Budshead Medical Practice

Quality Report

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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this service	Requires improvement
Are services safe?	Requires improvement
Are services effective?	Good
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

Budshead Medical Practice is a GP practice providing primary care services for people in Plymouth. It provides services from one location in Plymouth where we carried out an announced inspection on 12 November 2014.

Patients who use the practice have access to community staff including district nurses, health visitors, mental health staff, counsellors and midwives.

We rated this practice overall as requires improvement.

Specifically, we found the practice requires improvement for providing safe services and also for well led services. It was good for providing an effective, caring and responsive service to the patient population groups.

Our key findings were as follows:

- Patients felt they were treated with dignity and respect and in a professional manner that showed kindness and care towards them.
- Patients considered the appointment system to be fair and easy to use. They were able to see a GP on the day of requesting an appointment.
- The practice ethos was patient-centred with a pro-active management of patient care and recognition of vulnerable patients who may need additional support and care.
- The practice benefited from positive support of education and further learning promoted for staff by the partners.
- Patient safety was compromised because systems and processes were not in place to minimise risks to safety. Whilst significant events were discussed at a whole staff meeting, the practice did not have a designated system in place for reporting, recording and monitoring, which showed learning from significant events. Emergency equipment was not managed safely.

Summary of findings

- The practice had a clear complaints procedure that was displayed in the waiting room where there were also leaflets for patients. Information was also available on the website. However there was a lack of detailed recording, or actions taken.
- The practice did not have a defined leadership structure in place and limited formal governance arrangements.

Importantly the provider must:

- Ensure staff have clear procedures to follow to ensure medicines and equipment required for resuscitation and other medical emergencies are regularly checked, maintained and in date.
- Ensure recruitment arrangements include all necessary risk assessments and employment checks for all staff.
- Ensure that a risk assessment is in place in relation to testing for legionella.
- Ensure there are formal governance arrangements in place including systems for assessing and monitoring risks and the quality of the service provision.

In addition the provider should:

- Ensure systems are in place to monitor, analyse and learn from complaints and significant events.
- Ensure that staff receive training about equality and diversity awareness according to their role.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement 

The practice is rated as requires improvement for providing safe services as there are areas where it should make improvements. There were good systems in place in relation to safeguarding vulnerable adults and children. Staff understood their responsibilities to raise concerns, and to report incidents and near misses. However, when things went wrong, reviews and investigations were not thorough and lessons learned were not communicated widely enough to support improvement. Medicines management was safe and effective. Although risks to patients who used services were assessed, the systems and processes to address these risks were not fully implemented to ensure patients were kept safe. Areas of concern included aspects relating to recruitment, emergency equipment, and infection control.

Are services effective?

Good 

The practice is rated as good for providing effective services.

Patient's needs were assessed and care was planned and delivered in line with current legislation. This included assessing patients' capacity to make informed decisions and promoting good health. Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. There had been some completed clinical audits which had led to improvements in patient outcomes, such as screening patients with particular long term conditions for signs of depression, this had driven changes to systems to effect change.

Are services caring?

Good 

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.

Are services responsive to people's needs?

Good 

The practice is rated as good for providing responsive services.

The practice had reviewed the needs of its local population and was working towards putting in place a plan to secure improvements for the areas identified. Patients said they were able to make an

Summary of findings

appointment with a named GP in advance and urgent appointments were available the same day. The practice was equipped to treat patients and meet their needs. Patients could get information about how to complain in a format they could understand.

Are services well-led?

Requires improvement

The practice is rated as requires improvement for being well-led.

GPs and practice staff were committed to delivering high quality care and promoting good outcomes for patients. The practice had a vision and a strategy but not all staff were aware of this and their responsibilities in relation to it. Staff were positive and proactive about caring for their patient population but there was no clear leadership structure or lines of accountability and staff reported that communication between different teams needed improvement. The practice had a number of policies and procedures to govern activity and some systems were working well, but some policy reviews were overdue. Governance meetings were held regularly but did not always include all relevant staff.

The practice sought feedback from patients and had a patient participation group (PPG) however feedback from patients was that the practice needed to show how it responded to the issues raised. All staff had received regular performance and development reviews.

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

Good

The practice is rated as good for the care of older people. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. Care and treatment of older people reflected current evidence-based practice, and all older patients had been notified of their named GP. Care plans were in place where necessary and had a range of enhanced services, for example, in end of life care. It was responsive to the needs of older people, and worked with other health and social care organisations to provide support and care for them.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. Nursing staff 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.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. 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. Immunisation rates were high (98%) for all standard childhood immunisations. Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this. 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. The practice had good working relationships and signposting for young people to age appropriate support organisations.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students). The needs of the working age population and those recently retired had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. For example there were two days a week when late appointments

Summary of findings

were available. The practice had tried offering Saturday morning appointments for patients who worked routine Monday to Friday office hours however there was little uptake by this group of patients. The practice was not within a student catchment area.

The practice was proactive in offering online services including prescriptions and booking appointments. The practice had a range of health promotion and screening that reflected the needs for this age group.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including those with a learning disability, patients at risk of hospital admission and carers. It had carried out annual health checks for people with a learning disability and carers. It offered longer appointments for people with a learning disability.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people and were keen to seek ways to involve groups of patients, for example, those on low income or with social issues such as housing, and vulnerable patients with mental health issues, so they could feel confident about seeking treatment, care and support.

They had told vulnerable patients about how to access various support groups and voluntary organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

The practice did not hold a register of vulnerable patients who may be homeless people or were travellers. People in these circumstances were directed to another service.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). They held a register of patients experiencing poor mental health, who had received an invitation to an annual physical health check. The practice also had a register of patients diagnosed with dementia. The staff regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. They carried out advance care planning for patients with dementia who were living in care homes.

Summary of findings

Patients experiencing poor mental health were offered the first appointment of the afternoon to avoid having to sit in a full waiting room. They were also offered longer appointments. The practice carried out drug monitoring and offered patients community psychiatric nurse appointments at the practice.

The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations. It had a system in place to follow up patients who had attended the accident and emergency department, where they may have been experiencing poor mental health. Clinical staff had received training on how to care for people with mental health needs and dementia.

Summary of findings

What people who use the service say

We spoke with 10 patients and received eight comments cards completed by patients. These were patients of all ages including young people, parents of children registered at the practice, working age and recently retired people, older people and people with long term conditions. We also read the minutes of the patient participation group (PPG) meetings however we were not able to meet with anyone representing this group. The PPG is a group that acts as a voice for patients at the practice.

Patients all spoke positively of the GPs and nurses. They considered they felt listened to and valued as a person as well as a patient. Patients told us they were always treated respectfully by the GPs and nurses, and appointments were not rushed. Parents told us they felt comfortable about bringing their children to the practice.

Patients told us the receptionists were polite and courteous both on the telephone and at the reception desk. Patients said sometimes they experienced difficulty asking for certain types of appointments because they felt overheard by people in the waiting room. However, patients felt reception staff respected confidentiality.

All the comments cards were positive with a caring theme.

People told us that the appointment system was fair and if they needed to see a GP on the same day they had been able to do so. Staff at the practice told us that an online appointment system was available to patients and text reminders were sent for some appointments, particularly health checks. Patients told us they liked this reminder.

Two patients told us the practice had asked for feedback. One of these patients however said they felt the practice could do more to demonstrate how it acted on feedback. Four patients told us they had never been asked for feedback.

All the patients we spoke with told us they had not needed to make a complaint and they were not all aware of how to make a complaint, they also told us they would find out if they needed to do so.

Areas for improvement

Action the service MUST take to improve

- Ensure staff have clear procedures to follow to ensure medicines and equipment required for resuscitation and other medical emergencies are regularly checked, maintained and in date.
- Ensure recruitment arrangements include all necessary risk assessments and employment checks for all staff.
- Ensure that a risk assessment is in place in relation to testing for legionella.
- Ensure there are formal governance arrangements in place including systems for assessing and monitoring risks and the quality of the service provision.

Action the service SHOULD take to improve

- Ensure systems are in place to monitor, analyse and learn from complaints and significant events.
- Ensure that staff receive training about equality and diversity awareness according to their role.

Budshead Medical Practice

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, an emergency care practitioner specialist advisor and an expert by experience. (This is a person who has personal experience of using or caring for someone who uses this type of service).

Background to Budshead Medical Practice

Budshead Medical Practice provides care and treatment to approximately 6000 patients of whom older people, single parents and unemployed people are higher in numbers than the national average. This practice is located in a suburb of Plymouth which is recognised as the fourth most deprived area in Devon. The premises have undergone three major refurbishments and upgrades over 25 years to ensure services are provided from a building that is compliant with the Disability Discrimination Act 2005.

There are three partner GPs (two male and one female). GP partners hold managerial and financial responsibility for running the business. The practice has undergone significant change since 2011 with the retirement of two partners within six months of one another, and an unsuccessful subsequent partnership. There was a period when a locum GP was used to cover the gap between the partnerships. The current partnership is the third GP partnership within the past three years. It is relatively new with the third partner joining in October 2013. One salaried GP (female) joined the practice in October 2014. The practice is a teaching practice for second year students.

One of the partners became an approved trainer in August 2014 and the practice was anticipating its first trainee GP to start in January 2015. The practice has three practice nurses. There is also one healthcare assistant. There is a practice manager and a reception manager who manages five reception/admin staff who cover all aspects of both these roles.

The practice has an active patient participation group (PPG).

Budshead Medical Practice provides services from one location, 433 Budshead Road, Plymouth PL5 4DU. We carried out an announced inspection here on 12 November 2014.

Budshead Medical Practice is part of the Tamar Alliance group which is a federation of nine practices in North West Plymouth and totals over 50,000 patients.

The practice operates an urgent appointment system for 50 percent of the daily appointment times, bookable appointments (up to four weeks in advance) fill the rest. There is a duty GP each day, to ensure patients can see a GP on the day of requesting an emergency appointment. The practice opening times are Monday, Wednesday and Friday 8am to 6.30pm, and Tuesday and Thursday 8am to 7.30pm. The practice is closed on Saturdays. Telephone lines are open from 8am to 6pm daily.

Out of Hours services are provided by another organisation. Outside of opening hours a recorded telephone message advises patients of the emergency GP service. Patients are also signposted to contact NHS 111.

Detailed findings

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme. This provider had not been inspected before and that was why we included them.

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Please note that when referring to information throughout this report, for example any reference to the Quality and Outcomes Framework (QOF) data, this relates to the most recent information available to the CQC at that time.

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. Organisations included the local Healthwatch, NHS England, the local clinical commissioning group and local voluntary organisations.

We requested information and documentation from the provider which was made available to us either before, during or within 48 hours after the inspection.

We carried out an announced visit on 12 November 2014. During our visit we spoke with a range of staff including four GPs, two practice nurses, the practice manager, the reception manager, and three reception/administration staff. We reviewed some redacted personal care or treatment records of patients in order to see the processes followed by the staff. We observed how the practice was run and looked at the facilities and the information available to patients. We looked at documentation that related to the management of the practice. We observed staff interactions with other staff and with patients and made observations throughout the internal and external areas of the building.

During the inspection we spoke with 10 patients who used the service, carers and family members of patients. We reviewed 8 comment cards where patients and members of the public shared their views and experiences of the service.

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

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

We also looked at how well services 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 whose circumstances may make them vulnerable
- People experiencing poor mental health (including people with dementia)

Requires improvement

Are services safe?

Our findings

Safe track record

The practice had access to 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. We were told, for example, that when the GPs received Medicines and Healthcare products Regulatory Agency (MHRA) alerts (medical alerts about medicines safety) they may search their individual patient lists to check whether any patients would be affected, to ensure they took appropriate actions to protect patients. A message may be put on the patient record or an alert to remind the GP to review, for example, a particular medicine the patient was prescribed. Individual GPs managed their own patients according to their reading of the alert.

Learning and improvement from safety incidents

The practice had a system in place for reporting and recording significant events. The information about how a significant event was investigated was scant as was any information about the resolution. We looked at significant events relating to how or what learning had taken place, and how the event(s) could be avoided or services improved in the future, however there was a lack of evidence of communication with staff to support learning and change in practice.

Reliable safety systems and processes including safeguarding

The practice had appointed a GP as lead in safeguarding vulnerable adults and children. They and the other GPs at the practice had been trained to the appropriate level and could demonstrate they had the necessary training to enable them to fulfil this role. The newly appointed salaried GP had yet to undertake vulnerable adults training, but was able to describe incidents in their previous job which demonstrated knowledge and understanding of safeguarding vulnerable adults.

We asked members of medical, nursing and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities. Staff we asked did not know who the lead GP was, however they said they would always raise any concerns with either a GP or the practice manager. The practice manager confirmed that all staff had access to a flowchart showing them what to do and contact details of relevant agencies.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments, for example, patients who were known to be at risk of domestic violence. If a patient was known to have history of violence, this was recorded on their patient record and NHS 111 was also informed. As a safety precaution the practice had changed its system for children being brought to appointments for immunisations by anyone other than the child's parent. This ensured it was logged on the child's patient record who brought the child and that it was with the parent's consent.

There was a chaperone policy, which was displayed in consulting rooms. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). All nursing staff, including health care assistants, had been trained to be a chaperone. Reception staff could act as a chaperone if nursing staff were not available and had also undertaken training.

Medicines management

The practice had identified a GP lead with responsibility for medicines management and prescribing. This GP met quarterly at the practice with the clinical commissioning group medicines management team, and twice a year with all the prescribing lead GPs in the area.

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. The practice staff followed the policy.

Processes were in place to check medicines were within their expiry date and were suitable for use. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

The practice nurses administered vaccines using directions that had been produced in line with legal requirements and

national guidance. We saw up-to-date copies of both sets of directions and evidence that nurses had received appropriate training to administer vaccines. The nurses told us about an issue on the previous 12 months when a patient group directive (PGD) had arrived late for a new medicine. In line with good practice the nurses had used a patient specific directive (PSD) until the PGD arrived.

The practice offered travel vaccinations. Patients requiring a yellow fever vaccination were referred elsewhere as the practice was not a registered yellow fever centre.

There was a system in place for the management of high risk medicines, which included regular monitoring in line with national guidance. Appropriate action was taken based on the results. For example, the nurses routinely searched records to identify patients who were due or overdue for a medical review if they were prescribed strong and high risk medicines. If recent blood tests could not be identified, the patient record defaulted to alert GPs and nurses the patient was due for an annual medical review.

Cleanliness and infection control

We observed the premises to be clean and tidy. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control. We were told a deep clean of the premises had taken place three months prior to this inspection however there was no written record of this. Staff were not confident there was a rota or schedule for this to happen routinely. The practice manager confirmed it was likely to be implemented annually. There was no evidence of regular weekly or monthly cleaning schedules.

It was not clear who in the practice was the lead for infection control. Staff were not able to confirm if there was a named lead person.

We saw that personal protective equipment including disposable gloves, aprons and coverings were available for staff to use. Staff were able to describe how they would use these to comply with for example, the practice's spillage policy. There was a policy for disposal of sharps bins when these were filled to the maximum level. There was also a policy for needle stick injury and staff knew the procedure to follow in the event of an injury. The infection control policy suggested that clinical staff should dress to the standard of bare below the elbow. We noted nurses complied with this however GPs did not.

Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms. There was no cleaning spray or wipes available to clean the area after use in the baby changing area and the pedal bin for nappy disposal was broken.

The practice had not carried out a legionella risk assessment and did not carry out testing for legionella (a bacterium that can grow in contaminated water and can cause serious illness).

Reception staff were responsible for any spillages of bodily fluids in the waiting areas, for which they had received appropriate training.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. We saw equipment maintenance logs and other records that confirmed calibration of relevant equipment, for example, weighing scales, spirometers and blood pressure measuring devices. We also saw records showing portable electrical equipment had been tested and displayed stickers indicating the last testing date. A fire safety equipment log showed six monthly visits by an external contractor.

Staffing and recruitment

The practice had a recruitment policy that set out the standards to be followed when recruiting clinical and non-clinical staff. However records we looked at did not contain evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks through the Disclosure and Barring Service (DBS). We looked at four staff files. One did not have any evidence of references, one had no criminal records check and another had a criminal record check carried out for another practice. The fourth file was found to contain information about two different staff members.

The practice manager confirmed that criminal record checks or risk assessments had not been undertaken for administration and reception staff. This was a risk to patients because we saw that some of these staff were involved in chaperone duties.

Requires improvement

Are services safe?

We found that for locum nursing staff there was a reliance on assumption that as they came from other practices they were therefore qualified and met all requirements to do the job. For locum GPs, the practice manager checked they were on the performers list before they started at the practice and they were required to email the practice manager a copy of their annual updated registration with the appropriate professional body. However there were no annual checks of professional registration for locums used regularly by the practice.

Monitoring safety and responding to risk

The practice had some systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included medicines management and staffing. There was no fire risk assessment in place.

We saw that staff were able to identify and respond to changing risks to patients including deteriorating health and well-being. For example, if during a health review a nurse recognised that a patient was not their usual self, the nurse would speak with a GP and/or refer the patient for a GP consultation. The GPs were also able to provide examples of responding to patient emergencies, including those with long term conditions and learning disabilities. For example, practice had put in place necessary arrangements to act more swiftly in the event of further decline for a patient with deteriorating mental health, who was declining a referral to be seen by a psychiatrist.

Arrangements to deal with emergencies and major incidents

Records showed that staff had received training in basic life support in December 2012. The practice manager confirmed training was booked for all staff in February 2015. Emergency equipment was easily available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). We found the airway equipment was not single use, which posed an infection control risk and the equipment did not comply with the current requirements set out in the resuscitation guidelines. There were no supra-glottic airway devices (these are versatile airway management tools designed to minimise airway trauma while maximising ventilation and are more comfortable for patients). There were three sets of automated external defibrillator pads however two of these were out of date. There were no resuscitation medicines available and staff told us this was because the general hospital was only two miles away from the practice, where patients would receive emergency care. A very limited supply of anaphylaxis medicines were kept at the practice.

There was no specific record check for the automated external defibrillator battery. We saw a sheet of paper that was used as a diary check and this showed dates that equipment was checked. The copies of resuscitation guidelines available to staff were current although the anaphylaxis guide referred to it being due for review in 2010.

The practice had one cylinder of oxygen, kept on the resuscitation trolley. It was checked and replaced or replenished annually by an external contractor. The practice did not have a medical gas policy in place.

An external contractor had carried out a fire risk assessment that included actions required to maintain fire safety at the practice in 2012. This had not been reviewed or updated.

We were told there was pressure on staff numbers if someone was absent for sickness. If anyone left, the practice manager carried out an assessment of the impact and whether cover could be adapted by other staff. The practice used locum GPs to cover GP absence. These were locum GPs known to the practice in preference to using agency locum GPs. Locum nurses were also used to cover nurse absence.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE), from local commissioners and also used the internet to search for latest evidence based data and information. The GPs told us that relevant key messages were identified from best practice guidelines and shared. Team discussion may follow to change practice policy. For example, a template for hypertension was changed to prompt referral for 24 hour blood pressure monitoring in line with latest guidance. Specific issues were discussed at the weekly meeting held by the GPs and they also shared learning at daily meetings. The staff we spoke with and the evidence we reviewed confirmed that these actions were designed to ensure that each patient received support to achieve the best health outcome for them. We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate.

The GPs told us they lead in specialist clinical areas such as geriatric medicine, family planning and contraception. Practice nurses had specialist knowledge in areas such management of respiratory conditions. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support. The GP partners observed consultations by the new salaried GP and were open to being asked for advice and support in areas where the new GP felt less confident. They also sat in, ad hoc, on consultations of locums particularly if there were any concerns.

One of the GP partners showed us a template they had set up to challenge their prescribing of broad spectrum antibiotics, because they had recognised antibiotic prescribing had increased within the practice. The practice used computerised tools to identify patients with complex needs who had multidisciplinary care plans documented in their case notes. All patients on the unplanned admissions register had a care plan. At the time of this inspection 132 patients had care plans. There were alerts to show that care plans were completed and up to date or due a review. We saw there was also an alert system for unplanned admissions to hospital or if older patients moved elsewhere for a respite stay. We were told that a new process had recently been put in place by the practice to review patients recently discharged from hospital by telephone within three days.

National data showed that the practice was in line with referral rates to secondary and other community care services for all conditions. We noted that the referral rejection rate was low and GPs told us their administration staff support was thorough and prompt. The reception manager was responsible for overseeing all referrals to the Choose and Book scheme (Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital) and ensuring relevant information such as blood test results, was sent with the referrals. The GPs also kept their own lists of referrals to check these had been sent. We saw that referrals for patients needing to be seen within two weeks were made in line with national standards unless it was a Friday in which case the referral was made immediately.

Discrimination was avoided when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were cared for and treated based on need and the practice took account of patient's age, gender, race and culture as appropriate.

Management, monitoring and improving outcomes for people

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, and managing child protection alerts and medicines management.

We saw a completed audit of screening for depression in patients with Chronic Obstructive Pulmonary Disease (COPD) undertaken in February 2014. This audit resulted in changes being made to practice policy including raising staff awareness about the importance of diagnosing depression in patients with COPD and adding screen alerts on patient records to encourage clinical staff to ask about depression. Another audit was undertaken in 2011 to look at diagnosis of patients with lung cancer. The learning from this audit suggested that early chest x-rays should be carried out for patients with unusual symptoms. The re-audit of three new cases in 2014 found that in one case possibly an earlier chest x-ray could have resulted in earlier

Good

Are services effective?

(for example, treatment is effective)

diagnosis. This second audit had heightened to GPs the importance and value of chest x-rays. We were also told about another clinical audit of contraceptive implants that was being planned.

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 regarding the prescribing of branded medicines which could be prescribed more cost effectively if prescribed generically. Following the audit, the GPs carried out medication reviews for patients who were prescribed these medicines and altered their prescribing practice.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. For example, the practice met all the minimum standards for QOF in patients with diabetes and better than average for reported numbers of patients with COPD. This practice was not an outlier for any QOF (or other national) clinical targets although the practice reported some delay in QOF work due to nurses on sick leave and maternity leave. Areas outside QOF, for example, multiple sclerosis and coeliac disease had been identified as potential areas for future clinical audits. The GPs recognised that audit in practice would improve learning and outcomes for patients

There was a protocol for repeat prescribing which was in accordance with national guidance. In line with this, staff checked that patients receiving repeat prescriptions had been reviewed by the GP. They also checked that all routine health checks were completed for long-term conditions such as hypertension, diabetes and asthma, and that the latest prescribing guidance was being used. Monitoring of patients with long term conditions that were outside QOF, for example, Parkinson's disease, was reliant on patient lead prompts and computer pop-up prompts for blood tests, blood pressure checks and so forth. All patients were given a medicines review date and were encouraged to take responsibility. The evidence we saw confirmed that the GPs had oversight and a good understanding of best treatment for each patient's needs.

The practice had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss the care and support needs of patients and their families. The practice has a complete register available of all patients in need of palliative care/support irrespective of age. There was good liaison with the local hospice team and the palliative care team.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. The practice manager was setting up an online training package which would include, for example, safeguarding, fire safety, information governance, and serious incident reporting. Training packages would be tailored to individual staff roles. Staff undertook annual appraisals that identified learning needs from which action plans were documented. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses, for example, business studies and a health studies degree. Although staff were able to tell us about training they had attended or competed online, there was no central record available of training staff had undertaken and there was nothing in staff files to evidence training either.

Practice nurses were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties, for example, on administration of travel vaccines and care of patients with COPD.

We noted a good skill mix among the GPs with one having additional diplomas in family planning and another with a diploma in geriatric medicine. 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). The practice was a new training practice, with its first trainee due to start in January 2015. New GPs and locums working at the practice had access to a senior GP throughout the day for support.

The practice manager told us where poor performance had been identified appropriate action had been taken to manage this.

Working with colleagues and other services

Good

Are services effective?

(for example, treatment is effective)

The practice worked with other service providers to meet patients' needs and manage those of patients with complex needs. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from communications with other care providers on the day they were received. The GP who saw these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well. There were no instances identified within the last year of any results or discharge summaries that were not followed up appropriately.

The practice was commissioned for the new enhanced service and had a process in place to follow up patients discharged from hospital. (Enhanced services require an enhanced level of service provision above what is normally required under the core GP contract). This was a new process for the practice.

The practice held weekly clinical meetings to discuss the needs of complex patients, for example those with end of life care needs or children on the at risk register. These meetings were attended by the GP partners (the salaried GP attended monthly as this meeting was held on her day off),and other teams such as district nurses, long term condition nurses and palliative care nurses. Nurses were invited to this meeting monthly when the meeting was more nurse-focused.

There were good working relationships with the mental health teams. Patients registered at the practice were able to access community psychiatric nurse (CPN) consultations offered in the practice weekly. Multi-disciplinary meetings were held with the consultant psychiatrist, GP and CPN if required for specific patients. Medicines of patients with mental health issues were monitored by the GPs who were forming good working relations with secondary care. In a mental health crisis, the community mental health team (CMHT) would accommodate seeing the patient where they needed to be seen, including at home. The GPs were able to send urgent faxes to request a patient be seen within a week or the same day.

The practice had a joint working arrangement with the midwifery team. We were told about cases where the GP had called the triage number and the patient had been seen the same day at the local hospital. A midwifery clinic was held weekly at the practice and the midwife called in during the week to see the GPs if there were any concerns. Staff told us that working arrangements with health visitors were difficult because the practice was not able to engage with them. Health visitors called into the practice to collect messages however staff reported they rarely saw them and they rarely attended multi-disciplinary meetings held at the practice. We were told this was in contrast to the district nurses who called into the practice daily to collect messages and discuss patients with the GPs.

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 through the Choose and Book system. Staff reported that this system was easy to use.

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record EMIS WEB to co-ordinate, document and manage patients' care. All staff were fully trained on the system, and were able to use the system. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference. The practice manager and reception manager attended a quarterly EMIS support group which looked at, for example, troubleshooting issues, training and any other issues with the system.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice. Staff were unsure if the practice had a policy to help them with some specific scenarios where capacity to make decisions was an issue for a patient, or how patients should be supported to make their own decisions and how these should be documented in the medical notes.

Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it) and had a

Good

Are services effective?

(for example, treatment is effective)

section stating the patient's preferences for treatment and decisions. Staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision. All clinical staff demonstrated a clear understanding of Gillick competencies. (These are used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions).

There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures, a patient's verbal consent was documented in the electronic patient notes with a record of the relevant risks, benefits and complications of the procedure.

Health promotion and prevention

One of the GP partners had met with the CCG to discuss the implications and share information about the needs of the practice population and the health and social care needs of the local area. This information was used to help focus health promotion activity.

It was practice policy to offer a health check with the health care assistant / practice nurse to all new patients registering with the practice. The GP was informed of all health concerns detected and these were followed up in a timely way. All new patients were screened for their use of alcohol. We noted a culture among the GPs and nurses to use their contact with patients to help maintain or improve mental, physical health and wellbeing, for example, by offering opportunistic chlamydia screening to patients aged 18 to 25 years.

The practice also offered NHS Health Checks to all its patients aged 40 to 75 years. Staff told us these checks were helpful to pick up any health related issues such as high cholesterol or raised blood glucose. They told us these checks seemed to help patients to be more aware of a maintaining a healthy lifestyle.

The practice had ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice kept a register of all patients with a learning disability and they were offered an annual physical health check. This list was validated annually by the learning disability team. Similar mechanisms of identifying 'at risk' groups were used for patients who were identified as being at high risk for unplanned hospital admissions and those receiving end of life care. The practice had identified 432 patients over the age of 75 years and they had all been notified of their named GP. The GPs held personal lists. These groups were offered further support in line with their needs.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. There was a clear policy for following up non-attenders by the named practice nurse. Young people were signposted to other services offering, for example, counselling for 12 to 25 years old. Teenage pregnancy was not high at the practice however young patients could be referred to a specialist unit in Plymouth.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey in February 2014, which included a survey of patients undertaken by the practice's patient participation group (PPG). The evidence from this source showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the national patient survey showed that 80% of practice respondents said the GP/nurse was good at listening to them and 78% saying the GP/nurse gave them enough time.

Patients completed CQC comment cards to tell us what they thought about the practice. We received eight completed cards and these were all positive with a caring theme. Patients said they felt the practice offered a good service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. We also spoke with 10 patients on the day of our inspection. They all told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Disposable 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 consultation / treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

We observed that reception staff managed patients sympathetically and sensitively. They were pleasant yet direct in informing patients, for example, where they needed to go or how to use the check-in screen.

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. Patients we spoke with on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. Patient feedback on the comment cards we received was also positive and aligned with these views.

Care plans were in place for patients the practice had identified as being at risk. This included older people and patients needing end of life planning. The GPs reported good liaison with the hospice team and palliative care team which ensured patients were involved in their planning and treatment. They also gave us a number of examples where they had supported patient choice for treatment and told us they discussed all treatment options with possible outcomes including if the patient chose not to have treatment.

Patient/carer support to cope emotionally with care and treatment

The patients we spoke with on the day of our inspection and the comment cards we received were consistent about the emotional support provided by the practice and rated it well in this area. For example, these highlighted that staff responded compassionately when they needed help and provided support when required.

Notices in the patient waiting room told patients how to access a number of support groups and organisations. The practice's computer system alerted staff if a patient was also a carer and linked the carer with the cared for patient. There was also an alert for cared for patients to show they had a main carer registered at another practice. Patients completed a form to show if they were a carer or cared for by a carer. Each party signed each form to show they consented to this information being shared.

Staff told us that if families had suffered bereavement, a GP usually contacted them. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service.

The practice offered longer appointments for postnatal follow ups. This allowed GPs time to assess for signs of post natal depressions. We found the GPs had a strong awareness of vulnerable patients, in particular those with mental health issues, and finding ways to involve these patients in their care and treatment.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

Patients told us that they were able to see a GP when they needed. Where possible the same locum GPs were used. Locum nurses were used to cover staff absence for sickness and maternity leave. The nurses had a positive outlook and were pro-active about meeting patients' needs. Feedback from patients showed that they experienced good patient-nurse contact.

We saw in the patient participation group PPG minutes 2012/2013 that changes had been made to improve the appointments system and introduce online access. The last meeting minutes available were for a meeting held in January 2014 when the group discussed ways to raise the profile of the PPG and engage new members.

Tackling inequity and promoting equality

One of the GP partners had met with the CCG to look at health inequalities and how this needed to be addressed with specific investment to improve health outcomes, for example, patients with a learning disability or with mental ill health.

Staff told us they were able to book an interpreter from a translation service for patients who did not have English as a first language. We were told the practice did not have high numbers of patients who did not have English as a first language and most patients had a family member able to translate for them.

The premises and services had been adapted to meet the needs of patient with disabilities. This included level access to all patient consultation rooms located on the ground floor. We saw that the waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities.

Access to the service

The practice was open Monday, Wednesday and Friday from 8am to 6.30pm, and Tuesday and Thursday 8am to 7.30pm. It was closed on Saturdays. Telephone lines were open from 8am to 6pm daily. Emergency appointments were released daily at 8am. Telephone consultations were available between 12.10 and 1.50pm. Additional patients could be added into these appointment slots on the day. Pre-bookable appointments were available up to six weeks in advance. Where possible morning appointments were offered for blood tests in the morning before the courier collected all samples. Home visits were booked in the morning of the following day so the GPs knew in advance who they would be seeing. Any urgent home visits were covered by the duty GP.

Information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits and how to book appointments through the website. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients.

Longer appointments were available for patients who needed them. This also included appointments with a named GP or nurse. Patients experiencing poor mental health were offered the first appointment of the afternoon so they did not have to sit in a busy waiting room which they may find stressful. Appointments were available outside of school hours for children and young people.

Patients were offered the choice to see a different GP if their preferred GP was on holiday. They were able to request to see a female or male GP.

Patients were generally satisfied with the appointments system. They confirmed that they could see a GP on the same day if they needed to. They also said they could see another doctor if there was a wait to see the GP of their choice. Comments received from patients showed that patients in urgent need of treatment had been able to make appointments on the same day of contacting the practice. Most of the patients we spoke with had used the urgent appointment system and had been seen on the same day of contacting the practice. One patient told us they had been late arriving for their appointment however they had still been seen. We also observed patients arriving late and being reassured by the reception staff that they would still be seen.

Listening and learning from concerns and complaints

Good

Are services responsive to people's needs?

(for example, to feedback?)

The practice had a process for recording complaints and there was a designated responsible person who handled all complaints in the practice. The practice complaints policy however was a generic document not specific to the practice. For example, elements of the policy were not completed with information relevant to the practice.

We saw that information was available to help patients understand the complaints system in the main area of the waiting room. There was also a box with pens and paper available so patients could write comments or complaints without having to approach reception staff to ask. None of the patients we spoke with had ever needed to make a complaint about the practice. They were not all aware of the process to follow if they wished to make a complaint however they said if they needed to complain, they would find out.

There were six complaints recorded during 2014. The practice manager told us that verbal complaints were not recorded. We reviewed the complaints folder, which contained correspondence, although there was a lack of information about investigation, or any action taken by the practice as a result. There was no information for patients about how to take a complaint further if they were not satisfied with the outcome of the practice investigation of their complaint.

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

GPs and practice staff were committed to delivering high quality care and promoting good outcomes for patients, details of which we saw in the practice statement of purpose. This included treating patients as individuals and with respect, and working in partnership with patients to ensure they received the best option of treatment and care available to them. All the GPs and staff we spoke with were positive and pro-active about providing person-centred care and treatment for their patients.

Governance arrangements

The leadership structure was not clear for staff. For example, a GP partner was the lead for safeguarding and another GP partner was the lead for medicines management but staff were not able to identify these named leads. Also there was a discrepancy about who was the lead for infection control, if anyone, in practice. Staff were clear about their own roles and responsibilities. They told us they felt valued, well supported and knew who to go to in the practice with any concerns. However staff felt there was poor communication within the practice team as a whole with little opportunity to meet together, with information often not being passed on between teams.

The practice did not have a clinical governance policy. We were told monitoring of governance had occurred through the clinical governance meeting where serious untoward incidents were discussed. A list of bullet points recorded the matters raised at the last two meetings held in January and March 2014. We were told these meetings were changing to be practice development days held twice a year and used for staff training such as resuscitation and safeguarding. We were also told that any clinical review of governance of the practice would only take place at partnership meetings when any staffing issues were also discussed.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed it was under performing with some national standards. Explanations were given to us for the cause of this. One of the GP partners had a taken a lead role on behalf of the practice to champion equality of access to services which had been identified as different to health inequalities.

Leadership, openness and transparency

There was no formal leadership from the partnership to direct the responsibilities of the practice, the practice manager or lead roles within the practice role. We found there was a lack of definition and delegation of work between roles of GPs and the practice manager.

The practice had a system in place for taking up references and other checks for GPs who requested locum work. When a locum was employed, their performance was reviewed and if unacceptable, the practice stopped using them. The practice had not undertaken an audit of all complaints received to identify themes and develop action plans or identify training needs. Complaints were not discussed to ensure all staff were able to learn and contribute to determining any improvement action that might be required.

The nurses reported that they enjoyed working at the practice and as a team they felt well supported by each other. Clinical meetings were held weekly by the GPs. Sometimes these included the nurses and occasionally service issues were discussed. There were no regular formal practice meetings to involve the nurses to be able to influence how the practice was run.

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

The practice had gathered feedback from patients through a patient survey at the beginning of 2014, and complaints received. We looked at the results of the annual patient survey however there was no practice report or minutes of a practice meeting or action plan to show how the practice had addressed the results of this survey. We were told the practice was introducing the Friends and Family test from the beginning of December 2014 and a monthly report of results would be sent to NHS England.

The practice had a patient participation group (PPG) which was small and seeking to increase in size including representatives from various population groups such as young people and vulnerable people. The PPG had added four questions to the practice annual survey in February 2014. Three meetings had been held in 2014 and we looked at minutes for two meetings. The third held in May 2014 was an open evening and no minutes were taken. The last meeting planned for June we were told, had been cancelled and there had not been another since.

Are services well-led?

Requires improvement

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

Staff told us they could give feedback and discuss any concerns or issues with colleagues, although we received mixed views about giving feedback to management. The nurses told us they received good support for personal development, for example, attending training for travel vaccinations and care of patients with chronic obstructive pulmonary disease. Staff told us they felt involved and engaged in their teams. However they felt there was a lack of continuity across the practice due to several meetings being held between different staff teams about a variety of subjects for clinical, practice and business matters. Minutes were kept of only some of the meetings held. Clear lines of communication across the practice as a whole were not apparent.

Management lead through learning and improvement

Nurses told us that the practice supported them to maintain their clinical professional development through training and mentoring. The practice manager told us that she tried to keep an overview of each of the nursing team's individual training and also checked this at their annual review. These appraisals were carried out by the practice manager and a GP partner. At the time of this inspection an online training system was being set up for all staff to access and use. Any online training sessions would be allocated to staff to complete during their working hours.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers How the regulation was not being met: We found the provider did not regularly assess and monitor the quality of all services provided or identify, assess and manage all risks related to health, welfare and safety. This relates to; quality assurance system (incorporating patient feedback and complaints); clarity re lines of accountability; and consistent identification, recording and investigation of incidents and dissemination of learning from significant events and complaints to staff. This was in breach of Regulation 10 Health & Social Care Act 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision, which corresponds to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Regulation 10(1)(a)(b)(2)(b)(i)(c)(i)(ii)(2)(e)

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 16 HSCA 2008 (Regulated Activities) Regulations 2010 Safety, availability and suitability of equipment How the regulation was not being met: We found that people who use services and people who work in or visit the premises were not protected against the risks of harm from unsafe or unsuitable equipment.

This section is primarily information for the provider

Requirement notices

This is a breach of Regulation 16 Health & Social Care Act 2008 (Regulated Activities) Regulations 2010 Safety, availability and suitability of equipment which corresponds to Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This relates to: Staff did not have clear procedures to follow to ensure medicines and equipment required for resuscitation and other medical emergencies were regularly checked, maintained, in date and suitable for its purpose.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers How the regulation was not being met: We found that the provider did not have effective recruitment and selection procedures in place. The provider had not risk assessed all staff roles deemed to not require criminal records checks, such as for chaperone duties, temporary GPs and nursing staff.

This is a breach of Regulation 21 Health & Social Care Act 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers which corresponds to Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control How the regulation was not being met: We found that the provider did not have a risk assessment in place for legionella testing.

This section is primarily information for the provider

Requirement notices

This is a breach of Regulation 12 Health & Social Care Act 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers which corresponds to Regulation 12(2) (h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014