were given to the patient. Individual blank prescription sheets were handled in accordance with national guidance.

Cleanliness and infection control

We observed the premises to be visibly clean and tidy. The practice employed two cleaners who cleaned the practice on a daily basis following a cleaning schedule. We saw these cleaning schedules were in place and cleaning records were kept. For example, we saw records had been completed in February 2015 on the cleaning of all practice areas. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control. The practice had a newly appointed lead for infection control. Despite having not undertaken further training to enable them to provide advice in the practice, they demonstrated a good understanding of this element of their role. Infection control policies and procedures were in place. We asked to see evidence that staff had received training in infection control processes and staff informed us this had not taken place recently. All staff we spoke with were aware of infection control practices. The practice manager informed us that staff who had not yet received up to date training would receive this in the (near) future but would have received this training previously in their role specific education. An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. Personal protective equipment (PPE) including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these to comply with the practice's infection control policy. Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms. We saw a notice indicating the availability and presence of suitable baby changing facilities. Spillage kits were available from the cleaning area, including a mercury spillage kit. We saw records to confirm that patient privacy curtains were changed on a regular basis. The practice used only single use instruments for all minor operations they performed. The practice had a policy for the management, testing and investigation of legionella (a term for particular bacteria which can contaminate water systems in buildings) but did not have any certificates in place evidencing recent testing;

staff were unable to confirm this had been done. There was no risk assessment in place to address this but we were informed following our inspection that the practice would address this within the two weeks following our inspection. We saw that the practice had arrangements and notices in place for the segregation of clinical waste at the point of generation. Sharps containers were available in all consulting rooms and treatment rooms, for the safe disposal of sharp items, such as used needles. During the inspection we saw records showing staff immunisation against Hepatitis B.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. We found that the practice had sufficient stocks of equipment and single-use items required for a variety of clinics, such as the respiratory and diabetes clinic. Staff told us that all equipment was tested and maintained regularly and we saw equipment maintenance records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. Testing was overdue by three months but we were shown an action plan that this would be addressed by mid April. We saw evidence (certificates) that calibration of relevant equipment was up to date.

Staffing and recruitment

Records we looked at contained evidence that the majority of appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, qualifications and registration with the appropriate professional body. We asked to see current Disclosure and Barring Service (DBS) checks for clinical staff and were informed that evidence of these was not in place, with the exception of one member of staff. We were shown an action plan indicating that all staff were to undergo a DBS check with evidence submission to the local authorities in the next month. As part of the upcoming merger the practice reassured us that DBS checks would be performed on every member of staff caring for patients. The practice had a recruitment policy and employee handbook that set out the standards it followed when recruiting clinical and non-clinical staff. We saw that clinical staff had up to date registration with the appropriate professional bodies. Staff told us about the arrangements for planning and monitoring the number and mix of staff needed to meet patients' needs. There was an arrangement in place for members of the nursing and administrative staff to cover each other's roles. Staff we spoke with confirmed that this happened and these arrangements worked well. Staff told us there was enough staff to maintain the smooth running of the practice and there were always enough staff on duty to ensure patients were kept safe. A new GP was due to start work at the practice five weeks after our inspection, which staff told us would help with the clinical workload.

Monitoring safety and responding to risk

The practice had considered the risks of delivering services to patients and staff and had implemented systems to reduce risks. We reviewed a comprehensive risk register that was in place. This included assessment of risks associated with fire safety, IT system failure and staff sickness. The risk register had been recently reviewed and updated. We spoke with both clinical and non-clinical staff about managing risks and found that they had the skills to safeguard patient safety. We observed that the practice environment was organised and tidy. Safety equipment such as fire extinguishers and defibrillators were checked and sited appropriately and the last fire alarm test was done one week before our inspection. Health and safety information was displayed for staff to see and CCTV was active within communal areas of the premises. We saw that staff were able to identify and respond to changing risks to patients including any deteriorating health and well-being or medical emergencies. The practice performed annual medication reviews for patients with long term conditions such as diabetes and chronic obstructive pulmonary disease (COPD – severe shortness of breath caused by chronic bronchitis, emphysema). These were monitored by the reception staff, who flag these up with the GPs.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Medical equipment including defibrillators and oxygen were available for use in the event of a medical emergency. The equipment was checked daily to ensure it was in working condition. All staff had received training in basic life support and defibrillator training to enable them to respond appropriately in an emergency. The basic life support training for clinical staff had occurred but was recently overdue for renewal; there was an action plan in place indicating this would be done shortly after our inspection. Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included medicines for the treatment of

Requires improvement

Are services safe?

cardiac arrest, anaphylaxis and hypoglycaemia. Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use. Staff explained how they responded to patients experiencing an emergency medical situation, including supporting them to access emergency care and treatment. A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included loss of utilities, loss of medical records and response to a major incident. The document also contained relevant contact details for staff to refer to. For example, contact details of IT engineers should the IT system failed. The plan included action cards for different members of staff, detailing what to do in case of activation of the plan and a copy was kept off-site so that it was always accessible. The practice had carried out a fire risk assessment and records showed that all staff were up to date with fire training.

Requires improvement

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Care and treatment was delivered in line with recognised best practice standards and guidelines. The practice ensured they kept up to date with new guidance, legislation and regulations. The GPs and nursing staff we spoke with could clearly outline the rationale for their treatment approaches. They were familiar with current best practice guidance, accessing guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. NICE guidelines were electronically available on the practice's intranet and were also circulated by the receiving GP, who reviewed incoming guidelines for required action. We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs, in line with NICE guidelines and these were reviewed when appropriate. The GPs and nurses reviewed and supported patients with long-term conditions like diabetes, heart disease and asthma. The practice employed two nurse practitioners who specialised in the on-going care and support for patients with long term conditions, with support from the GPs, which allowed the practice to focus on specific conditions. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support. GPs told us this supported all staff to continually review and discuss new best practice guidelines. However, we found no evidence of formal recent educational meetings or continuous performance monitoring for clinical staff. Staff we spoke with confirmed this did not take place. Staff explained they maintained awareness of guidelines on their own initiative or were handed paper copies of updates. Staff felt that they could approach colleagues or seniors as and when required and acknowledged that the performance monitoring would improve following the imminent merger with Southgates Medical and Surgical Centre. The senior GP partner explained to us that data from the local CCG showed that the practice's performance for antibiotic prescribing was better than local practices. The practice used computerised tools to identify patients with complex needs who had multidisciplinary care plans documented in their case notes. A GP explained the process the practice used to review patients discharge letters from hospital, which were reviewed within 48 hours by their GP. Discrimination was avoided when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were cared for and treated based on need and the practice took account of patient's age, gender, race and culture as appropriate.

Management, monitoring and improving outcomes for people

Information about people's care and treatment, and their outcomes, was routinely collected and monitored and this information used to improve care. Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews and managing child protection alerts and medicines management. The practice routinely collected information about patient care and treatment outcomes. Blood results, hospital discharge summaries, accident and emergency reports and reports from out of hours services were seen and acted upon by a GP on the day they were received. In the absence of a patient's named GP, the duty GP within the practice was responsible for ensuring the timely processing of these reports. We were told the practice's office staff followed these up to ensure completion. We saw evidence that these were acted on within 48 hours. The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. For example, 88.7% of patients with diabetes had a record of retinal screening in the preceding 12 months, which was above the CCG average. The practice achieved 80.6% of the maximum 2013/14 Quality and Outcomes Framework (QOF) results. QOF is a voluntary incentive scheme which rewards practices for how well they care for patients. The practice used QOF to assess its performance. QOF data showed the practice performed lower in comparison to the national and local average overall; considerably low in some areas (for example for depression, hypertension and learning disabilities) but above average in some others (for example for asthma, epilepsy and palliative care). The practice had a system in place for undertaking clinical audit cycles and had instigated several audits. None were yet complete. Examples of clinical audits included a bladder cancer audit, an effectiveness of Zoladex implants (hormonal therapy for certain cancer treatments) audit and a palliative care audit. As none of the audits in the last 12 months had been completed the practice was unable to demonstrate actual evidence of learning resulting in improved patient care since the initial audit. Staff we spoke with confirmed this but explained that due to other

Requires improvement

Are services effective?

(for example, treatment is effective)

priorities the audits had not been proactively addressed recently. A prescribing quality update from the clinical commissioning group indicated that the practice compared equally to other local practices and a review of prescribing data, for example, patterns of antibiotic and hypnotics within the practice showed that the practice performance was in line with national trends.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all administrative staff were up to date with mandatory training such as annual basic life support. The basic life support training for clinical staff had occurred but was recently overdue for renewal; there was an action plan in place indicating this would be done shortly after our inspection. All GPs were up to date with their yearly continuing professional development requirements and all either had been revalidated or had a date for revalidation (every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England). Most staff had not received annual appraisals that identified learning needs from which action plans were documented. For those staff whose appraisals were due, the practice management told us plans were in place to complete these. Our interviews with staff confirmed that the practice was proactive in providing development through open discussion and training (courses), for example spirometry courses were planned for two nurses. The practice had appointed a nurse lead nurse for infection prevention and control three months previously and although training was yet to be undertaken, they informed us this was planned. Most reception and administrative staff had undergone training relevant to their role. For example, records evidenced they had received training in patient confidentiality. We found that staff files and training records were incomplete and did not demonstrate a comprehensive overview of training delivered across the practice and as such we did not see enough evidence of training relevant to staff roles. Staff described feeling well supported to develop further within their roles. Two members of staff had been developed and promoted internally to new positions. For example, a former receptionist was now working towards becoming a health care assistant and a practice nurse was promoted to nurse manager. All staff we spoke with explained that they understood the pressure the GPs were under and were highly expectant that the upcoming merger would improve their training and development programmes.

Working with colleagues and other services

We found the practice worked with other service providers to meet patient needs and support patients with complex needs. The practice effectively identified patients who needed on-going support and helped them plan their care. For example, the practice had developed effective working relationships with local care homes. One of the GPs visited each care home on an annual basis to carry out patient reviews, or more frequently as required. All the residents had care plans in place. Anticipatory care planning for those patients reflected the patients' wishes relating to unplanned hospital admission avoidance and palliative care. We spoke with five care homes that the practice had patients at and they all confirmed the GPs were easily accessible and provided a good level of care. GPs at the practice had proactively delivered training to staff in a local care home to support them to deal with deaths appropriately. A representative from the care home confirmed that this had enabled them to provide an improved level of care for the patient and their family The GPs readiness to visit and these interactions helped to build trust between the practice and the care homes so that they were better able to manage problems 'over the phone' rather than actually have a physical visit from the GP. All the care homes we spoke with spoke in high regard about the practice. The practice held multidisciplinary team meetings monthly to discuss patients with complex needs, for example those with palliative care needs or children at risk. These meetings were attended by community matrons, district nurses, social workers and palliative care nurses. Decisions about care planning were documented in notes and action plans. Staff felt this system worked well and remarked on the usefulness of the forum as a means of sharing important information. The practice participated in all the enhanced service from the clinical commissioning group (CCG), Public Health and NHS England (Enhanced services require an enhanced level of service provision above what is normally required under the core GP contract).

Information sharing

There was effective communication, information sharing and decision making about a patient's care across all of the services involved both internal and external to the

Requires improvement

Are services effective?

(for example, treatment is effective)

organisation, in particular when a patient had complex health needs. Care was delivered in a co-ordinated and integrated manner with appropriate sharing of patient sensitive data. There were arrangements to receive hospital summaries of recently discharged patients. These were directed to the relevant GP for their review and any follow up action. The practice used electronic systems to communicate with other providers; staff reported that this system was easy to use. The practice had systems to provide staff with the information they needed. Staff used an electronic patient record system to coordinate, document and manage patients' care. All staff were fully trained on the system, and commented positively about the system's safety and ease of use. The practice had a system to communicate with other providers. We saw evidence of information sharing, for example with the out-of-hours service, palliative care team and the Macmillan service.

Consent to care and treatment

Patients we spoke with told us that the GPs and nurses always obtained consent before any examination took place. We found that staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice. The practice had a consent policy to help staff with highlighting how patients should be supported to make their own decisions and how these should be documented in the medical notes. Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they and / or their carers were involved in agreeing. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it).When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision. All clinical staff we spoke with demonstrated a clear understanding of Gillick competencies (these are used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions). There was a practice policy for documenting consent. For example, expressed consent (written or verbal) was obtained for any procedure which carried a risk that the patient would likely consider as being substantial. A note was made in the medical record detailing the discussion about the consent and the risks. The practice consent policy gave clear guidelines to staff in obtaining consent prior to treatment. The policy also gave guidance about withdrawal of consent by a patient. A form was available to record consent where appropriate. The GPs we spoke with told us they always sought consent from patients before proceeding with treatment. GPs told us they gave patients information on specific conditions to assist them in understanding their treatment and condition before consenting to treatment.

Health promotion and prevention

It was practice policy to offer a health check to all new patients registering with the practice. The GP was informed of all health concerns detected and these were followed up in a timely way. We noted a culture among the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example the practice had identified the smoking status of patients with physical and or mental health conditions and had opportunistically offered smoking cessation advice. The practice carried out a range of national vaccination programmes such as seasonal flu for eligible patients and childhood immunisations. Uptake evidence we reviewed showed that the practice was performing to the expected targets. Patients with long term conditions such as coronary heart disease, diabetes and respiratory conditions were regularly monitored. Patients with learning disabilities and mental ill-health were offered an annual physical health check and an agreed care plan. This was a proactive process managed by a member of staff designated as recall clerk and supervised by one of the management team. However practice data showed that this process could be improved as not all these patients had an agreed care plan. The evolving needs of every patient receiving care at the end of their lives were discussed during primary health care team meetings. At these meetings the needs of the relatives of terminally ill patients was also considered. We also noted that patients who were caring for others were identified at the point of their registration as new patients and provided with information about other local services which was also available on the practice website. The practice had numerous ways of identifying patients who needed additional support and it was proactive in offering additional help. For example, the practice kept a register of all patients with a learning disability. However, records showed that only 12 out of 23 of these patients had received a check up in the last 12 months. We saw that 13 out of 14 patients with mental health needs had care plans

Requires improvement

Are services effective?

(for example, treatment is effective)

in place. The practice also actively offered nurse-led smoking cessation clinics to patients. The practice's performance for cervical smear uptake was 88.9%, which was better than the national average. There was a process to offer telephone reminders for patients who did not attend for cervical smears and there was a named nurse responsible for following up patients who did not attend screening.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the 2013/2014 GP satisfaction survey and the GP patient open survey last updated in January 2015. The GP patient open survey indicated that 83% of patients described their overall experience of this surgery as good with 98% saying the last nurse they saw or spoke to was good at treating them with care and concern. Data from the 2013/2014 GP satisfaction survey showed the practice was rated slightly higher than the national average for patients who stated that they always or almost always see or speak to the GP they prefer, with 80.7% of practice respondents saying that the last time they saw or spoke to a GP, the GP was good or very good at treating them with care and concern and 87.4% stated that the last time they saw or spoke to a nurse, the nurse was good or very good at involving them in decisions about their care.86% of patients described the overall experience of their GP surgery as fairly good or very good. This was just above the national average. Patients completed CQC comment cards to tell us what they thought about the practice. We received 46 completed comment cards of which 38 were positive, seven were generally positive with negative comments regarding the obtaining of appointments and one was negative around a delay in specific care received. We spoke with two patients during our inspection, including one member from the patient participation group (PPG). The PPG is a group of patients registered with the practice who have no medical training, but have an interest in the services provided. PPGs are a means for patients and GP practices to work together to improve the service and to promote and improve the quality of care. The patients we spoke with told us that they trusted staff at the practice and that they felt that they received a good level of care. One patient expressed their opinion that the practice provided a sincere service and that GPs and nurses ensured that patients were seen and that their needs were met as conveniently and quickly as possible. The comment cards reflected these views, most with very positive comments around the staff and their professionalism, friendliness and helpfulness. GPs and staff had received training on information governance. Staff had a good understanding of confidentiality and how it applied to their working practice. For example, reception staff spoke discretely to avoid being overheard and a sign on the reception desk politely requested that patients waiting to speak with a receptionist stood away from the desk to allow the patient before them some privacy. Staff respected patients and preserved their dignity and privacy. Privacy curtains were in place in every consultation room. We noted that consultation and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard. We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. The practice switchboard was located at the reception desk which potentially inhibited keeping patient information private, but we observed the receptionist talking in controlled quiet voices during our inspection. The waiting room was located in a separate area but the two were note isolated from each other. Music was playing in the waiting room to help discussions from being overheard.

Care planning and involvement in decisions about care and treatment

The GP patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment by the GPs and generally rated the practice well, but just below average, in these areas. For example, data from the national patient survey showed 71.8% of practice respondents said the GP involved them in care decisions and 80.7% felt the GP was good or very good at treating them with care and concern. For nurses this was higher than the national average at 87.4% and 96.5% respectively. Patients we spoke with on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. Patient feedback on the comment cards we received was also positive and aligned with these views. Staff told us that translation services were available for patients who did not have English as a first language. There was a hearing loop available for patients with hearing aids.

Patient/carer support to cope emotionally with care and treatment

The patients we spoke with on the day of our inspection and the comment cards we received were consistent with highlighting that staff responded compassionately when

Good

Are services caring?

they needed help and provided support when required. Information in the patient waiting room told patients how to access a number of support groups and organisations, including bereavement support. The practice's computer system alerted GPs if a patient was also a carer. We saw the written information available for carers to ensure they understood the various avenues of support available to them. Staff told us that if families had suffered a bereavement, their usual GP contacted them. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service. The practice recognised the support needs for young carers but had none on its register at the time of our inspection.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patients' needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered. The practice offered on-line prescribing and appointment booking. Care and support was offered on site and at local care homes for the elderly to ensure that the needs of these patients were identified and met. Joint working arrangements were in place with the West Norfolk Carers Service to support carers and to make use of the practice facilities. The patient participation group (the PPG is a group of patients registered with the practice who have no medical training, but have an interest in the services provided. PPGs are a means for patients and GP practices to work together to improve the service and to promote and improve the quality of care) was at reduced capacity due to a lack of engagement from patients but supported the practice to improve. Two weeks previous to our inspection the practice had held a public meeting announcing the proposed merger with Southgates Medical and Surgical Centre. The meeting was opened by a PPG representative and attended by in excess of 140 local residents. The practice had signed up to the clinical commissioning group's (CCG's) enhanced services and this encouraged the practice to regularly engage with the CCG and other practices to discuss local needs and service improvements that needed to be prioritised. The practice offered onsite additional services to avoid, those requiring this, having to travel elsewhere, including physiotherapy, midwifery, phlebotomy and weekly anti coagulation clinics. The practice provided extra Saturday clinics when carrying out its annual flu vaccinations to which patients were invited to attend. The practice provided a blood pressure machine loan service to help patients monitor their blood pressure if so required.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. Five local care homes we spoke with informed us that the practice delivered a good quality of care and that the GPs were accessible. The practice told us that over the years they had built up trust and improved health issues by understanding the affluence of the population they served. The practice held monthly multi-disciplinary meetings with health professionals, including health visitors and community nurses. These meetings included discussions on supporting patients whose circumstances make them vulnerable, including vulnerable children. The practice had access to translation services if required. An induction loop was provided at the practice for patients who had a hearing impairment. The premises and services were accessible for patients with a physical disability and patient services were all on the ground floor. The receptionist told us that the member of staff working on the front desk would always provide assistance if required. We saw that the waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice. We asked to see evidence that equality and diversity training had been provided and staff confirmed that it had not. Nevertheless staff we spoke with demonstrated a good understanding of the core principles. An equality and diversity policy was in place.

Access to the service

The practice was open Monday to Friday between 8.30am and 12.30pm and between 3pm and 5.30pm. The practice did not operate extended opening hours. The GP told us that they had tried extended opening hours but had stopped this service due to lack of interest from working age patients at whom this service was aimed. The practice staff told us this didn't address the access needs as they had expected and decided to withdraw the extended hours. The practice operated a doctor call back service where a patient could request to speak with a doctor instead of attending in person. This service was available between 8.30am and 9.30am Monday to Friday. Patients could book appointments online, over the phone or in person. Comprehensive information was available to patients about appointments on the practice website and within the practice information leaflet. Information provided included how to arrange urgent appointments and home visits. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, a recorded message gave the telephone number they should ring for the out-of-hours service. Longer appointments were also available for people who needed them including those with long-term conditions. This also included appointments with a named GP or

Good

Are services responsive to people's needs?

(for example, to feedback?)

nurse. Home visits were available to patients who were unable to attend the practice including patients who lived in care homes. Patients were generally satisfied with the appointments system. Information from the national GP patient survey, published in January 2015, showed that 87% of those who responded were able to get an appointment to see or speak to someone, which was similar to other practices locally.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. The complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. This was available on the intranet for all staff to access at any point. Lessons learned from individual complaints had been recognised and acted on. There was a designated responsible person who handled all complaints in the practice. We saw that information was available to help patients understand the complaints system. This was displayed in the practice, in the practice leaflet and on the practice website. None of the patients we spoke with had ever needed to make a complaint about the practice. We looked at 18 complaints received in the last 12 months and found 12 of these were dealt with in a timely manner. One was ongoing and of the other four complaints records we were unable to determine whether they were dealt with in a timely manner or not as no closing dates were recorded; from summaries we saw we did see evidence that they were dealt with appropriately. The practice informed us that all complaints would follow procedure, including recording of all related dates, from our inspection onwards. All complaints were dealt with in an open and transparent manner, providing explanations or apologies when required.

Are services well-led?

Requires improvement

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

Our findings

Vision and strategy

The practice staff shared the guiding principle for the practice which included the provision of good quality primary care services delivered in a clean, suitably equipped and safe environment, pro-active management of long term conditions, efficient use of NHS resources, inclusion of patient involvement and ensuring all team members have the right skills and training to carry out their duties competently. Staff we spoke with knew and understood the principles and knew what their responsibilities were in relation to these. As the practice was approaching an imminent merger with Southgates Medical and Surgical Centre there was a long term business plan in place and consideration for future risks would be addressed through this plan. The practice told us that matters like this would also be discussed with the clinical commissioning group and the neighbouring practices.

Governance arrangements

The practice had a number of protocols, policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the practice. We looked at 12 of these protocols, policies and procedures and 11 had been reviewed annually and were up to date. There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead nurse for infection control and one of the GPs was the lead for safeguarding. We spoke with five members of staff and they were all clear about their own roles and responsibilities. They all told us they felt well supported and knew who to go to in the practice with any concerns. The practice used the Quality and Outcomes Framework (QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures) to measure its performance. The QOF data for this practice showed it was performing below national and local standards overall. QOF data was not regularly discussed at team meetings as regular practice meetings had not taken place since November 2013. The practice had a system in place for undertaking clinical audit cycles. However the audit cycles had not been completed in the previous 12 months which meant the practice was unable to demonstrate the impact of its audit work on patient outcomes. We reviewed a comprehensive risk register that was in place. This included assessment of risks associated with fire safety, IT system failure and staff sickness. The risk register had been recently reviewed and updated. The practice had recently held a significant events (SE) meeting (two weeks prior our inspection), in which the SEs were discussed and actions were highlighted and reviewed, We noted that the last time such a meeting was held was 18 months previously.

Leadership, openness and transparency

We saw from minutes that team multi-disciplinary team (MDT) meetings were held monthly and were attended by a variety of other health care providers, for example district nurses and social services. During these meetings different topics were discussed, for example the palliative care register, safeguarding for children and families, new cancer patients, deaths and unplanned admissions. The MDT meeting also provided a forum to address any other business. Staff told us that there was an open culture within the practice and they had the opportunity, and were happy to, raise issues directly with the GPs and management. An assistant practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example whistleblowing policy, recruitment policy and chaperone policy which were in place to support staff. Staff we spoke with knew where to find these policies if required. There was scope to ensure that staff understood and felt empowered to use the whistleblowing policy as necessary. The whole team adopted a philosophy of care that put patients and their wishes first. All staff confirmed that meetings were not held regularly and changes in the practice hierarchy over the last year had affected teamwork and performance. This was confirmed by the lead GP who was aware of the shortcomings but felt the practice was understaffed which impeded improvements being achieved. All staff confirmed they felt the GPs and management team were approachable. All staff, including the GPs, felt the upcoming merger with Southgates Medical and Surgical Centre would resolve the existing gaps in clinical and practice leadership and would allow for improved development and training of staff and team meetings. Staff members we spoke with told us they felt their contribution to providing good quality care was valued by the patients they served.

Are services well-led?

Requires improvement

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

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

We saw that the practice had a Patient Participation Group (PPG) that was accessible through the practice web-site. A PPG is a forum of patients whose feedback is sought about areas that GP practices might need to improve upon. The practice told us that the PPG has had declining membership but a recent meeting to discuss merger with Southgates Medical & Surgical Centre had increased the membership to 140. The practice intended to capitalise on this increased interest and have scheduled a further meeting on 28 April 2015. We spoke with a member of the PPG. They told us that the PPG usually met quarterly but the meetings were informal and no notes were kept. The last meeting they attended was in 2012. They also told us the meetings were usually very informative and supportive and recalled that clinical subjects of interest were often discussed. For example osteoporosis. Staff we spoke with were very positive about the impending merger with Southgates Medical & Surgical Centre and hoped that better communication and staff support arrangements would emerge as a result.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring but a lack of available time prohibited this. Some staff told us that the practice was supportive of training but we noted that there was no evidence of team educational meetings being held and staff told us these did not take place regularly. Two members of staff, clinical and administrative, had been developed and promoted internally to new positions. For example, a former receptionist was now working towards becoming a health care assistant and a practice nurse was promoted to nurse manager. The practice had completed reviews of significant events (SE) and other incidents but had no forum to allow these to be effectively shared with staff at meetings to ensure the practice improved outcomes for patients. For example, the last SE meeting dated back 18 months. We were shown a record which detailed summaries and current status of actions on SE's. The practice ethos was in line with ensuring its staff performed well and developed within a learning culture. The emphasis in this process was on development, promoting opportunities to learn, improve and maintain good clinical practice. This was mirrored in the practice's approach to internally promote two members of staff to new positions. But in practice this proved challenging due to the lack of performance 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 19 HSCA (RA) Regulations 2014 Fit and proper persons employed (3) The following information must be available in relation to each such person employed – (a) the information specified in Schedule 3, and (b) such information as is required under any enactment to be kept by the registered person in relation to such persons employed.