Dr Ajay Birly

Quality Report

Acorn Medical Centre
149 Long Lane
Hillingdon
Uxbridge UB10 9JN
Tel: 01895 237474

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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.

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Summary of findings

Overall summary

Dr Ajay Birly is registered as an individual GP provider. The practice provides NHS primary care services to patients in the Hillingdon area through a General Medical Services contract. The practice currently has approximately 5900 patients on its list.

We carried out an announced inspection of the service on 28 August 2014. The team, led by a CQC inspector, included a GP, a former practice manager and a second CQC inspector. We spoke with six patients attending the practice on the day of the inspection and collected 30 comment cards which patients had completed about the service in the days running up to the inspection.

The practice had systems in place to manage risks associated with medicines management, staff recruitment, child protection and adult safeguarding and medical emergencies. Practice procedures on infection control and information governance required improvement. Staff were recruited safely but staff involved in chaperoning patients had not had DBS checks. There were mechanisms to investigate and learn from incidents and complaints. Patients' needs were assessed and treatment and referral patterns were in line with current guidelines.

Staff participated in collaborative clinical audits and external peer group meetings and used performance information, particularly from the Quality and Outcomes Framework to improve.

Most patients we spoke with were happy with the service they received at the practice. They said they were involved in decisions about their treatment and most staff were sensitive. We observed that reception staff greeted patients in a polite and friendly manner.

The practice was responsive to the needs of its patients. It provided services tailored to particular patient groups, extended opening hours and provided different ways for patients to access the service, including a recently introduced online booking system.

Patients were able to access appointments when they needed them although some patients told us they had difficulty booking an appointment with the same doctor which affected their experience of the service. The practice promoted health and prevention of illness.

The service was well-led in some respects but some areas needed improvement. There were governance arrangements in place and an open reporting culture. However, we found some confusion over roles and responsibilities for example in relation to infection control. The practice responded to complaints and had placed a suggestion box in the waiting room. However it did not otherwise actively engage with patients and the public. The practice did not have its own website or a patient participation group.

The practice provided services for specific patient groups and some outstanding practice for patients with substance misuse problems and also patients with a history of violence in general practice settings. The practice demonstrated good links and collaboration with other agencies and professionals.

The practice was in breach of regulations related to:

- Care and welfare of patients
- Cleanliness and infection control
- Requirements relating to workers
- Assessing and monitoring the quality of care

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.

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

There were systems in place to report and learn from incidents, share safety alerts and raise any safeguarding concerns. However significant events had not been collated in once place making them more difficult to track.

Prescribing was managed safely and vaccines were stored at the correct temperature. Prescription pads were stored securely, however, prescription serial numbers were not recorded upon receipt or distribution.

The practice offered a chaperone service to patients undergoing physical examination. Staff acting as chaperones understood the role but they had not been subject to Disclosure and Barring Service (DBS) checks within the last three years. Some staff were also unclear about "whistleblowing" and how to report concerns other than to the GP principal.

The practice was cleaned daily but it was not following its own policy on infection control. Staff had not been trained on infection control procedures and there was no written cleaning plan for the cleaners to follow. Cleaning products and equipment were not being used appropriately. There had been no risk assessment for Legionella. The practice had not conducted any audit of its infection control procedures.

There were sufficient clinical staff to meet the needs of patients. The 2014 national GP patient survey scores for the practice on availability of appointments were better than the regional average.

Staff were trained to deal with emergencies and provide basic life support in the event of a medical emergency. The practice had a good range of emergency medicines and equipment. However a number of items of equipment were out of date and needed replacement. The building was well maintained and serviced but the fire alarm was not routinely tested and the practice had not simulated a fire evacuation in recent years.

Are services effective?

Patients' needs were suitably assessed and treatment was delivered in line with current legislation and guidelines.

There were arrangements in place to monitor clinical effectiveness. The practice had recently successfully focused on reducing its prescribing expenditure. The practice participated in clinical audits and external peer group meetings to improve the service.

Summary of findings

There were arrangements in place to support staff appraisal, learning and professional development.

The practice worked in collaboration with other health and social care professionals to provide integrated patient care and support patients' needs. The practice provided patients with suitable advice and guidance about health promotion and illness prevention and participated in population screening programmes. The practice was in the process of introducing health checks for adults aged between 40 and 74. New patients however received a face-to-face health check if their completed health screening questionnaires indicated an increased risk of health problems.

The practice premises had recently been redecorated and patients commented positively on the practice environment.

Are services caring?

The practice had systems in place to respect patients' privacy and dignity. Patients were offered a choice of seeing a male or female GP when booking appointments in advance. Reception staff were aware of the practice confidentiality policy.

The 2014 national GP patient survey showed that the majority of patients were positive about their experience of care but the practice scored below the regional average for treating patients with care and concern and involving patients in decisions about their care.

The clinical staff sought verbal consent from patients before any examination, treatment, referral or immunisation. The practice used a telephone interpreting service to ensure that patients whose first language was not English were able to give informed consent to care.

The GPs we spoke with had knowledge of the Mental Capacity Act (2005). The doctors were aware of Gillick and Fraser guidelines to assess younger patients' maturity to make decisions without the consent of their parents when this was appropriate.

Are services responsive to people's needs?

The practice was able to demonstrate an understanding and awareness of the needs of the local population including people with a range of long term conditions. The practice provided a number of services tailored to particular patient groups by participating in "local enhanced schemes".

There was good collaborative working between the practice and other health services which helped to ensure patients' needs were met.

Summary of findings

Patients were able to access appointments when they needed them although patients told us they had difficulty seeing the same doctor.

The practice learned from patients' concerns and complaints to improve the service. The practice population was relatively young but the practice did not have a website and online information available about the practice on NHS Choices was out of date. The practice was developing an online booking and electronic prescriptions service.

Are services well-led?

The GP principal was the practice lead and had a vision for how they saw the service developing. Governance arrangements were in place with identified leads for specific clinical areas of the service and regular clinical meetings.

However roles and responsibilities for other aspects of the service, such as infection control were unclear. As a consequence the practice did not always have robust procedures in place to minimise risk. The practice did not have a development plan, team objectives or a risk register. There were shortcomings in the practice's management of information governance.

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 national standards.

Staff described a positive culture of openness and the ability to talk with senior staff regularly although opportunities for the staff team to meet together to reflect on the quality of service were limited.

The practice did little to actively seek the views of patients through the use of email, practice surveys or a Patient Participation Group and had not explored reasons why some of its scores on the 2014 national GP patient survey were relatively low.

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 had a relatively low proportion of registered patients aged over 75 but was participating in an integrated care project to case manage patients with complex needs. It was also providing a number of other services that were particularly relevant to this group of patients including dementia screening, end of life care and treatment for cancer of the prostrate. There were effective arrangements to identify vulnerable and frail older patients at risk of abuse. Care and treatment was planned with appropriate reviews to meet the identified needs of patients over the age of 75.

People with long-term conditions
The practice cared effectively for people with long term conditions. It was performing in line with national and local targets for a range of conditions including diabetes and asthma and the practice recalled eligible patients for regular review. The 2014 national GP patient survey suggested that patients sometimes found it difficult to obtain an appointment with their preferred doctors and this concern was also expressed by some patients who participated in the inspection. Two patients with long term conditions we spoke with said this adversely affected their experience of care and they preferred to wait to see the doctor of their choice.

Mothers, babies, children and young people
The practice offered postnatal checks for mothers and babies and participated in childhood immunisation programmes. The practice monitored uptake of immunisations and referred families to the local immunisation task force team if immunisations were repeatedly missed. The practice had a policy on child protection which included information on how to raise an alert with local contact details. Staff understood their responsibilities in relation to protecting children from the risk of abuse and had recently undergone refresher training about this.

The working-age population and those recently retired
The practice had a relatively large proportion of registered patients of working age. The 2014 national GP patient survey findings were positive about the availability of appointments and access to the service. The practice was open outside normal working hours and had recently expanded the range of ways for patients to access the

service, for example through online appointment booking. The practice had signed up to the NHS health check programme for patients aged between 40 to 74 and offered annual influenza vaccinations to patients over 65.

People in vulnerable circumstances who may have poor access to primary care

The practice provided additional services designed to enable certain groups of patients to access primary care.

The practice was providing a scheme for patients with a history of violence in healthcare settings. The service was available to patients across the borough of Hillingdon on referral. The practice staff were sensitive to the particular needs of this group of patients.

The practice provided shared care for people experiencing problems with substance misuse and was working closely with the specialist substance misuse services in Hillingdon. The lead consultant for specialist substance misuse services told us the practice provided an outstanding service for this group of patients.

The practice invited patients with a learning disability to an annual review of their care. The practice contributed to the development of an individual health action plan for each patient with learning disability which was tailored to their needs and preferences.

People experiencing poor mental health

The practice provided primary care mental health services and referred patients with more acute or severe mental health problems to specialist services including child and adolescent mental health services if required. A counsellor was attached to the practice one day a week and patients were able to access this service for common mental health problems on referral by their GP.

Summary of findings

What people who use the service say

The 2014 national GP patient survey found that only 59% of respondents would recommend the practice to others, which was below the regional average. The practice scored more positively than the regional average to the survey questions about access to the service and availability of appointments however.

We spoke with eight patients during the inspection, seven of whom were happy with the service provided by the practice. Patients told us that they had received an emergency appointment when required, that staff were polite and their privacy was respected. Patients also praised the doctor who was working on the day of the inspection. They were positive about this doctor's caring manner and had confidence in their clinical skills.

We received 30 comment cards which were completed by patients attending the practice in the days preceding the inspection. Twenty-six patients made wholly positive comments about their care. Three patients commented about the difficulty in seeing the same doctor at each appointment. This concern was also raised by two of the patients we spoke with and the 2014 national GP patient survey.

Areas for improvement

Action the service MUST take to improve

- The practice must implement effective procedures to minimise the risk of infection
- The practice must have effective procedures in place to improve information governance.
- Staff involved in chaperoning patients require DBS checks to determine if they are suitable for this role
- The practice had a comprehensive set of policies which had recently been reviewed. However some staff members were unfamiliar with certain key policies, such as whistleblowing
- The practice must improve its methods of engaging with patients and obtaining feedback on the quality of its services
- The practice had an incident reporting system and process. However, some incident reports were being stored centrally and some in individual clinician's appraisal folders, increasing the risk that learning opportunities might be missed

Action the service SHOULD take to improve

- The practice did not have a longer-term development plan, risk register or team objectives
- The practice should improve the security of prescription materials
- The practice should review security arrangements in relation to access to the vaccination fridge
- The wider staff team had limited opportunities to meet and reflect on policy and practice

Outstanding practice

The practice was providing outstanding care to vulnerable patients. In particular

- Providing primary care services to violent patients
- Providing shared care for patients with substance misuse problems

Dr Ajay Birly

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC inspector and also included a GP, a specialist in general practice management, an expert by experience and a second CQC inspector. An expert by experience is a person who has personal experiences of using or caring for someone who uses this type of service. All team members were granted the same authority to enter Dr Ajay Birly's practice as the CQC inspectors.

Background to Dr Ajay Birly

Dr Ajay Birly provides services to approximately 5900 patients in the surrounding areas of Hillingdon and Uxbridge from a single site. The practice is known as Acorn Medical Centre and the premises have been adapted and modernised to provide a suitable practice environment. The building is accessible to people with disabilities.

The local area is characterised by relatively low levels of socio-economic deprivation with higher than average rates of employment and educational achievement. The practice population is relatively young and culturally and ethnically diverse. The practice currently has few patients aged over 75.

Appointments are currently available throughout the day between 8.30am and 6.00pm, four days a week with extended evening hours each Thursday and Saturday mornings. The practice has recently introduced an electronic appointment booking system and an electronic prescription service for its patients.

Out of hours primary care is accessible through the "111" telephone line and an Urgent Care Centre at Hillingdon Hospital.

The practice is led by a male individual GP partner. The GP partner specialises in providing care for patients recovering from substance misuse and patients with a history of violence referred from other practices in the borough. Three part-time salaried GPs (one of whom is female) and a part-time practice nurse provide general medical services to the local practice population. The practice also employs a practice manager and a team of receptionists.

Why we carried out this inspection

We inspected this GP practice as part of our new inspection programme to test our approach going forward. This practice had not been inspected before and that was why we included them.

How we carried out this inspection

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

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

The inspection team always looks at the following six population areas at each inspection:

- Vulnerable older people (over 75s)

Detailed findings

- People with long term conditions
- Mothers, children and young people
- Working age population and those recently retired
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing poor mental health.

Before visiting, we reviewed a range of information we hold about the service and asked other organisations to share what they knew about the service. We liaised with Hillingdon Clinical Commissioning Group, NHS England and Hillingdon Healthwatch. We also obtained feedback from a senior consultant at the specialist substance misuse service who had experience of working with this practice.

We carried out an announced visit on 28 August 2014 between 08:30 and 17:30. During our visit we spoke with a range of staff including the GP partner, one of the salaried GPs, the practice manager and three reception staff. We spoke with eight patients who used the service and we reviewed comment cards left by 30 patients sharing their views.

We observed how people were greeted during our visit and viewed the premises, emergency equipment, medicines storage and locum packs. We reviewed information that had been prepared by the practice for the inspection and we clarified a number of points with the GP-partner after the visit. Information reviewed during the inspection included practice policies and procedures, complaints and incidents, audits, records of staff training and recruitment checks, performance monitoring information and health information and advice leaflets.

Are services safe?

Our findings

Safe patient care

The practice had procedures in place to report and review incidents, share safety alerts, manage prescribing safely and raise any safeguarding concerns. The practice was staffed by a number of part-time sessional GPs. There were procedures in place to ensure that patient test results and requests were picked up by another doctor when a GP was away.

Clinical and administrative staff were clear that they would report incidents and concerns to the GP principal. The GP principal could be contacted by mobile telephone when not attending the practice and staff consistently told us that the GP principal responded quickly. However, practice procedures in relation to equipment, infection control and information governance were not systematically embedded in day to day practice.

The Care Quality Commission had not received any concerns or notifications relating to the safety of the service and Hillingdon Clinical Commissioning Group and Hillingdon Healthwatch did not raise concerns about the practice. Our analysis of published quality and performance indicators suggested the practice had been performing safely, for example around prescribing.

Learning from incidents

Incidents and significant events at the practice had been recorded. Between one and three incidents had been reported per year over the previous three years. The practice kept a central file of incident reports allowing any patterns to be analysed and actions monitored. However, three incidents had been recorded in doctors' individual appraisal and revalidation documentation but had not been included in the central file.

The GP principal, one of the sessional GPs and the practice manager regularly met to review significant incidents and other events. A written summary of each incident with learning and action points was forwarded to the part-time clinical staff members by email and we saw some of these emails. Non clinical events, such as negative feedback from the NHS Choices website, were shared with all staff.

Safeguarding

The practice had policies on child protection and safeguarding of vulnerable adults which included details of local statutory arrangements and contact details for relevant agencies. Safeguarding concerns were directed to the practice manager for escalation to the GP principal and external agencies as appropriate. All staff members we spoke with confirmed they knew how to contact the GP principal when he was away from the practice if a serious incident or safeguarding concern arose. Staff had been trained on safeguarding and child protection. The doctors had been trained to Level 3 in child protection. Other staff had recently undergone online Level 1 training to raise their awareness of the issue and their responsibilities. The electronic records system alerted staff when a patient known to be at risk attended the practice. Staff told us they had not yet needed to formally raise a child protection or safeguarding concern.

The practice offered a chaperone service to patients undergoing physical examination. We spoke with one of the receptionists who sometimes acted as a chaperone. They understood the purpose of the role and were able to explain how they observed the examination discreetly. They confirmed they had received a training session from the GP principal about chaperoning although the date and content of this session were not recorded.

Staff acting as chaperones had not been subject to Disclosure and Barring Service (DBS) checks within the last three years. We were told that this was because staff members had been employed at the practice for many years and were well known and trusted. There was no documented risk assessment to support these judgements.

Monitoring safety and responding to risk

The practice had a comprehensive set of policies including the management of medicines, infection control, safeguarding vulnerable adults, child protection, health and safety, information security and repeat prescribing. Staff were aware of how to access the written policies if they needed to refer to them.There was also a business continuity plan. All practice policies had been reviewed in August 2014. However, staff members were sometimes unclear about the content of certain practice policies, for example the "whistleblowing" policy and how to report concerns other than to the GP principal.

National NHS safety alerts were received electronically by the GP principal and forwarded to other clinicians in the practice. We were shown a recent alert about the Ebola virus that the GP principal had received and forwarded to other colleagues by email.

Are services safe?

Medicines management

The practice had a policy for repeat prescribing. Prescriptions issued as repeat prescriptions were issued for a set number of repeats and then were reviewed by a GP. Staff told us that prescriptions were processed within 48 hours and several patients told us the system for obtaining a repeat prescription worked well. Requests were not normally accepted over the telephone.

We were told that patients who had been prescribed high risk medicines were regularly reviewed and received health checks in line with relevant guidelines and this was borne out by published performance statistics (General Practice Outcome Standards 2013).

The practice had procedures to ensure that the correct temperature was maintained for the storage of temperature-critical vaccines. There was a process for staff to follow should the vaccine fridge temperature deviate from the accepted range and put the integrity of stored vaccines at risk. The maximum and minimum fridge temperatures were recorded once daily and we saw comprehensive records showing temperatures had been maintained. We also randomly checked the vaccine stock and found that all items checked were in date. The vaccine fridge was not kept locked.

Prescription pads were stored securely in a locked safe. However, prescription serial numbers were not recorded upon receipt or distribution. Staff told us they would not be able to check if prescription forms had gone missing.

One patient told us that the doctor had explained the importance of not over prescribing antibiotics when they were unlikely to be of clinical benefit.

Cleanliness and infection control

Patients told us the practice appeared clean, especially since it had been redecorated. They told us that staff washed their hands and wore gloves before performing examinations.

The practice was equipped with personal protective equipment including gloves and wipes and the practice used single-use and disposable supplies to reduce the risk of cross-infection. All the treatment and consulting rooms were appropriately equipped with hand washing facilities. Antibacterial hand gel was available throughout the practice including at the reception desk.

However the practice was not following the NHS Code of Practice on the prevention and control of infections (Health and Social Care Act 2008). There was a lack of clarity within the practice about who was the named infection control lead and what this responsibility entailed. Some staff members thought the GP principal was the lead and others thought it was the practice manager or the practice nurse.

The practice was not following its own policy on infection control. For example, staff had not been trained on infection control procedures. We also found that there was no written cleaning plan for the cleaners to follow. Cleaning products and equipment were stored separately and securely but domestic products were being used which were inappropriate in a clinical setting. The cleaning mop heads had been replaced before the inspection but staff told us these had not been previously been changed for over six weeks. We saw wet cleaning equipment being stored in buckets. The practice had not colour coded its cleaning equipment.

There was a waste management contract in place for the collection of clinical waste, including sharps bins. Sharps bins were correctly installed and were not overfull but had not been labelled with the date of installation.

The practice manager was unsure if the practice was supplied by a water tank within the building and therefore if a risk assessment for Legionella was warranted. No such risk assessment had been carried out.

The practice had not conducted any audit of its infection control procedures.

Staffing and recruitment

The practice was owned by one GP principal who employed four part-time doctors and one part-time practice nurse to provide general medical services to the local population. The GP principal told us that clinical staffing was calculated according to the size of the practice population weighted by age as an indicator of need. The practice also planned to increase its medical staffing sessions over the winter months when patient demand was higher.

There were sufficient clinical sessions to meet the needs of patients. The 2014 national GP patient survey scores for the practice on availability of appointments were better than the regional average. The practice was able to see emergency patients the same day on a walk-in basis and to prioritise sick children for same day appointments. The

Are services safe?

2014 national GP patient survey found that more patients reported having to wait more than 15 minutes after arriving at the practice than the regional average. On the day of our visit, patients were being seen promptly and this included two “walk-in” patients with emergency appointments.

The number of practice nursing hours for the size of the practice population was relatively low. We were told that it was proving difficult to recruit a full-time or additional part-time practice nurse. The practice had considered taking on an agency nurse but this was in still in process. The practice adapted its staffing by using GPs to carry out some responsibilities that would more typically be carried out by a practice nurse, for example, health checks and regular reviews of patients with long-term conditions. Health checks for newly registered patients were only carried out if a patient requested this or if their responses to written health screening questionnaires indicated a health risk.

The practice was able to respond to changes in staffing at short notice, for example, when staff were unwell. The reception staff told us that there was some flexibility to reorganise doctors’ sessions to minimise the cancellation of appointments.

Dealing with Emergencies

Staff were trained to deal with emergencies and provide basic life support in the event of a patient suffering cardiac arrest. The clinical staff were trained annually and other staff received training every other year. Training certificates were kept in staff members' recruitment files.

The practice had an atrial defibrillator which was fitted with pads that were in date. The practice was also equipped with an oxygen cylinder which was working but the practice could not show us any written record of this being checked. The oxygen mask pack had been opened and was out of date (October 2012). There was also a biohazard kit which was out of date (February 2005). The practice had a nebuliser available for use in an emergency. Both masks within the nebuliser pack were out of date (2010 and 1979).

The practice kept a range of emergency medicines on the premises, including medicines to treat anaphylactic shock. The practice nurse was responsible for monitoring and checking the stock of emergency medicines and we saw that these checks were recorded and were complete. The emergency medicines were all in date.

The fire alarm was not routinely tested and the practice had not simulated a fire evacuation for about ten years.

The practice had a business continuity plan which had been reviewed in August 2014. This covered arrangements to handle a number of potentially disruptive events, such as a sudden failure of the computer server. Staff told us they had not experienced any such events but would contact the GP partner and refer to the plan if the need arose.

Equipment

The building was owned by the GP principal. We saw records showing that the building was well maintained and the fire alarms and extinguishers serviced regularly. The practice was appropriately equipped. The premises had recently been redecorated and the waiting room and patient toilet refurbished. Patients spoke positively about the improved practice environment.

The clinical staff we spoke with said they had access to appropriate equipment and supplies. We were told by two GPs that the blood pressure monitors were replaced annually. However we saw that some obsolete or out-of-date items of equipment including oxygen masks in the nurse's cupboard had not been removed from the premises and risked being used in error.

Are services effective?

(for example, treatment is effective)

Our findings

Promoting best practice

Clinical staff followed National Institute of Health and Care Excellence (NICE) guidelines in the assessment and planning of patients' healthcare needs. This was evident in the management of long-term conditions within the Quality and Outcomes Framework (QOF) and enhanced services. For example, the practice kept registers of patients with long-term conditions such as diabetes and high blood pressure and reviewed patients regularly.. The QOF forms part of the national GP contract and rewards GP practice achievement across a range of targets. QOF targets include the management of common long-term conditions; patient experience; the provision of additional services; and how well the practice is organised.

The practice followed national and locally agreed policies for referrals, for example, we were shown performance data showing that patients with cancers were referred within two weeks. The practice had an electronic referral template in place. This enabled the doctors to systematically obtain and assess the information needed to make a referral to the appropriate specialist. Most acute referrals went to Hillingdon Hospital. If a patient preferred to be seen at another hospital, the practice used the "Choose and Book" system to accommodate this.

The practice used a nationally-recognised software tool to identify patients with complex needs who might benefit from multidisciplinary care planning and inclusion in the local integrated care project.

Management, monitoring and improving outcomes for people

The practice undertook clinical audits, for example, a monthly audit of prescribing to meet various QOF targets, enhanced service targets and benchmarking exercises organised collaboratively by the Clinical Commissioning Group (CCG). Individual GPs had undertaken audits as part of their revalidation and appraisal process. The practice also supplied examples of completed audit cycles (that is, where the practice had re-audited an aspect of service to ensure that improvements had been made). Examples included repeat prescribing, substance misuse, A&E attendances and cost-effective prescribing.

The GP principal met with CCG pharmacists and reviewed performance data. Monthly audits were conducted for prescribing on all medicines. The practice attended monthly meetings with specialists to look at the appropriateness of referrals which was then fed back to clinical staff and the practice manager. We were given examples of meetings focusing on orthopaedics and ENT which had been relatively high locally suggesting that some referrals might be unnecessary. The practice had recently successfully focused on reducing its prescribing expenditure and had achieved the lowest spend on prescribing of GP practices in Hillingdon.

A group of four local practices regularly met (representing 42000 patients). The GP principal took a lead role in this group and in developing the agenda for meetings, for example setting up a recent discussion to explore ways of increasing patient access.

Staffing

Practice staffing included medical, nursing, managerial and administrative staff. The GP principal had additional diplomas in substance misuse and professional expertise in forensic medicine and provided shared care for patients with substance misuse and a primary care service for violent patients.

The GPs were up-to-date with their yearly continuing professional development requirements and maintained records of their professional development. All the GPs had either been revalidated or had a date for revalidation. (Every GP is appraised annually and every five years undertakes a fuller assessment called revalidation. Only when revalidation has been confirmed by NHS England can the GP continue to practice and remain on the performers list with the General Medical Council).

Administration staff had received training such as basic life support, health and safety, safeguarding adults, and child protection. Staff told us they had received in-house training on protecting patient confidentiality; however staff were not confident about their responsibilities in relation to information governance and had not received training about this. For example, staff told us they sometimes did not lock or log out of their computer accounts before leaving their desks and staff sometimes used computers when these were still logged into another staff member's account making it difficult to audit record keeping.

Working with other services

The practice worked in partnership with a range of external professionals in both primary and secondary care to ensure

Are services effective?

(for example, treatment is effective)

a joined up approach for patients. The GP principal provided us with many examples of how the practice engaged with external colleagues and agencies, for example, to reduce unnecessary hospital admissions and the practice prescribing budget. The practice was keen to share good practice and attended local CCG and practice network meetings. The GP principal was the clinical lead for the local practice network.

The practice ran multidisciplinary team meetings each month to consider the case management of patients with complex needs and any patients coming to the end of their life. These meetings were attended by one of the salaried GPs, the practice nurse and community health services staff.

Outside of practice hours patients were directed to the out-of-hours service. The practice received notifications by fax each morning of any patients who had attended the out-of-hours service and these were reviewed by the duty doctor. The practice also communicated with the out-of-hours service to notify them of patients on the palliative care register. The out-of-hours contact number was available to patients in the practice leaflet and patients we spoke with said they knew how to contact the out-of-hours service.

Patients could make an appointment to discuss the results of their tests, or could telephone the practice at a designated time to receive their results. The practice had a system in place to ensure that test results were followed-up when a GP was away. We checked this on the day of inspection and saw that all incoming results and letters had been passed to an available doctor.

Health, promotion and prevention

The practice participated in national screening and health promotion programmes, including routine child immunisations, cervical screening and influenza vaccination for patients over 65 or at risk groups. The practice was performing in line with or better than other practices in the area for immunisation rates of children at 12 months, 24 months and five years of age.

All new patients were asked to complete a medical history and screening questionnaires covering alcohol intake and smoking history. Patients whose responses indicated a potential health risk were offered a health check with one of the GPs. The practice was in the process of introducing a new service offering health checks for patients between the ages of 40 and 74 to assess and reduce the risk of developing heart disease and other common long-term conditions.

We were told that the practice used the reviews of patients with long term conditions or learning disability to involve patients in the self-management of their condition as well as to provide general health promotion and prevention advice.

There was a range of health promotion information in the waiting areas. Information covered cancer, breast screening, the shingles vaccine, backache, meningitis, overuse of antibiotics, child immunisation and smoking cessation.

Are services caring?

Our findings

Respect, dignity, compassion and empathy

The practice had systems in place to respect patients' privacy and dignity. Clinical rooms had privacy screens for use during examinations and a chaperone service was available during intimate examinations. Patients were offered a choice of seeing a male or female GP when booking appointments in advance. The practice had recently placed a radio in the waiting room to reduce the risk of waiting patients overhearing conversations at the reception desk although it had not yet obtained the appropriate licences for this as required by the Copyright, Designs and Patents Act 1988.

We asked reception staff how they protected patient confidentiality. Reception staff were aware of the practice confidentiality policy. Staff told us if a patient needed to discuss a sensitive issue they could use a private room within the practice. There was no written notice informing patients about this.

The majority of patients we spoke with and who completed comment cards were positive about the quality of care they received and reported being treated with dignity and respect. The 2014 national GP patient survey showed that 70% of patients replied positively when asked if the GP treated them with care and concern which was below the regional average. The practice had received several complaints from patients about the manner of one doctor. The GP principal told us they had discussed the issue with the doctor concerned and would be monitoring the situation.

The practice referred patients who had recently been bereaved to a specialist bereavement counselling service. An information booklet on bereavement was provided to patients.

Involvement in decisions and consent

The 2014 national GP patient survey found that two thirds of respondents said that the last GP they saw or spoke to at the practice was good at involving them in decisions about their care, which was below the regional average. The patients we spoke or who completed comment cards were positive with some patients telling us they had been equal partners in their care. One patient commenting on the NHS Choices also highlighted their experience of good involvement in their care.

The clinical staff told us they sought verbal consent from patients before any examination, treatment, referral or immunisation. The practice used a telephone interpreting service to ensure that patients whose first language was not English were able to give informed consent to care. The GPs we spoke with had knowledge of the Mental Capacity Act (2005) and were aware they may need to assess mental capacity when treating patients for example, with learning disabilities and dementia and involve social services professionals and the patient's carers.

The doctors were aware of Gillick and Fraser guidelines to assess younger patients' maturity to make decisions without the consent of their parents when this was appropriate.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice provided a service to a diverse population with a wide range of needs. Most of the patients we spoke with and who completed comments cards said the practice met their needs.

The practice was able to demonstrate an understanding and awareness of the needs of the local population including people with mental health needs and people of working age. The practice had extended its opening hours in response to patient concerns. The GP principal provided examples of how that they explored ways of improving and coordinating services within the area for example on obesity.

The practice engaged with commissioners and other providers to co-ordinate care to meet the needs of the different patient groups it served. The practice participated in a number of "local enhanced services" (LES) schemes to improve the management and delivery of care to specific patient groups, for example to identify patients with dementia and to support people to better manage diabetes.

Patients over 75 had a named GP. The practice also provided a named GP to patients receiving shared care for substance misuse, patients with learning disability, patients who received end of life care and patients with a history of violence in health care settings. These patients were able to access the doctor who was familiar with their history and treatment at each appointment.

The practice delivered services to meet the needs of different patients. Patients with long term conditions were encouraged to attend the practice for review, monitoring and supervision of treatment. The GPs screened and actioned all test results the same day and had a system for checking test results when individual doctors were away. The GP principal and practice manager ensured there were no outstanding results to be screened on Friday evenings.

Referrals were screened by the GP principal to ensure they were appropriate. Urgent referrals were confirmed on the electronic system and tracked to ensure that patients received timely care.

Access to the service

Patients had access to appointments outside of normal working hours. The practice was open from 08:00 to 18:30 on Monday to Friday and was also open on Saturday mornings. The practice scored positively in the 2014 national GP patient survey for questions about access to services with 86% of respondents reporting they were able to access the service when they needed and 76% reporting they were satisfied with the opening times. These figures were higher than the regional averages.

The practice had recently started to offer online booking of appointments and was in the process of introducing an electronic prescribing service. Posters displayed in the waiting room explained how to use the booking system. The patients we spoke with during the inspection had all telephoned or visited the practice in person to book an appointment.

The practice was accessible to patients with disabilities. The practice staff spoke a number of different languages and one patient told us they greatly appreciated being able to communicate with the doctor in their first language. The practice also used a telephone interpreting service when required.

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 and there was a designated responsible person, the GP principal, who handled all complaints in the practice.

The practice had received a number of written complaints in the previous twelve months. The practice had investigated and responded to each of these in line with the practice policy. In one case, a complaint about the waiting room had triggered the redecoration and purchase of new furniture. The practice wrote to the complainant with an apology when their complaint was upheld. The practice manager and GP principal had also met with one patient who had remained unhappy about an issue following the investigation.

Information about how to make a complaint was displayed in the waiting room and also in the practice leaflet. This information included details on who to contact if patients were unhappy with the practice's response and wanted to take the complaint further.

Are services responsive to people's needs?

(for example, to feedback?)

The practice had also recently reviewed comments posted on NHS Choices and where these were negative had invited the person posting the comment to contact the practice so their concerns could be followed-up.

The practice population was relatively young but the practice did not have a website. Some information about the practice was available online through the NHS Choices website but this was limited and some of the information was out of date.

Are services well-led?

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

Our findings

Leadership and culture

The GP principal was the practice lead and staff consistently told us he was visible and approachable. The practice manager was responsible for supervising the administrative team. Staff told us there was an open culture and they felt able to talk to the practice manager and GP principal.

The GP principal articulated a vision to improve services for the community, with a focus on strengthening health promotion and developing the practice's services for vulnerable patients. We were shown evidence that the GP principal was engaging with colleagues in commissioning and community health services to share ideas for improving care for example around obesity.

Governance arrangements

The practice had identified leads among the GPs and nurse for different clinical areas, such as end of life care, integrated care and wound care. The GP principal regularly met with one of the sessional GPs and the practice manager to review clinical issues including incidents, complex cases and new service developments. However the GP principal did not attend the practice every day and day-to-day roles and responsibilities were sometimes unclear to staff. This was evident for example, in the arrangements for infection control and the collation of significant event reporting. Leadership was assumed to rest with the GP principal with the result that no one was taking overall responsibility for implementing and monitoring robust procedures. The practice did not have a development plan, team objectives or a risk register.

Staff were aware of the importance of protecting patient confidentiality but there were shortcomings in the practice's systems for information governance, for example, staff did not always ensure that they were correctly logged in and out of the electronic records system. Staff members could not recall receiving training on information governance and there was no evidence of completed training on information governance in the staff folders that we reviewed.

Systems to monitor and improve quality and improvement

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 national standards. We saw that QOF data was regularly discussed at monthly team meetings and action plans were produced to maintain or improve outcomes.

GPs we spoke with described their involvement in significant event analysis, clinical audit, and networking with other practices, health and social service providers and the CCG. The GP principal provided many examples of collaborative working such as their work with the local clinical network and shared care service for substance misuse. The practice primarily monitored the quality of service through the QOF and contract monitoring of its enhanced services and used these mechanisms to promote improvement. The practice also used complaints as a mechanism for learning and improvement.

Patient experience and involvement

The 2014 national GP patient survey showed that the practice scored well with patients on access to appointments. However the practice consistently achieved scores on patient involvement and experience that were below the regional average. The practice had not taken any action to explore why this might be the case.

The practice did not have a website and did not conduct its own surveys. The practice did not have a Patient Participation Group and had no active plans to recruit one. The practice had installed a suggestion box in the waiting room but there had been little response to this. Aside from responding to concerns and complaints we found the practice did not proactively engage with patients or the public. The GP principal was disappointed with some of the findings in the national patient survey but the lack of engagement meant that the practice had been unable to explore these findings further.

Staff engagement and involvement

Practice staff told us they were able to raise any concerns or suggestions for improvement with the GP principal or practice manager and thought they would be listened to. However there were few formal mechanisms to engage the wider staff team, for example in meetings or through other feedback mechanisms.

Learning and improvement

There was an open reporting culture within the practice. Staff were comfortable discussing incidents that had occurred and actions they had taken to prevent the risk of recurrence. However there were relatively few

Are services well-led?

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

opportunities for staff to meet as a team and reflect on the service. We were told that this was in part due to the extended opening hours of the practice and also the number of staff working part time. The GP principal told us this was an issue that was under review.

Identification and management of risk

The practice did not keep a formal risk register. The practice manager told us that they regularly discussed issues and risks with the GP principal as they arose.

However we found that the practice staff did not always follow statutory and good practice guidance to reduce known risks, for example, in infection control and information governance.

The practice had a business continuity plan in place with set procedures for staff to follow to minimise any risk to patients and disruption to the service.

Older people

All people in the practice population who are aged 75 and over. This includes those who have good health and those who may have one or more long-term conditions, both physical and mental.

Our findings

The practice had a relatively low proportion of registered patients aged over 75 but was participating in an integrated care project and providing a number of other enhanced services that were particularly relevant to this group of patients. We spoke with two older patients on the day of the inspection who were both positive about the care they received at the practice. We spoke with one of these patients through an interpreter (family member) and they told us they were able to speak directly to their preferred doctor in their first language and greatly appreciated this.

The integrated care project aimed to identify those patients at highest risk of emergency hospital admission and provide planned primary and community care to avoid health crises and unnecessary admissions in this group of patients. Patients at high risk were identified from the registered patient list by a validated software tool. Most of these patients were over 75 and had multiple health conditions. The practice attended monthly multidisciplinary meetings to discuss individual cases. The meetings were also attended by hospital consultants from various specialties, the palliative care team, psychologists and nursing and social care professionals. A health and social care coordinator was attached to the practice for two days a week to facilitate the project. We were told that the practice had achieved the highest number of completed care plans for eligible patients of all participating practices in Hillingdon.

The practice also provided an enhanced service to identify patients at risk of dementia and refer these patients to the specialist memory clinic. There were clear referral criteria and a designated "pathway" to ensure patients with memory loss were assessed consistently and could access specialist support early in their illness. The practice invited all patients with a diagnosis of dementia for an annual health review which also included consideration of their primary carer's needs.

The practice provided an enhanced service for end of life care. The aim was to ensure that patients known to be reaching the end of their lives could experience a "good death", for example in familiar surroundings and in the company of family and friends. The practice typically only had two or three patients receiving end of life care at any one time. These patients tended to be over 75. The practice had a lead doctor for end of life care who liaised with the palliative care team through a district nurse key worker. They had recently reviewed the needs of patients who were reaching the end of the life but were not on a cancer "pathway". The doctor had received update training on palliative care in 2013. The practice was also able to refer patients directly to specialist palliative care services and could request support for patients from a palliative care nurse.

The practice provided an enhanced service for the treatment of cancer of the prostrate, the incidence of which increases with age. The practice was managing the prescribing of certain medicines (gonadorelins) for eligible patients with the aim of providing care that was safe, more convenient and closer to home than hospital.

Few of the practice's older patients lived in care homes. However, the GP principal told us that the practice had provided the surgery bypass telephone number to one care home which had a number of patients registered with the practice so they had ready access to the service at busy times.

People with long term conditions

People with long term conditions are those with on-going health problems that cannot be cured. These problems can be managed with medication and other therapies. Examples of long term conditions are diabetes, dementia, CVD, musculoskeletal conditions and COPD (this list is not exhaustive).

Our findings

The practice had scored highly on the Quality and Outcomes Framework (QOF) the previous year for the management of long-term conditions including atrial fibrillation, coronary heart disease, diabetes, asthma and dementia and had continued to make good progress with its QOF achievement in the current year.

The practice was signed up to a number of enhanced services designed to provide effective care for people with specific long-term conditions. The practice participated in the primary care diabetes enhanced service. All patients with diabetes were offered an annual review which covered how well their condition was being managed and on-going care planning. The practice had carried out audits of impaired glucose regulation and micro-albuminuria management as part of this service. The practice did not generally run regular nurse-led condition specific clinics, but instead, once a year, systematically checked and recalled all eligible patients who had not yet attended the practice for a review.

The practice worked with other health professionals and services to provide patients with long term conditions with appropriate support. We were given examples of how the practice had worked with the rapid response team (social services), district nursing and community matrons and the local cardiac rehabilitation and heart failure services to provide "joined up" care. We spoke with one patient who had recently experienced heart bypass surgery and they described the aftercare and advice they had received from the practice as excellent.

The 2014 national GP patient survey suggested that although patients were able to access appointments at the surgery, it was sometimes difficult for patients to get an appointment with the doctor of their choice. Forty-six per cent of respondents said they were usually able to see their preferred GP which was below the regional average. The GP principal employed three sessional GPs all of whom worked part-time. The lack of continuity particularly affected patients with long term conditions. Two patients we spoke with said they preferred to wait for an appointment to see their preferred doctor even if this meant waiting over a week for an appointment to become available.

Mothers, babies, children and young people

This group includes mothers, babies, children and young people. For mothers, this will include pre-natal care and advice. For children and young people we will use the legal definition of a child, which includes young people up to the age of 19 years old.

Our findings

The practice did not directly provide antenatal care beyond the initial confirmation of pregnancy and referral to the local maternity unit and midwifery services. The practice had a maternity services policy setting out the process for making this referral and describing what women could expect from their antenatal care including the timing of screening tests and scans. This policy did not address how the practice should respond to women wishing to give birth at alternative hospitals however.

The practice provided routine postnatal and baby checks six weeks after the birth in line with the national child health programme. These checks included screening questions to identify women at high risk of post-natal depression. The practice also had written procedures to ensure that children with developmental concerns were identified and referred appropriately. The practice offered routine child immunisation in line with national policy and monitored uptake. The practice referred cases where children had missed their immunisation to the local Immunisation Task Force team for follow-up.

Clinical staff we interviewed were aware of relevant guidelines and criteria in obtaining informed consent from young people.

A child protection policy and procedure were in place and clinical staff were confident they would identify and respond to any concerns about abuse. The child protection policy included a list of local agencies with contact details to which staff were able to refer. The computer records system alerted staff when children known to be “at risk” attended the practice. Clinical staff were trained to the required level on child protection. Administrative staff had recently undergone online training to refresh their awareness.

Working age people (and those recently retired)

This group includes people above the age of 19 and those up to the age of 74. We have included people aged between 16 and 19 in the children group, rather than in the working age category.

Our findings

Patients had access to appointments outside of normal working hours. The practice was open from 08:00 to 18:30 on Monday to Friday and was also open on Saturday mornings. The practice scored positively on the 2014 national GP patient survey for questions about access to services with 86 per cent of respondents reporting they were able to access the service when they needed and 76 per cent reporting they were satisfied with the opening times. These figures were higher than the regional averages.

The practice had recently started to offer online booking of appointments and was in the process of introducing an electronic prescribing service. Posters displayed in the waiting room explained how to use the new booking system. The patients we spoke with during the inspection with had all telephoned or visited the practice in person to book an appointment. This suited some patients more than others and two patients reported frustration with having to telephone the surgery on consecutive days to secure a non-urgent appointment if they had other commitments such as work or getting children ready for school.

The practice had signed up to the NHS health check programme for patients aged between 40 to 74 and was in the process of installing point of care cardio testing equipment to facilitate this. All new patients were asked to complete screening questionnaires, for example on alcohol consumption, and offered a consultation with a doctor if any health risks were identified.

The practice was registered for the enhanced service, influenza and pneumonia. There was an annual campaign of the influenza vaccination aimed at specific patient groups, including those aged 65 and over.

People in vulnerable circumstances who may have poor access to primary care

There are a number of different groups of people included here. These are people who live in particular circumstances which make them vulnerable and may also make it harder for them to access primary care. This includes gypsies, travellers, homeless people, vulnerable migrants, sex workers, people with learning disabilities (this is not an exhaustive list).

Our findings

The practice provided additional services designed to enable certain groups of patients to access primary care.

The practice was providing a scheme for patients with a history of violence in healthcare settings. The GP principal had extensive expertise in forensic medicine and generally provided the clinical care for this group of patients to ensure continuity of care. The service was available to patients across the borough of Hillingdon on referral. On receipt of a referral, the GP principal undertook a rapid risk assessment and provided consultations, in a secure setting if necessary. The practice premises had been adapted to protect the safety of staff, for example with a toughened security screen in reception. The receptionists told us they had not experienced problems in supporting this group of patients and were aware of their needs and minimised disruption and delays. Staff were able to call for immediate assistance in an emergency and we were told that colleagues responded immediately to any alarm. The practice communicated relevant information to the local out of hours service about violent patients.

The practice provided shared care for people experiencing problems with substance misuse. The practice was working closely with the specialist substance misuse services in Hillingdon and was moving towards a “recovery model”; that is, supporting people to reduce their dependency on drugs over time. The practice provided referral to and follow-up after detox programmes and provided longer term drug replacement and maintenance programmes.

The GP principal was able to give us examples of the complexity of these patients’ needs and the importance of continuity of care for this group of patients, for example in identifying other health problems, providing health promotion advice and referring patients to specialist services including mental health services.

There were systems in place to regularly review patients on the shared care programme and checks in place to reduce the risk of medicines being obtained and used inappropriately. However, the practice needed to improve the security of prescriptions and the medicines fridge which was not kept locked. We spoke with a senior consultant at the specialist service who described the practice as outstanding because of a willingness to treat challenging patients from outside the practice boundary; a clear understanding of when to refer patients back to the specialist team; and the desire to learn and develop the service for the benefit of patients.

The practice provided an enhanced service for patients with learning disability. The practice kept a register of patients aged 14 or over and offered these patients annual health checks. The aim of the checks was to review patients’ physical and mental health with them, including health promotion, medicines and communication needs. The practice told us that the emphasis was on involving patients and carers in their care and making sure that services were well coordinated, including transitional arrangements if the patient was reaching adulthood. Patients with learning disability were provided with a tailored health action plan.

People experiencing poor mental health

This group includes those across the spectrum of people experiencing poor mental health. This may range from depression including post natal depression to severe mental illnesses such as schizophrenia.

Our findings

The practice provided primary care mental health services and referred patients with more acute or severe mental health problems to specialist services. A counsellor was attached to the practice one day a week and patients were able to access this service on referral by their GP. The GPs also referred patients with common mental health problems such as depression and anxiety to the Hillingdon Primary Care Psychological Therapies service.

The GP principal told us there were good links between the practice and local specialist mental health services including child and adolescent mental health services. Referrals were screened by specialist services promptly and the practice was notified in writing within three working days of the outcome of the referral. The doctors knew how to make urgent referrals and discussed individual cases with specialist colleagues when this was helpful.

The practice kept a register of patients diagnosed with psychotic illness and invited these patients for an annual review. The review covered blood lipid levels in patients aged over 40, plasma glucose levels, weight, smoking, alcohol use, blood pressure in line with national guidelines. Women were offered cervical screening if appropriate. The practice had achieved its QOF targets for mental health the previous year. Routine published data (General Practice Outcome Standards, 2013) also indicated that this group of patients received health checks.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 16 HSCA 2008 (Regulated Activities) Regulations 2010 Safety, availability and suitability of equipment **The provider had not made suitable arrangements to protect patients from the use of unsafe equipment. In particular, the provider was not ensuring that equipment was properly maintained and suitable for its purpose.** Regulation 16 (1)(a)(4)(a)(b)

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control **The provider was not ensuring that patients and staff were protected against the risks of acquiring a health care associated infection. The practice did not have effective systems to prevent and control the spread of health care associated infections. The practice was not maintaining appropriate standards of cleanliness and hygiene.** Regulation 12(1)(a)(b)(2)(a)(c)(i)

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers **The provider did not have fully effective systems to assess and monitor the quality of the service and identify and manage risks. In particular, the provider was not actively seeking the views of patients and incident reports were not systematically collated.** Regulation 10 (1)(a)(b) 2(c)(i)(ii)(e)

This section is primarily information for the provider

Compliance actions

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers **The provider was not operating effective recruitment procedures. In particular the provider had not obtained Disclosure and Barring Service checks on some staff members who carried out chaperone duties.** Regulation 21(a)(i)(b)