

The Chapel Street Surgery

Quality Report

Chapel Street
Newhaven,
East Sussex
BN9 9PW

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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?

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 carried out an announced comprehensive inspection of The Chapel Street Surgery on 4 February 2015. We visited the practice location at Chapel Street, Newhaven, East Sussex, BN9 9PW.

Overall the practice is rated as requires improvement. Specifically, we found the practice to be good for providing caring and responsive services. It required improvement for providing safe, effective and well led services. It also required improvement for providing services for 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 and people experiencing poor mental health (including people with dementia).

The inspection team spoke with staff and patients and reviewed policies and procedures. The practice understood the needs of the local population and

engaged effectively with other services. The practice was committed to providing high quality patient care and patients told us they felt the practice was caring and responsive to their needs.

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

- Patients' needs were assessed and care was planned and delivered following best practice guidance.
- The practice understood the needs of the local population and planned services to meet those needs.
- The practice worked closely with external agencies and community services to meet the needs of patients and ensure continuity of care.
- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses.
- Risks to patients and staff were not always assessed and well managed.

Summary of findings

- Staff had generally received training appropriate to their roles and any further training needs had been identified and planned. However, some staff had not received training in the safeguarding of children and vulnerable adults.
- 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.

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

Importantly, the provider must:

- Ensure that all staff are trained in safeguarding of children and vulnerable adults.

- Ensure all staff are supported by means of receiving appraisals.
- Ensure a programme of audit of infection control processes is in place in order to ensure that policies and processes are effectively implemented.
- Ensure risk assessment and monitoring processes effectively identify, assess and manage risks relating to the health, safety and welfare of patients and staff.

In addition the provider should:

- Establish a process to ensure more formal sharing of information and learning from incidents 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?

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. Information about safety was recorded, monitored, appropriately reviewed and addressed. However, lessons learned were not always communicated widely to support improvement. Staff had some understanding of procedures relating to the safeguarding of children and vulnerable adults. However, not all staff had received training in adult and child safeguarding at a level appropriate to their role. Risks to patients and staff were not always assessed and well managed. For example, the practice had not undertaken an audit or assessed the risks associated with their infection control procedures. The practice had also not assessed the risks associated with fire safety and evacuation procedures.

Requires improvement



Are services effective?

The practice is rated as requires improvement for providing effective services. Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from National Institute for Health and Care Excellence and used it routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had in the main, received training appropriate to their specific roles and any further training needs had been identified and planned to meet those needs. However, not all staff had received training in adult and child safeguarding and there was a lack of evidence of appraisals and personal development plans for some staff. Staff worked closely with multidisciplinary teams and external services.

Requires improvement



Are services caring?

The practice is rated as good for providing caring services. Data showed that patients rated the practice higher than others for several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information to help patients understand the services available was easy to understand. We also saw that staff treated patients with kindness and respect and maintained confidentiality. The practice advertised local support groups so that patients could access additional support if required. Staff within the practice felt well supported by management and the wider team.

Good



Summary of findings

Are services responsive to people's needs?

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. The practice had recognised the needs of the high number of vulnerable patients within the local population and provided services to meet those needs. Patients were generally satisfied with their ability to access the practice by phone. Urgent appointments were available on the same day. The practice provided a system of GP led triage for patients requesting urgent appointments. The practice was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand and the practice responded quickly to issues raised.

Good



Are services well-led?

The practice is rated as requires improvement for being well-led. It had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt well supported by management. Recruitment processes were well documented and comprehensive induction arrangements were in place for administrative staff. However, not all staff had received regular performance reviews. Some staff had not received up to date training in mandatory areas such as safeguarding of children and vulnerable adults. Risks to staff and patients were not always assessed and well managed. The practice had a number of policies and procedures to govern activity and held regular governance meetings. Incidents were recorded and there was some evidence of lessons learned. However, governance arrangements were not formalised to ensure learning was disseminated to the whole practice team. The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group (PPG) was active.

Requires improvement



Summary of findings

The six population groups and what we found

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

Older people

The practice is rated as requires improvement for the care of older patients. The provider was rated as good for caring and responsive overall and this includes for this population group. The provider was rated as requires improvement for providing safe, effective and well-led services. 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 dementia and end of life care. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs. The practice was well supported by a community physician who specialised in the care of older patients. All patients over the age of 75 years had a named GP.

Requires improvement



People with long term conditions

The practice is rated as requires improvement for the care of patients with long term conditions. The provider was rated as good for caring and responsive overall and this includes for this population group. The provider was rated as requires improvement for providing safe, effective and well-led services. The concerns which led to these ratings apply to everyone using the practice, including this population group.

Nurses and GPs had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. All these patients had a named GP and a structured annual review to check that their health and medication needs were being met. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Requires improvement



Families, children and young people

The practice is rated as requires improvement for the care of families, children and young patients. The provider was rated as good for caring and responsive overall and this includes for this population group. The provider was rated as requires improvement for providing safe, effective and well-led services. The concerns which led to these ratings apply to everyone using the practice, including this population group.

Requires improvement



Summary of findings

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. Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with midwives and health visitors.

Working age people (including those recently retired and students)

The practice is rated as requires improvement for the population group of working-age patients (including those recently retired and students). The provider was rated as good for caring and responsive overall and this includes for this population group. The provider was rated as requires improvement for providing safe, effective and well-led services. 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 adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. Extended hours telephone consultations were available on three evenings per week from 6:30pm until 7.30pm. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflected the needs for this age group.

Requires improvement



People whose circumstances may make them vulnerable

The practice is rated as requires improvement for patients whose circumstances may make them vulnerable. The provider was rated as good for caring and responsive overall and this includes for this population group. The provider was rated as requires improvement for providing safe, effective and well-led services. 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 homeless people and those with a learning disability. It had carried out annual health checks for people with a learning disability. The practice regularly worked with multi-disciplinary teams in the management of vulnerable people. It provided vulnerable patients with information about how to access various support groups and voluntary organisations. Staff had some understanding of their responsibilities regarding information

Requires improvement



Summary of findings

sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours. However, some staff had not received up to date training in the safeguarding of children and vulnerable adults.

People experiencing poor mental health (including people with dementia)

The practice is rated as requires improvement for patients experiencing poor mental health (including patients with dementia). The provider was rated as good for caring and responsive overall and this includes for this population group. The provider was rated as requires improvement for providing safe, effective and well-led services. The concerns which led to these ratings apply to everyone using the practice, including this population group.

People experiencing poor mental health had received an annual physical health check. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. They undertook dementia screening of patients and ensured early referral to memory assessment services. The practice provided patients experiencing poor mental health with information about how to access various support groups and voluntary organisations.

Requires improvement



Summary of findings

What people who use the service say

Patients told us they were satisfied overall with the practice. Comments cards had been left by the Care Quality Commission (CQC) before the inspection to enable patients to record their views on the practice. We received 14 comment cards which contained mainly positive comments about the practice. We also spoke with four patients on the day of the inspection.

The comments we reviewed were generally positive and described the professional, friendly service received by patients. One of the comment cards described the excellent care received in managing an acute health problem during the last year. One of the comment cards commented on difficulty associated with obtaining an appointment but this was not reflected in other comments we received. All of the patients we spoke with on the day of inspection told us that all staff were helpful, caring and professional. They told us they felt listened to

and well supported. Three of the four patients we spoke with on the day of inspection told us that GP lists often ran late and they experienced delays when waiting for their appointment. Three of the patients we spoke with told us that children were always prioritised for urgent appointments.

We reviewed recent GP national survey data available for the practice on patient satisfaction. The survey showed that 85% of respondents described the overall experience of the practice as good, which matched the national average of 85%. The survey found that 84% of patients said the last GP they saw was good at involving them in decisions about their care, compared with a national average of 81%. Over 85% of patients who responded said they found it easy to get through to the practice on the phone, compared with a national average of 75%.

Areas for improvement

Action the service **MUST** take to improve

- Ensure that all staff are trained in safeguarding of children and vulnerable adults.
- Ensure all staff are supported by means of receiving appraisals.
- Ensure a programme of audit of infection control processes is in place in order to ensure that policies and processes are effectively implemented.

- Ensure risk assessment and monitoring processes effectively identify, assess and manage risks relating to the health, safety and welfare of patients and staff.

Action the service **SHOULD** take to improve

- Establish a process to ensure more formal sharing of information and learning from incidents for all staff.

The Chapel Street Surgery

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 advisor, a CQC Inspector and a practice manager specialist advisor.

Background to The Chapel Street Surgery

The Chapel Street Surgery provides primary medical services to approximately 6,200 registered patients. The practice delivers services to a higher number of patients who are aged 65 years and over, when compared with the local clinical commissioning group (CCG) and England average. Care is provided to a small number of patients living in local residential and nursing homes. The practice delivers services to high numbers of vulnerable patients living within a population of higher than average deprivation.

Care and treatment is delivered by three GP partners and two salaried GPs. Three of the GPs are female and two are male. The practice employs a team which comprises a nurse practitioner, three practice nurses and two healthcare assistants. GPs and nurses are supported by the practice manager and a team of reception and administration staff.

The practice is a GP training practice and supports new registrar doctors in training and medical students.

Services are provided from:

Chapel Street, Newhaven, East Sussex, BN9 9PW.

The practice has opted out of providing out of hours services to its own patients and uses the services of a local out of hours service.

Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider was 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 the practice we reviewed a range of information we hold. We also received information from local organisations such as NHS England, Health watch and the NHS High Weald Lewes Havens Clinical Commissioning Group (CCG). We carried out an announced visit on 4 February 2015. During our visit we spoke with a range of staff, including GPs, practice nurses and administration staff.

We observed staff and patient interaction and spoke with four patients. We reviewed policies, procedures and operational records such as risk assessments and audits. We reviewed 14 comment cards completed by patients, who shared their views and experiences of the service in the two weeks prior to our visit.

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

Detailed findings

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

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

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

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts, as well as comments and complaints received from patients. The staff we spoke to were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses.

We reviewed safety records, incident reports and minutes of meetings where these were discussed. This showed the practice had managed these consistently over time and so could show evidence of a safe track record over the long term.

Learning and improvement from safety incidents

The practice had systems in place for reporting, recording and monitoring significant events, incidents and accidents. The practice kept records of significant events that had occurred and these were made available to us. The practice told us that significant events were discussed at regular partners meetings. We saw records of partners meetings held in January and May 2014 but there was no evidence that incidents had been discussed at those meetings. There was some evidence of learning from incidents, as learning points had been recorded on the incident forms used but it was unclear how this learning was shared with the whole practice team.

However, we saw records of incidents were completed in a comprehensive and timely manner. We saw evidence of action taken as a result. For example, the practice had recently reviewed their arrangements for monitoring the competency of staff members involved in taking blood from patients following an incident and a subsequent complaint received from one patient.

National patient safety alerts were disseminated to practice staff. Staff we spoke with were able to give examples of recent alerts relevant to the care they were responsible for. They also told us alerts were discussed at meetings to ensure all staff were aware of any that were relevant to the practice and where they needed to take action.

Reliable safety systems and processes including safeguarding

The practice had systems in place to manage and review risks to vulnerable children, young patients and adults. A designated GP partner 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 GP partners had undertaken training appropriate to their role. However, not all staff had received training in the safeguarding of children and vulnerable adults at a level appropriate to their roles. Staff had some knowledge to enable them to identify concerns. All of the staff we spoke with knew who the practice safeguarding lead was and who to speak to if they had a safeguarding concern. We saw that safeguarding flow charts and contact details for local authority safeguarding teams were easily accessible within the practice.

Some staff we spoke with described recent incidents in which they had reported safeguarding concerns to the safeguarding lead or external services. Staff described the 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 computer system and patient electronic record. This included information so staff were aware of specific actions to take if the patient contacted the practice or any relevant issues when patients attended appointments. For example, children subject to child protection plans.

A chaperone policy was in use within the practice and this was clearly advertised to patients in the consulting rooms. A chaperone is a person who can offer support to a patient who may require an intimate examination. The practice policy set out the arrangements for those patients who wished to have a member of staff present during clinical examinations or treatment. All nursing staff, including health care assistants, could be asked to be a chaperone. We were told that some reception and administration staff had also been trained to undertake chaperone duties. These staff had not been subject to a criminal records check via the Disclosure and Barring Service but the practice had undertaken a risk assessment of each role to support this decision.

Are services safe?

Patients' individual records were written and managed in a way to help ensure safety. Records were kept on an electronic system, which collated all communications about the patient including clinical summaries, scanned copies of letters and test results from hospitals.

GPs were appropriately using the required codes on their electronic system to ensure risks to children and young people who were looked after or on child protection plans were clearly flagged and reviewed. GPs were aware of vulnerable children and adults and records demonstrated good liaison with partner agencies such as social services.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators. We found they were stored securely and were only accessible to authorised staff. There was a clear process for ensuring medicines were kept at the required temperatures. We reviewed records to confirm this. The correct process was understood and followed by the practice staff and they were aware of the action to take in the event of a potential power failure.

The practice had processes to check medicines were within their expiry date and suitable for use. All the medicines we checked at the time of inspection were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

The nurses administered vaccines using directions that had been produced in line with legal requirements and national guidance. We saw that nurses had received appropriate training to administer vaccines.

The practice implemented a comprehensive protocol for repeat prescribing which was in line with national guidance. The protocol complied with the legal framework and covered all required areas. For example, how staff who generate prescriptions were trained and how changes to patients' repeat medicines were managed. This helped to ensure that patients' repeat prescriptions were still appropriate and necessary. Reviews were undertaken for patients on repeat medicines. All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were handled in accordance with national guidance and kept securely at all times.

The practice had identified a lead GP for medicines management. The practice prescribing lead worked closely in conjunction with the local clinical commissioning group (CCG) and the practice participated in prescribing audits and reviews.

Cleanliness and infection control

We observed the premises to be clean and tidy. We saw there were cleaning schedules in place and that cleaning records were kept. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

Hand washing notices were displayed in all consulting and treatment rooms. Hand wash solution, hand sanitizer and paper towels were available in each room. Disposable gloves were available to help protect staff and patients from the risk of cross infection. Disposable curtains were in place in clinical and consulting rooms. Spillage kits were available within the practice.

The practice had a lead nurse for infection control who had received training to enable them to provide advice on the practice infection control policy and to carry out staff training.

However, the practice had not recently carried out an audit or risk assessment of their infection control processes.

We saw that the practice had arrangements in place for the segregation of clinical waste at the point of generation. Colour coded bags were in use to ensure the safe management of healthcare waste. An external waste management company provided waste collection services. Sharps containers were available in all consulting rooms and treatment rooms, for the safe disposal of sharp items, such as used needles.

Equipment

Staff we spoke with told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. A schedule of testing was recorded. We saw evidence of calibration of relevant equipment which had been carried out in October 2014. For example, digital blood pressure machines and weighing scales.

Are services safe?

Records showed essential maintenance was carried out on the main systems of the practice. For example the boilers and fire alarm systems were serviced in accordance with manufacturers' instructions. We saw evidence that fire safety equipment, including the fire alarm and fire extinguishers, had been serviced in October 2014. We saw that electrical appliance testing had last been carried out in May 2014.

Staffing and recruitment

Records we looked at contained all the evidence required to show that robust recruitment procedures were in place and that appropriate checks had been undertaken prior to employment. For example, files reviewed contained proof of identification including photographic identification, evidence of professional registration and evidence of professional qualifications achieved.

Comprehensive competency based induction training programmes were in place to support administration and reception staff. We were told that some reception and administration staff had been trained to undertake chaperone duties. These staff had not been subject to a criminal records check via the Disclosure and Barring Service but the practice had undertaken a risk assessment of each role to support this decision.

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. There had been a number of new staff appointed to the reception team recently due to the retirement of other members of the team.

Monitoring safety and responding to risk

The practice had considered some of the risks of delivering services to patients and staff and had implemented some systems to reduce risks. For example, we reviewed one assessment of risk in relation to health and safety of the environment. This included recent action taken by the practice in response to risks associated with window blind cords. The practice manager told us that a daily visual inspection of the practice identified immediate risks. However, the practice had not assessed the risks associated with fire safety and evacuation procedures. The practice had not undertaken an audit or risk assessment

relating to infection control processes within the practice. There was no further evidence of risk assessment relating to the environment or activities undertaken within the practice.

The practice had health and safety policies and procedures in place. Health and safety information was displayed for staff to see. Safety equipment such as fire extinguishers and emergency oxygen were checked and sited appropriately.

We saw that staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies. For patients with long term conditions and those with complex needs there were processes to ensure these patients were seen in a timely manner. Staff told us that these patients could be urgently referred to a GP when necessary. The practice had employed the use of a risk stratification tool to identify patients most in need of high levels of support and who may be at higher risk of frequent accident and emergency attendances and unplanned hospital admissions. The practice held monthly multidisciplinary meetings which included health visitors, the community matron, community psychiatric nurses and district nurses, in order to identify and minimise the risks to these groups of patients.

The practice worked closely with one local hospice and community support teams to manage the care of patients receiving palliative care. Monthly meetings to review the needs of those patients receiving palliative care were attended by the GP lead, the nurse practitioner and palliative care and district nurse teams. We noted that the practice had included an end of life care patient charter on their website. This document outlined the care which the practice aimed to offer to patients nearing the end of their life.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly.

Are services safe?

Emergency medicines were available in a secure area of the practice and all staff knew of their location. 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.

Panic alarms were available to staff in all consulting and treatment rooms in case of an emergency. Records showed that fire alarms and emergency lighting were routinely tested.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Risks identified included power failure, adverse weather, unplanned sickness and access to the building.

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. 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 practice had appointed GP leads for specialist clinical areas such as diabetes and respiratory conditions. GPs and nurses were well supported in their specialist roles and described a culture of information sharing, transparency and continual learning. For example, the practice employed a nurse practitioner who was also a nurse prescriber. They met weekly with the GPs to review best practice guidelines and to discuss for example, those patients most at risk of unplanned hospital admission.

The practice ensured that patients had their needs assessed and care planned in accordance with best practice. The practice used computerised tools to identify and review registers of patients with complex needs. For example, patients with learning disabilities or those with long term conditions.

The practice managed patients with a range of long term conditions in line with evidence based practice. For example, we saw the practice nurses managed the care of a number of patients with leg ulcers. The nurses worked closely with the local tissue viability nurse and lymphoedema nurse (lymphoedema is a long term condition which causes swelling in the body's tissues) in the ongoing assessment and management of these patients. The nurses had received updated training in the management of leg ulcers and in the application of four layer bandaging which formed part of the patients' treatment. The assessment and review of those patients

was complimented by the regular taking of photographs to monitor the progress of healing. Nurses felt well supported by the practice in providing extended appointments for these patients.

The practice referred patients appropriately to secondary and other community care services. The GP partners told us that referrals were regularly reviewed in conjunction with the clinical commissioning group.

The practice was well supported by a community physician who specialised in the care of older patients. GPs were able to access support from the physician to manage older patients with complex healthcare needs. Those patients were provided with home visits by the physician if required.

We saw no evidence of discrimination when making care and treatment decisions. Interviews with GPs showed the culture in the practice meant patients were referred to other services based upon need and that age, sex and race was not taken into account in this decision-making.

Management, monitoring and improving outcomes for people

Staff from across the practice had key roles in the monitoring and improvement of outcomes for patients. These roles included data input and quality, clinical review scheduling, long term condition management and medicines management. The information staff collected was used to determine clinical audits.

The practice had systems in place for completing clinical audit cycles. The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). (QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures).

For example, we saw an audit review of the management of patients with high blood pressure and monitoring of coronary heart disease. As part of the audit review the practice had reviewed guidelines from the National Institute for Health and Care Excellence (NICE) for the diagnosis and management of hypertension. The practice had adjusted their protocol for the monitoring of patients

Are services effective?

(for example, treatment is effective)

and corresponding medicine reviews as a result of the audit. The GP lead had ensured improved dissemination of information and guidance in managing these patients, across the practice team.

The practice achieved 97.5% of the maximum Quality and Outcomes Framework (QOF) results 2012/13. The practice also used the information they collected for the QOF and their performance against national screening programmes to monitor outcomes for patients. QOF data showed the practice performed well in comparison to the regional and national average. For example, the number of patients with diabetes who had received an influenza immunisation was recorded as 95.2%, with the national average being 93.5%. The practice was identified as being an outlier for the level of prescribing of hypnotic medicines. (Hypnotic medicines are those which have a sleep inducing or sedative effect). We found the practice had monitored their prescribing data and had determined the high level was due to the number of patients receiving support and treatment to manage substance misuse.

The GPs we spoke with discussed how as a group they reflected upon the outcomes being achieved and areas where this could be improved. This included for example, information relating to unplanned admissions rates, secondary referrals, home visits and all QOF data. Regular clinical and educational meetings provided GPs and nurses with the opportunity to regularly review outcomes, new guidance and alerts and for the dissemination of information.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that some staff were not up to date with all mandatory training courses. Some nursing and administration/reception staff had not received training in the safeguarding of children and vulnerable adults. A number of reception and administrative staff were required to act as chaperones within the practice and had received appropriate training to support this role.

The practice nurses provided support to a wide range of patients with long term conditions, such as asthma, diabetes and chronic obstructive pulmonary disease (COPD). They had previously undergone advanced training in the support and management of these conditions and had recently received updated training. The infection

control lead nurse had undertaken appropriate training to support this role. Staff told us they attended regular external training events supported by the local clinical commissioning group and designated time was identified on a monthly basis to support internal training and meetings.

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).

Some staff we spoke with told us they had not received regular appraisals which would have given them the opportunity to discuss their performance and to identify future training needs. Personnel files we examined confirmed this. For example, a practice nurse who had been employed within the practice for approximately two years had not yet undergone appraisal. They told us that the planning of a date for appraisal had been mentioned by their line manager. Another nurse told us they had undergone appraisal with one of the GP partners in 2014, however we were unable to see evidence of the appraisal. The practice manager told us that outstanding appraisals had been planned.

Working with colleagues and other services

We found the practice worked with other service providers to meet patient needs and manage complex cases. The practice effectively identified patients who needed on-going support and helped them plan their care. For example, the practice worked closely with a local consultant and specialist nurse, to provide shared care services to patients who required support to manage substance misuse. The specialist nurse supported a weekly clinic within the practice on one afternoon per week. The practice also worked closely with local pharmacists in providing support and timely prescription services to these patients.

A designated GP within the practice provided support to a local community development project which also involved a number of other local practices. The project had been established to meet local community needs and to

Are services effective?

(for example, treatment is effective)

empower residents to make lifestyle changes. For example, in providing support to encourage healthy eating and exercise and to signpost young mothers to local support services.

The practice held regular multidisciplinary team meetings to review the care of patients with complex needs and those at risk of unplanned hospital admissions or accident and emergency attendance. For example, those patients receiving end of life care. The practice invited representatives from social services, mental health, district nursing, the community matron and local hospice teams. Decisions about care planning were documented in a shared care record. Care plans were also shared via a secure electronic system with the out of hours provider and ambulance service. The practice told us that systems to review the most vulnerable patients had resulted in reduced use of out of hours services and had also reduced the number of unplanned hospital admissions for patients with Chronic Obstructive Pulmonary Disease (COPD).

Blood results, hospital discharge summaries, accident and emergency reports and reports from out of hours services were seen and action taken 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. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting upon any issues arising from communications with other care providers on the day they were received.

Referrals were made using the 'Choose and Book' service. We saw evidence of the practice's referral process and its effectiveness. (The Choose and Book system enables patients to choose which hospital they will be seen in and to book their own outpatient appointments in discussion with their chosen hospital).

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. Electronic systems were also in place for making referrals, and the practice made some referrals through the Choose and Book system.

The practice had systems to provide staff with the information they needed. Staff used the electronic patient

record to coordinate, document and manage patients' care. All staff were fully trained on the system. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

Consent to care and treatment

The GPs we spoke with told us they always sought consent from patients before proceeding with treatment. GPs told us they would give patients information on specific conditions to assist them in understanding their treatment and condition before consenting to treatment. Patients consented for specific interventions for example, minor surgical procedures, by signing a consent form. Patient's verbal consent was also documented in the electronic patient notes with a record of the relevant risks, benefits and complications of the procedure discussed with the patient.

We found that staff were aware of the Mental Capacity Act 2005 and their duties in fulfilling it. The GPs and nurses we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice.

Patients with more complex needs, for example dementia or long term conditions, were supported to make decisions through the use of care plans, which they were involved in agreeing. These care plans were reviewed annually or more frequently if changes in clinical circumstances dictated it and had a section stating the patient's preferences for treatment and decisions.

Health promotion and prevention

Health checks were available with a nurse or healthcare assistant to any new patient registering with the practice. GPs and nurses we spoke with told us that regular health checks were offered to those patients with long term conditions. We saw that medical reviews for those patients took place at appropriately timed intervals. The practice also offered NHS health checks to all its patients aged 40 to 75 years.

The practice had ways of identifying patients who needed additional support, and were pro-active in offering additional help. For example, the practice kept a register of all patients with learning disabilities and provided annual

Are services effective?

(for example, treatment is effective)

checks for these patients. Nurses told us they were able to signpost patients to local health and wellbeing services, for example to support patients in maintaining a healthy weight or reducing their alcohol intake.

The practice offered a full range of immunisations for children, some simple travel vaccines, flu and shingles vaccinations in line with current national guidance. We

reviewed our data and noted that 87% of children aged up to 24 months who attended the practice, had received their mumps, measles and rubella vaccination. Data we reviewed showed that 95% of patients with diabetes had a flu vaccination within the six month period between September and March. This was higher than the national average of 93%.

Are services caring?

Our findings

Respect, dignity, compassion and empathy

Patients completed CQC comment cards to tell us what they thought about the practice. We received 14 completed cards and all were positive about the service experienced. Patients said they felt the practice offered a caring service and staff were efficient, helpful and took the time to listen to them. They said staff treated them with dignity and respect. We also spoke with four patients on the day of our inspection. All told us they were generally satisfied with the care provided by the practice and said their dignity and privacy was respected. One of the comment cards described the excellent care received in managing an acute health problem during the last year.

We reviewed GP national survey data available for the practice on patient satisfaction. The evidence from the survey showed patients were satisfied with how they were treated and this was with compassion, dignity and respect. Data from the national patient survey showed that 85.9% of patients rated their overall experience of the practice as good. The practice was above average for its satisfaction scores on consultations with doctors, with 90.9% of practice respondents saying the GP was good at treating them with care and concern. We also noted that 83.4% of patients had responded that the nurse was good at treating them with care and concern.

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

We observed staff were careful to follow the practice's confidentiality policy when discussing patient treatment in order that confidential information was kept private. The main reception area and waiting room were combined but patients were requested to wait before coming forward to the reception desk. Some telephone calls were taken away from the reception desk so staff could not be overheard. Staff were able to give us practical ways in which they

helped to ensure patient confidentiality. This included not having patient information on view, speaking in lowered tones and asking patients if they wished to discuss private matters away from the reception desk.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example, data from the national patient survey showed 84.7% of practice respondents said the GP involved them in decisions about their care and 78.6% felt the nurse was good at involving them in decisions about their care.

Patients we spoke to 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.

Patient/carers support to cope emotionally with care and treatment

The results of the national GP survey showed that 90.9% of patients said the last GP they saw or spoke to was good at treating them with care and concern and that 83.4% of patients said the nurses were also good at treating them with care and concern. Patients we spoke with on the day of our inspection and some of the comment cards we received gave examples of where patients had been supported.

The practice held a register of patients who were carers and new carers were encouraged to register with the practice. The practice computer system then alerted GPs and nurses if a patient was also a carer. We saw written information was available for carers to ensure they understood the various avenues of support available to them. Notices in the patient waiting room and patient website signposted patients to a number of support groups and organisations.

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 clinical commissioning group (CCG) told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised.

The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered. For example, the practice had recognised the needs of the high number of vulnerable patients within the local population. These included patients who required support to manage substance misuse. Two GPs within the practice had undertaken training with the Royal College of General Practitioners in supporting patients to manage substance misuse. The practice worked closely with external services, such as a local consultant, to provide shared care services to this group of patients. A specialist nurse supported a weekly clinic within the practice on one afternoon per week. The practice also worked closely with local pharmacists in providing support and timely prescription services to these patients.

A designated GP within the practice provided support to a local community development project which also involved a number of other local practices. The project had been established to meet local community needs and to empower residents to make lifestyle changes. For example, in providing support to encourage healthy eating and exercise and to signpost young mothers to local support services.

The practice had implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from patients and through the patient participation group (PPG). We saw for example, the most recent survey indicated that a large proportion of patients were not aware of the newly developed practice website. Many patients had not viewed the website and were not aware that prescriptions could now be ordered online. The practice had improved signage and information available within the practice and on prescriptions to enhance patient awareness of these services.

The practice had developed a newsletter which was produced at regular intervals throughout the year. The newsletter was available to patients on the website and as a paper copy within the practice. Patients who had not attended the practice within the last 12 months were to be sent a copy of the newsletter in order to promote communication and information sharing.

The practice supported patients with complex needs and those who were at risk of unplanned hospital admission. Personalised care plans were produced and were used to support patients to remain healthy and in their own homes. Patients with palliative care needs were well supported. The practice had a palliative care register and worked closely with one local hospice. The practice had regular internal as well as multidisciplinary meetings to discuss patient and their families' care and support needs.

Patients with long term conditions had their health reviewed at regular intervals. The practice had recently begun to review how they could provide a holistic approach to the management of patients with multiple long term conditions. The practice provided care plans for asthma, chronic obstructive pulmonary disease (COPD), diabetes, dementia and mental health conditions.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. Vulnerable patients were very well supported. The practice provided care and support to patients with a learning disability and worked closely with community services to support their needs. The practice told us that patients without a permanent address could register and be treated at the practice. The practice provided care and support to patients living in a nearby supported housing facility and worked closely with community services to support their needs.

Staff told us that translation services were available for patients who did not have English as a first language.

The premises and services were suitable to meet the needs of patients with disabilities. We noted the waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Toilet facilities were available for all patients of the practice.

Access to the service

Are services responsive to people's needs?

(for example, to feedback?)

The practice was open from 8.30am until 6.00pm on weekdays. Extended hours telephone consultations were also available on three evenings per week from 6.30pm until 7.30pm. There were no online facilities for patients to book appointments. Appointments could be booked on the day or up to four weeks in advance by phoning the practice or attending in person. A number of urgent appointments were available on the day. The practice provided a system of GP led triage for patients requesting urgent appointments. Patients received a call back from the GP on call that day and were then invited to be seen within the practice according to need. We observed one patient attending the practice to request an urgent appointment for a child on the day of inspection. Appropriate advice and support was provided by reception staff in ensuring access to an appointment.

Patients were generally satisfied with their ability to access the practice by phone. Results of a recent GP patient survey showed that 85.5% of respondents found it easy to get through to the practice by phone. This was compared to a national average of 75.4%.

Information was available to patients about appointments on the practice website. This included how to arrange home visits, how to book appointments and the number to call outside of practice hours. There were arrangements in place to ensure patients received urgent medical assistance when the practice was closed. Patients were advised to call the out of hours' service.

Patients spoken with and comments left on CQC comment cards confirmed that patients were mainly happy with the

appointment system. Three patients told us they were happy with the GP led triage system and always received a timely call back from the GP. Two patients told us that it was sometimes difficult to get through to the practice early in the morning. The results from a recent GP patient survey indicated that 74.6% of patients were very satisfied or fairly satisfied with the practice's opening hours.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Their complaints policy was in line with recognised guidance and contractual obligations for GPs in England. The practice had identified a lead GP to manage complaints with the practice manager.

Complaints information was made available to patients in the practice and on the practice website. A Friends and Family test suggestions box was available within the patient waiting area and reception which invited patients to provide feedback on services provided, including complaints. The patients we spoke with said they had never had cause to complain.

We reviewed the practice complaints log for those received in the last twelve months and found these were all discussed, reviewed and learning points were noted. The practice reviewed complaints on an annual basis to detect themes or trends. Staff we spoke with knew how to support patients wishing to make a complaint and told us that learning from complaints was shared with the relevant team or member of staff.

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 had a clear vision to deliver high quality care and promote good outcomes for patients. The practice was clinically well led with a core ethos to deliver the best quality clinical care whilst maintaining a high level of continuity.

We spoke with 12 members of staff and they all knew and understood the vision and values of the practice and were clear about what their responsibilities were in relation to these.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff. All policies and procedures we looked at had been reviewed and were up to date.

The practice used the Quality and Outcomes Framework (QOF) to measure their performance. The QOF data for this practice showed it was performing in line with or above national standards.

The practice held regular meetings, including GP partner meetings and weekly clinical review meetings. The GP partner meetings facilitated communication between the GPs and the practice manager. The practice told us that significant events were discussed at those meetings. We saw records of partners meetings held in January and May 2014 but there was no evidence that incidents had been discussed at those meetings. There was some evidence of learning from incidents, as learning points had been recorded on the incident forms used but it was unclear how this learning was shared with the whole practice team.

The nurses told us they met regularly, however these meetings were not formally recorded. The reception and administration team held regular meetings and we saw the detailed and comprehensive minutes of those meetings which had been held at regular intervals throughout 2014. However, learning from incidents was not included within those meetings.

The practice told us that one GP had recently led the whole practice team in a review of communication systems across

the practice. The team had participated in a weekend meeting to achieve this and had also reviewed how a holistic approach to the management of multiple long term conditions could be adopted.

The practice had an ongoing programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. For example, we saw an audit review of the management of patients with high blood pressure and monitoring of coronary heart disease. As part of the audit review the practice had reviewed guidelines from the National Institute for Health and Care Excellence (NICE) for the diagnosis and management of hypertension. The practice had adjusted their protocol for the monitoring of patients and corresponding medicine reviews as a result of the audit. The GP lead had ensured improved dissemination of information and guidance in managing these patients, across the practice team.

The practice had considered some of the risks of delivering services to patients and staff and had implemented some systems to reduce risks. For example, we reviewed one assessment of risk in relation to health and safety of the environment. This included recent action taken by the practice in response to risks associated with window blind cords. The practice manager told us that a daily visual inspection of the practice identified immediate risks. However, the practice had not assessed the risks associated with fire safety and evacuation procedures. The practice had not undertaken an audit or risk assessment relating to infection control processes within the practice. We were unable to see any further evidence of risk assessment relating to the environment or activities undertaken within the practice.

Leadership, openness and transparency

Staff told us that there was an open culture within the practice. They had the opportunity to raise issues at any time with the GP partners and practice manager and were happy to do so. The nurses within the practice held nurse team meetings but records of these meetings were not documented. Administration and reception staff attended regular team meetings throughout the year. However, it was unclear how learning from incidents was shared with the whole practice team.

The practice had developed a clear leadership structure which included named members of staff in lead roles. For example, there was a lead GP for mental health and a GP

Are services well-led?

Requires improvement 

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

partners was the lead for child and adult safeguarding. Staff were aware of the leadership structure within the practice. Reception, administration and nurses we spoke with were clear about their own roles and responsibilities. They all told us that they felt valued and well supported.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example recruitment and whistleblowing policies which were in place to support staff. Staff we spoke with knew where to find these policies if required.

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

The practice had gathered feedback from patients via a patient survey which had last been published in February 2014 and via comments and complaints received. The practice had a small patient participation group (PPG) which met regularly. The practice also had a larger patient reference group (PRG) which did not meet but from whom the practice sought feedback. The practice manager showed us the analysis of the last patient survey, which was considered in conjunction with the PPG. We noted that a total of 303 patients had responded to this survey. The results and actions agreed from these surveys were available on the practice website.

We saw for example, the most recent survey indicated that a large proportion of patients were not aware of the newly developed practice website. Many patients had not viewed the website and were not aware that prescriptions could now be ordered online. The practice had improved signage and information available within the practice and on prescriptions to enhance patient awareness of these services.

The practice had developed a newsletter which was produced at regular intervals throughout the year. The newsletter was available to patients on the practice website and as a paper copy within the practice. Patients who had not attended the practice within the last 12 months were to be sent a copy of the newsletter in order to promote communication and information sharing.

The practice gathered feedback from staff through informal discussions and via team meetings. Staff told us they felt able to give feedback and discuss any concerns or issues with colleagues and management. Staff mostly told us they felt involved and engaged within the practice to improve outcomes for both staff and patients.

The practice had a whistleblowing policy which was available to all staff. Staff we spoke with were aware of the policy and how they could whistleblow internally and externally to other organisations.

Management lead through learning and improvement

The practice had systems in place for reporting, recording and monitoring significant events, incidents and accidents. The practice kept records of significant events that had occurred and these were made available to us. The practice told us that significant events were discussed at regular partners meetings. We saw records of partners meetings held in January and May 2014 but there was no evidence that incidents had been discussed at those meetings. There was some evidence of learning from incidents, as learning points had been recorded on the incident forms used but it was unclear how this learning was shared with the whole practice team.

However, we saw records of incidents were completed in a comprehensive and timely manner. We saw evidence of action taken as a result. For example, we saw the practice had recently reviewed their arrangements for monitoring the competency of staff members involved in taking blood from patients following an incident and a subsequent complaint received from one patient.

All of the GPs within the practice had undergone training relevant to their lead roles and areas of special interest such as gynaecology and child safeguarding. All of the GPs had undergone annual appraisal and had either been revalidated or had a date for revalidation.

Some staff we spoke with told us they had not received regular appraisals which would have given them the opportunity to discuss their performance and to identify future training needs. For example, a practice nurse who had been employed within the practice for approximately two years had not yet undergone appraisal. They told us that the planning of a date for appraisal had been mentioned by their line manager. Another nurse told us they had undergone appraisal with one of the GP partners in 2014, however we were unable to see evidence of the appraisal. The practice manager told us that outstanding appraisals had been planned.

Are services well-led?

Requires improvement



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

We reviewed staff training records and saw that many staff were not up to date with all mandatory training courses. Some nursing and administration/reception staff had not received training in the safeguarding of children and vulnerable adults.

The practice nurses provided support to a wide range of patients with long term conditions, such as asthma, diabetes and chronic obstructive pulmonary disease (COPD). They had previously undergone advanced training

in the support and management of these conditions and had recently received updated training. The infection control lead nurse had undertaken appropriate training to support this role. Comprehensive competency based induction training programmes were in place to support administration and reception staff. A number of reception and administrative staff were required to act as chaperones within the practice and had received appropriate training to support this role.

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

Diagnostic and screening procedures
Family planning services
Maternity and midwifery services
Surgical procedures
Treatment of disease, disorder or injury

Regulation

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

We found that the registered provider did not ensure that effective systems were in place to assess the risk of, and prevent, detect and control the spread of infections, including those that are healthcare associated.

This was in breach of regulation 12 (1) (a) (b) (c) (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12 (1) (2) (h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity

Diagnostic and screening procedures
Family planning services
Maternity and midwifery services
Surgical procedures
Treatment of disease, disorder or injury

Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing

We found that the registered person did not have suitable arrangements in place to ensure the persons employed for the purposes of carrying on the regulated activity were appropriately supported by means of receiving appropriate supervision and appraisal.

This was in breach of regulation 23(1) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 18 (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity

Diagnostic and screening procedures
Family planning services
Maternity and midwifery services
Surgical procedures
Treatment of disease, disorder or injury

Regulation

Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment

This section is primarily information for the provider

Requirement notices

We found that the registered person did not have suitable arrangements in place to prevent abuse of service users by means of providing appropriate training for staff.

This was in breach of regulation 11(1) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 13 (1) (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity

Diagnostic and screening procedures
Family planning services
Maternity and midwifery services
Surgical procedures
Treatment of disease, disorder or injury

Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

We found that the registered person had not always assessed, monitored and mitigated the risks relating to the health safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity.

This was in breach of regulation 10 (1) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17 (1) (2) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.