Dr AH Tak, Dr EG Stryjakiewicz & Dr M Sadik

Quality Report

Newington Healthcare Centre
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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	**Inadequate**
Are services safe?	**Inadequate**
Are services effective?	**Inadequate**
Are services caring?	**Requires improvement**
Are services responsive to people's needs?	**Inadequate**
Are services well-led?	**Inadequate**

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an unannounced inspection of Dr AH Tak, Dr EG Stryjakiewicz & Dr M Sadik.on the 2 December 2014 following concerns raised by the NHS England (North Yorkshire and Humber) Area Team. Overall the practice is rated as inadequate.

Specifically, we found the practice inadequate for providing safe, effective and responsive services and for being well led. It was also inadequate for providing services for the six population groups. Improvements were also required for providing caring services.

Our key findings are as follows:

- Lessons learned from significant events were not shared with staff so improvements could be made.
- Risk assessments had not been completed to identify any significant risks and the measures required to reduce harm occurring. The practice did not regularly monitor risks to patients, staff and visitors to the practice.
- Urgent appointments were usually available on the day they were requested. However, we found that the routine appointment system was not working, as patients experienced difficulty getting through on the telephone and were often waiting a long time for non urgent appointments.
- There was no evidence of completed audit cycles.
- Patients with long term conditions had not received annual reviews and medication reviews.
- Most patients were positive about their interactions with staff and said they were treated with compassion.
- Leadership within the practice was not effective.

The areas where the provider must make improvements are:

- Improve systems to so all staff receive appropriate training and are appraised annually.
- Put systems in place to ensure all clinicians are kept up to date with national guidance and guidelines.
- Put systems in place so patients with long term conditions and those taking medication have annual reviews.

Summary of findings

- Ensure there are formal governance arrangements in place, including systems for assessing and monitoring risks and the quality of the service provision.
- Ensure audits of practice are undertaken, including completed clinical audit cycles.
- Clarify the leadership structure and ensure there is leadership capacity to deliver all improvements
- Ensure staff have appropriate up to date policies and guidance to carry out their roles in a safe and effective manner which is reflective of the requirements of the practice.

On the basis of the ratings given to this practice at this inspection, I am placing the provider into special measures. This will be for a period of six months. We will inspect the practice again in six months to consider whether sufficient improvements have been made. If we find that the provider is still providing inadequate care we will take steps to cancel its registration with CQC.

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?

Inadequate

The practice is rated as inadequate for providing safe services as there are areas where it should make improvements. Staff understood their responsibilities to raise concerns, and to report incidents and near misses. Investigations were undertaken however the lessons learned were not shared with staff to so improvements could be made. There was no evidence to show significant events were analysed over time. Risk assessments had not been completed to identify any significant risks and the measures required to reduce harm occurring. The practice did not regularly monitor risks to patients, staff and visitors to the practice. For example there were no periodic checks of the building or the environment which would identify any risks so that measures could be put place to reduce the risk of harm to patients, staff or visitors.

Are services effective?

Inadequate

The practice is rated as inadequate for providing effective services, as there are areas where improvements should be made. Data showed patient outcomes were at or below average for the locality. Knowledge of and reference to national guidelines were inconsistent and there was no mechanism for implementing guidance in the practice. There were no completed audits of patient outcomes. We saw no evidence that audit was driving improvement in performance to improve patient outcomes. Multidisciplinary working was taking place and we saw evidence that staff worked together to ensure patients received appropriate care. The practice could not identify that all staff were appraised and had personal development plans.

Are services caring?

Requires improvement

The practice is rated as requires improvement for providing caring services, as there are areas where improvements should be made. Data showed that patients rated the practice lower than others for some aspects of care. The majority of patients said they were treated with compassion, dignity and respect. However, not all felt cared for, supported and listened to.

Are services responsive to people's needs?

Inadequate

The practice is rated as inadequate for providing responsive services. There was no evidence that the practice had reviewed the needs of its local population or had a plan to identify any improvements that may be required. Feedback from patients reported that access to a named GP and continuity of care was not available quickly, although urgent appointments were usually

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available the same day. The practice had good facilities and was equipped to treat patients and meet their needs. Patients could get information about how to complain and they were responded to appropriately. However, there was no evidence that learning from complaints had been shared with staff.

Are services well-led?

Inadequate

The practice is rated as inadequate for being well led. It did not have a clear vision and strategy. Staff we spoke with were not clear about their responsibilities in relation to the vision or strategy. There was no clear leadership structure and staff did not feel supported by management. The practice had a number of policies and procedures to govern activity, but a number of these had not been reviewed when required. The practice did not hold regular meetings and issues were discussed at ad hoc meetings. Staff told us they had not received regular performance reviews and did not have clear objectives.

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

Inadequate

The practice is rated as inadequate for the care of older people. Some older people did not have care plans where necessary. Nationally reported data showed that the practice was performing below the CCG average for conditions commonly found in older people, for example chronic obstructive airways disease and peripheral artery disease. Longer appointments and home visits were available for older people when needed, and this was acknowledged in feedback from patients. Patients over the age of 75 had a named GP.

People with long term conditions

Inadequate

The practice is rated as inadequate the care of people with long-term conditions. Emergency processes were in place and referrals were made for patients whose health deteriorated suddenly. Longer appointments and home visits were available when needed. However, not all these patients had a personalised care plan or had received an annual review to check that their health and care needs were being met.

Families, children and young people

Inadequate

The practice is rated as inadequate for the care of families, children and young people. The practice offered comprehensive vaccination programmes which were managed effectively. Immunisation rates were relatively high for all standard childhood immunisations. The practice monitored any non-attendance of babies and children at vaccination clinics and worked with the health visiting service to follow up any non- attendance. Appointments were available outside of school hours and the premises were suitable for children and babies. All of the staff were responsive to parents' concerns and ensured children who were unwell could be seen quickly by the GP or nurse. The practice did not respond to requests from local safeguarding teams when information was required with regard to children at risk.

Working age people (including those recently retired and students)

Inadequate

The practice is rated as inadequate for the care of working-age people (including those recently retired and students). The services available did not fully reflect the needs of this group. There were no early or extended opening hours for working people and telephone

Summary of findings

consultations were not available. Appointments could only be booked by telephone, there was no on-line appointment booking system. Health promotion advice was offered but there was limited accessible health promotion material available through the practice.

People whose circumstances may make them vulnerable

Inadequate

The practice is rated as inadequate for the care of people whose circumstances may make them vulnerable. While the practice held a register of patients with a learning disability, arrangements were not in place to ensure patients with a learning disability had an annual health check. There was no information about other people who may be vulnerable; such as homeless people or travellers although the practice did see patients if needed when 'Hull Fair' was taking place. Staff knew how to recognise signs of abuse in vulnerable adults and children, however not all staff were adequately trained in this regard. Systems were not in place for responding to requests from local children's safeguarding teams.

People experiencing poor mental health (including people with dementia)

Inadequate

The practice is rated as inadequate for the care of people experiencing poor mental health (including people with dementia).

The practice provided information for patients experiencing poor mental health about how to access various support groups and voluntary organisations including MIND and SANE. The practice maintained a register of patients who experienced mental health problems. Quality Outcomes Framework (QOF) data indicated that the practice was performing at or above the CCG average for mental health indicators.

The practice was performing significantly below the CCG average for patients newly diagnosed with depression. QOF data showed that the practice was 13.5% below the CCG average for patients receiving a face to face review in a twelve month period.

No systems were in place to follow up on patients who had attended accident and emergency where they may have been experiencing poor mental health. There was no evidence to show the practice had worked with multi-disciplinary teams in the case management of people experiencing poor mental health.

Summary of findings

What people who use the service say

As part of this inspection we provided CQC comment cards for patients who attended the practice to complete on the day of the inspection and we received responses from 15 patients. Feedback was mixed with nine patients making positive comments about the reception and nursing staff being good and helpful and the GPs being understanding and follow up care was good. Feedback from six patients was negative and said that some staff were rude and it was difficult to get an appointment.

We spoke with 20 patients during the inspection. Again feedback was mixed, patients told us that staff were caring and helpful and they were treated with respect. However eight patients told us that it was difficult to get through on the telephone to make an appointment, and to see a GP of their choice. Seven patients also said that they had to wait a long time when they arrived at the practice before going in to see the GP and five told us that they had to ring the practice to obtain test results.

The national GP survey results for 2014 completed by 121 patients showed the practice performed below the weighted CCG (regional) and national average in most areas. For example:

- 39% of respondents would recommend this surgery to someone new to the area - CCG local average: 74%
- 37% of patients said it was easy to get through to the practice on the phone - CCG local average: 73%
- 59% of respondents describe their overall experience of this surgery as good – CCG local average: 84%

These results were consistent with our findings on the day of the inspection.

Areas for improvement

Action the service MUST take to improve

The practice did not have arrangements in place for supporting staff. These included:

- Not all staff had received an annual appraisal.
- Lack of systems for ensuring staff received required training and this was monitored and recorded.
- The practice did not have systems to ensure all staff could access adequate support from peers.

The practice did not have arrangements to ensure patients' records were accurate and up to date. This included:

- Results from tests and investigations were not filed in a timely manner.
- Letters from other services were not filed in a timely manner.

The practice did not have adequate systems to ensure the care and welfare of patients was met. These included:

- Not all patients with long term conditions were receiving an annual review.
- Not all patients were having medication reviews when required.
- Systems were not in place to ensure best practice guidance was assessed and implemented in a structured way.

The practice did not have suitable arrangements in place for assessing and monitoring the quality of service provision. These included:

- The practice did not have systems in place to review the effectiveness of learning from incidents and complaints.
- The practice did not have systems in place to manage and monitor risks to patients, staff and visitors safety when visiting or working in the practice.
- Clinical audits were not used to monitor the quality of the service and deliver improvement.

Summary of findings

- The practice did not use information from the QOF, national and CCG performance data to monitor outcomes for patients and drive improvements in care for patients.
- Clear and planned governance structures were not in place.
- No risk management processes or strategies were used to monitor and improve the quality of service provided.

Dr AH Tak, Dr EG Stryjakiewicz & Dr M Sadik

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC inspector and the team also included a second CQC Inspector, CQC GP specialist advisor for the North Region, a second GP specialist advisor and a Practice Manager specialist advisor.

Background to Dr AH Tak, Dr EG Stryjakiewicz & Dr M Sadik

Dr Dr AH Tak, Dr EG Stryjakiewicz & Dr M Sadik is situated in the Newington Healthcare Centre in Anlaby Hull and provides primary medical care services, which includes access to GPs, minor surgery, family planning, ante and post natal care to patients living in the Anlaby area. The practice provides services to 8500 patients of all ages. There is a higher percentage of the practice population in the 65 to 74 years age group than the CCG and England average but a lower percentage in the 75 and over age group than the CCG and England average.

The practice has opted out of providing out of hours services for their patients. Information for patients requiring urgent medical attention out of hours is available in the waiting area and on the practice website. When the practice is closed patients access the Out of Hours Service at Hull Royal Infirmary.

The practice has three GP partners, all male. One GP has left the practice and is no longer working there. The remaining two partners work full time. There is one practice nurse who works 22 hours per week and a practice manager who works full time. They are supported by a team of administration, secretarial and reception staff. The partnership has another location approximately one mile from Newington Healthcare Centre which the staff also work at. CQC only inspected the Newington Healthcare Centre location on the 2 December 2014.

The CQC intelligent monitoring placed the practice in band one. The intelligent monitoring tool draws on existing national data sources and includes indicators covering a range of GP practice activity and patient experience including the Quality Outcomes Framework (QOF) and the National Patient Survey. Based on the indicators, each GP practice has been categorised into one of six priority bands, with band six representing the best performance band. This banding is not a judgement on the quality of care being given by the GP practice; this only comes after a CQC inspection has taken place.

The practice provides services to their patients through a General Medical Services (GMS) contract.

Why we carried out this inspection

We inspected this service following concerns being raised by the NHS England (North Yorkshire and Humber) Area Team. We carried out an unannounced inspection 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.

Detailed findings

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 patient'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
- Mothers, babies, children and young people
- The 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 attended a meeting organised by NHS England (North Yorkshire and Humber) Area Team. We reviewed a range of information we held about the service and asked other organisations to share what they knew about the service. We reviewed policies, procedures and other information the practice provided during and after the inspection. We carried out an unannounced visit on 2 December 2014.

During our visit we spoke with eight staff including, the GP, practice nurse, health care assistant, the practice manager, assistant practice manager, secretary and reception staff. We spoke with 20 patients who used the service and observed how staff spoke to, and interacted with patients when they were in the practice and on the telephone. We also reviewed 15 CQC comment cards where patients were able to share their views and experiences of the service.

Inadequate

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks, including reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. For example staff had recently reported an incident where a patient had administered an injection themselves as they were unable to get an appointment.

The practice had a record of the incidents that had occurred in the practice. There was no evidence available to show that incidents were analysed over time to identify any themes or trends, for example how many medicines related incidents or administration errors were occurring. Without this the practice would not know if actions they had put in place to reduce the risk of incidents happening again were working.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events. We saw there was an incident reporting policy in place which outlined why incidents should be reported, how to report them and how they would be investigated.

The practice had recorded 19 incidents since April 2013 and we saw evidence that internal investigations meetings had been held to discuss the incidents. The investigation meetings were attended by the GPs, nurse and practice manager. We looked at the minutes from the meetings and saw they identified learning points and actions required. However, there was no clear action plan developed identifying who was responsible for carrying out the action, the date it was to be completed by and if it had been completed. The practice's incident policy stated that incidents investigations should be reviewed after three to six months but there was no evidence to confirm this was happening.

The practice could not evidence they held regular meetings with staff to discuss issues such as significant events, safeguarding and complaints and that lessons learned from these were shared with relevant staff. Although we saw the GPs, nurse and practice manager were involved in meetings to investigate incidents, other staff that may be involved, for example receptionists, were not included. The staff we spoke with confirmed that even if they were involved in an incident they did not take part in the investigation. Also staff told us that they should receive an e mail informing them of the lessons learned and actions required following incidents but that this did not happen. The practice was unable to show any evidence that learning was shared with staff and improvements were made following incident investigations.

We discussed the process for dealing with safety alerts with the practice manager. Safety alerts inform the practice of problems with equipment or drugs, or give guidance on clinical practice. The practice manager told us the alerts came into the practice via e-mail and were then disseminated them to the GPs and nurse. They checked to see if the alert was applicable to the practice and if it was, then any action required was taken. Staff confirmed they were made aware of relevant safety alerts and action was taken in response to alerts. However; we found no written record of actions taken was available.

Reliable safety systems and processes including safeguarding

The practice had policies for the protection of 'vulnerable' adults and children. The policies provided staff with information about identifying, reporting and dealing with suspected abuse. They were available to staff in electronic format. Staff we spoke with were able to describe the types of abuse, the signs they might see in an adult or child being abused and how to raise concerns.

The practice had a GP appointed as lead in safeguarding vulnerable adults and children and they had completed Level 3 training in order for them to fulfil their role as safeguarding lead. Not all staff were clear who the safeguarding lead was. We were told staff had completed training in safeguarding adults and children but there were only records available to confirm this for four staff.

We found that two requests from the local authority safeguarding teams for GP reports had not been completed. The practice did not have a system to flag these requests as urgent. The health visitor visited the practice once a week however the GP told us they did not meet regularly with the health visitor to discuss vulnerable children. The GP told us there had been no meetings for

the past 12 months. The practice manager told us that vulnerable adults and children were identified on the electronic records system to ensure risks were clearly identified to practice staff.

There was a chaperone policy which outlined when a chaperone may be required and which staff would undertake this role. There was no information displayed in the practice informing patients that they could ask for a chaperone but information was available in the practice leaflet and on the website. The GP, nurse and practice manager told us that the nurse usually acted as a chaperone but occasionally a receptionist may be asked to do this. We found that reception staff who may be asked to chaperone had received training. This reduced the risk of abuse for patients and assisted in protecting the clinician against false allegations.

Medicines management

Medicines stored in the treatment rooms and refrigerators were stored securely and were only accessible to authorised staff. There was a procedure for ensuring that medicines were kept at the required temperatures and the action to take in the event of a potential failure. Fridge temperatures were recorded.

Processes were in place to check medicines were within their expiry date and suitable for use. The medicines we checked were within their expiry dates.

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

All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

Cleanliness and infection control

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

Infection prevention and control (IPC) procedures had been developed which provided staff with guidance and information to assist them in minimising the risk of infection. The cleaning company monitored the standards of cleaning, so any areas for improvement could be identified and actioned and we saw results from the monitoring audit completed in September 2014 when the practice had achieved 98.95%.

Staff told us there was always sufficient personal protective equipment (PPE) available for them to use, including masks, disposable gloves and aprons. We saw that hand wash; disposable towels and hand gel dispensers were also readily available for staff. We observed that there was hand gel in the waiting area for patients to use. Staff confirmed they had completed training in infection prevention and control. Sharps bins were appropriately located, labelled, closed and stored after use. There was a contract in place for the removal of all household, clinical and sharps waste and we saw evidence that waste was removed by an approved contractor. Staff told us that equipment used for procedures such as cervical smear tests and for minor surgery were disposable. Staff therefore were not required to clean or sterilise any instruments, which reduced the risk of infection for patients. We found a small number of disposable items that had expired and they were removed immediately by the nurse. Other equipment used in the practice was clean.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was checked annually and we saw records that this was completed. A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example we saw that the weighing scales and pulse oximeter had been checked in November 2014.

Staffing and recruitment

The practice was monitoring staffing levels and skill mix on an on-going basis as a result of the long term absence of two GP Partners. Locum GPs were employed to ensure they continued to meet the needs of patients. Staff we spoke with told us that locum GP cover had still not been

confirmed for the following week and patients were being asked to ring back the next day to make an appointment. The practice manager confirmed they were still sourcing a locum GP.

There was one nurse practitioner who was responsible for completing annual reviews for patients with long term conditions (LTC). Staff we spoke with told us there were still 400 patients with a LTC who needed to be reviewed before 31 March 2015. Agency nurses were providing support for childhood immunisation clinics two days a week.

The number and skill mix of management, reception and administration staff was reflective of the information on the practice website. There were arrangements in place for staff to cover each other for annual leave or sickness or for locums to be used.

The practice had a recruitment policy in place which outlined the process for appointing staff, and the pre-employment checks that should be completed for a successful applicant before they could start work in the practice. Staff who had been employed recently described the recruitment process and confirmed the checks carried out prior to them starting work. We discussed the recruitment process with the practice manager and they confirmed all the appropriate checks that were undertaken for any staff employed in the practice.

Monitoring safety and responding to risk

We found that staff recognised changing risks for patients using the service and were able to respond appropriately. Staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies. For example staff told us about referrals they had made for patients with respiratory problems whose health had deteriorated suddenly, including supporting them to access emergency care and treatment.

There was a health and safety policy and the practice manager took the lead for health and safety in the practice. Risk assessments had not been completed to identify any significant risks and the measures required to reduce harm occurring. The practice did not regularly monitor risks to patients, staff and visitors to the practice. For example there were no periodic checks of the building or the environment which would identify any risks so that measures could be put place to reduce the risk of harm to patients, staff or visitors.

The practice was located in a health centre that was shared with other GP practices and was maintained and cleaned by external companies. We saw evidence that maintenance was undertaken as required, for example for gas, electric and fire safety systems. There was a process in place for staff to report any faults or problems and they confirmed that issues were dealt with in a timely manner.

The practice had failed to demonstrate that it was aware of the risks associated with the practice. There was no central log of risks.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. We found the practice had emergency airway equipment and medicines available to be used in an emergency; these included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. Processes were in place to check whether emergency medicines were within their expiry date and suitable for use. The medicines we checked were in date and fit for use. The practice had oxygen but no automated external defibrillator (used to attempt to restart a person's heart in an emergency). The practice told us they had assessed the risks and decided they were not required as ambulances responded quickly in the event of an emergency. There was no record of the assessment.

Records showed that all staff had received training in basic life support and the staff we spoke with were able to describe what action they would take in the event of a medical emergency situation. Staff we spoke with knew the location of the emergency airway equipment and medicines. Records confirmed that it was checked regularly.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Risks identified included power failure, adverse weather, unplanned staff sickness and access to the building. The document also contained relevant contact details for staff to refer to.

The practice had carried out a fire risk assessment that included actions required to maintain fire safety. Records showed that staff were up to date with fire training and that they practised regular fire drills. We saw the record of one

Inadequate

Are services safe?

of the drills which was undated. There were a number of improvements identified as a result of the drill however no action plan had been developed to ensure they were implemented.

Inadequate

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Clinical staff told us they were familiar with current best practice guidance; accessing guidelines from the National Institute for Health and Care Excellence (NICE), journals and from local commissioners. They told us NICE guidance was received into the practice via e mail and then disseminated to GPs and nurses. There was no structured approach to dealing with best practice guidance to ensure it was discussed and any required actions agreed.

Intelligent monitoring data showed that the practice had a high number of emergency admissions for patients with ambulatory care sensitive conditions. These were conditions such as respiratory, heart failure and diabetes, also known as long term conditions (LTCs).There was a protocol outlining the process for recalling patients with long term conditions for regular periodic reviews. However the data indicated that there were a high number of these patients were not been managed appropriately and were attending the hospital as emergencies. The practice used the CCG electronic system to identify patients who were at high risk of admission to hospital. However they were not utilising this to ensure these patients were reviewed regularly so their needs were met to reduce the need for them to go into hospital.

The practice had agreed to deliver the enhanced service to identify patients at higher risk of being admitted to hospital as an emergency and had identified 128 patients as high risk. There was a target date of October 2014 for completion and the practice manager confirmed that none of the patients had had a review and care plan developed and there was no action plan outlining how they were going to deliver the enhanced service.

Due to the concerns raised by the NHS England (North Yorkshire and Humber) Area Team about the clinical management of patients the decision was made to review a sample of patient records. The CQC Regional GP Advisor reviewed the records of 20 patients. We found in seven of the records that medication reviews were overdue. Also there was evidence that past medical conditions or co-morbidities were not taken into account. For example one patient was reviewed as they had a cough but the GP did not take account of the fact that they had asthma and did not check their blood oxygen levels or peak flow (a test to check their breathing). We saw that another patient who attended to discuss blood test results was on medication to control their blood pressure (BP); however we found their BP had not been checked since October 2013 and the GP did not check it when they were seen.

The practice nurse described how they carried out comprehensive assessments and reviews for patients with LTCs. They explained how care was planned to meet identified needs and how patients were reviewed at required intervals to ensure their treatment remained effective. Feedback from patients confirmed they were referred to other services or hospital when required. The practice nurse told us there was a backlog for LTC reviews with 400 still to be completed before 31 March 2015.

National data showed that the practice was in line with referral rates to secondary and other community care services for all conditions. The GP we spoke with used national standards for the referral of patients, for example for patients with suspected cancers were referred and seen within two weeks.

The national data also showed that the practice's performance for prescribing was within expected ranges, for example for antibiotics and anti-inflammatory medicines.

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

Management, monitoring and improving outcomes for people

The nurse practitioner and practice manager were responsible for the management of the information submitted for the quality and outcomes framework (QOF), a national performance measurement tool for general practices. We found that the practice was performing below the CCG average in some areas of the QOF. For example chronic obstructive airways disease, asthma, peripheral artery disease, depression and diabetes. The practice was also performing below the England mean average in eleven areas of the general practice outcome standards (GPOS). These included; smoking cessation advice, emergency LTCs admissions, A/E attendance rates, satisfaction rates for

quality and access and depression assessment. It was evident that the practice was not using this information to lever improvement despite their comparative poor performance in the QOF and GPOS.

The practice manager told us they received performance reports from the Clinical Commissioning Group (CCG) regularly but these were not used to develop action plans to improve the service to patients.

The GP told us they had undertaken two clinical audits however they were unable to show us any examples or demonstrate any improvements as a result. The practice manager told us that the GPs decide which audits they want to do and they are done for the GP appraisals. Other staff we spoke with confirmed that that they were not involved in clinical audits and were not aware of any improvements made as a result of audit. The practice had signed up to the NHS England strategy "Avoiding Unplanned Admissions / Proactive Care Programme Enhanced Services". This was a strategy where the practice would liaise with local health and social care commissioners to work together for people with complex health needs. There was no evidence that the practice had acted to implement this strategy.

The nurse practitioner told us they had undertaken a review of childhood immunisations in 2014 when they started working at the practice and identified there was a backlog. Measures were put in place to address this and all children were now up to date with their immunisations, this was confirmed by Public Health England.

There was a protocol for repeat prescribing which was in line with national guidance. However we found repeat prescriptions were being issued after the patient's medication reviews were due and there was no evidence that appointments had been made for the patients to have a medication review. We found no evidence that medicines alerts were discussed or that the GPs had reviewed the use of the medicine in question and, where they continued to prescribe it outlined the reason why they decided this was necessary.

The practice had a palliative care register and had regular meetings which included members of the multi-disciplinary team to discuss the care and support needs of patients and their families.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed six staff files but were unable to find evidence that staff were up to date with essential training, for example health and safety and safeguarding adults and children. The practice manager told us they were developing a training matrix which outlined what training each member of staff required, when they had attended, or were due to attend and when any refresher training had taken place. We saw a copy of the matrix but it was not complete and did not confirm the training staff had received. The practice sent us a copy of the completed matrix after the inspection but it did not confirm that staff had received safeguarding or health and safety training. Also it did not identify when the training had taken place or when any refresher training was due. The practice did have regular protected learning time (PLT) sessions; however staff told us these were not productive and there was no evidence of the content for the PLTs.

There was an induction programme in place for new staff which covered generic issues such as fire safety and infection control. Staff told us that role specific induction was also available, for example immunisation training for nursing staff.

There were three GP partners at the practice but only one was working at the time of the inspection, two were on long term leave. The partner we spoke with was up to date with their yearly continuing professional development requirements and had been revalidated in 2014. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by NHS England can the GP continue to practise and remain on the performers list with the General Medical Council).

The GP and nurse practitioner were registered with their respective professional bodies such as the General Medical Council. However there was no process in place to check that doctors and nurses were meeting the requirement to remain registered with their professional bodies, and therefore were still deemed fit to practice. This increased the risk of registration lapsing for those staff that should only provide care and treatment whilst registered with a professional body.

The GP and nurse practitioner had received appraisals in 2014. There were no records available to confirm the practice nurse had been appraised by the GP. There was no evidence to confirm which management and

administration staff had been appraised in the last 12 months. One staff member did confirm they had had an appraisal and had completed some training identified during this process. The practice sent us evidence following the inspection for four staff who had received appraisals in 2014.

The nurse told us that they did not have formal clinical supervision sessions. However they said they could discuss their clinical practice at any time with the GPs.

The practice manager described the process they would follow for dealing with performance issues identified with any of the staff. The practice used an external human resources company for support with HR issues such as performance of staff.

Working with colleagues and other services

Staff told us that they met regularly with staff from the palliative care and community services to discuss how individual patients' needs would be met. We saw evidence that the practice staff worked with other professionals. Minutes from meetings confirmed that community nurses, palliative care nurses and social workers attended to discuss treatment and care to ensure it was meeting the needs of patients.

We found that although patients had been referred to hospital and received appointments to be seen, there was a backlog of referral letters that had not been sent. Without the referral letter the consultant would not have all the information available regarding the patient's past medical history and medicines they were taking. One patient told us they had been referred to the hospital but a test had not been completed first so they were sent back to the GP resulting in a delay to see the consultant. There was no clear plan of how the practice was going to address the backlog of referral letters.

We saw that when letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service were received both electronically and by post they were scanned into the patient's record. The practice did not have systems in place to ensure communications from other care providers and organisations were dealt with in a timely manner. There were 160 laboratory results outstanding dating back to 25 November 2014 and 217 scanned letters dating back to 20 October 2014, it was unclear if these had been read or actioned by the GP. For example one letter indicated a patient needed a prescription but it was unclear if the hospital or GP had to prescribe it or if the patient had been issued the prescription. We were also advised that there was a backlog of requests for medical reports dating back to January 2014, 35 were still outstanding that needed to be completed by the GPs.

The practice held multidisciplinary team meetings every two months to discuss the needs of complex patients, for example those with end of life care needs or adults with complex needs. These meetings were attended by district nurses and palliative care nurses and decisions about care planning were documented in the patients' care record.

There was an electronic system in place to ensure the out of hour's service had access to up-to-date information about patients who were receiving palliative care but the practice had not updated this since August 2014. We found that two patients' records should have been updated during this time but this had not happened. The two patients had not contacted the OOHs service since August 2014 so there had been no impact on their care.

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. (The Choose and Book system enables patients to choose which hospital they will be seen in and to book their own outpatient appointments in discussion with their chosen hospital).

Staff used an electronic patient record to coordinate, document and manage patients' care. All staff were fully trained on the system, and commented positively about the system's safety and ease of use. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference. We saw evidence that audits had been carried out to assess the completeness of these records and that action had been taken to address any shortcomings identified.

Consent to care and treatment

Inadequate

Are services effective?

(for example, treatment is effective)

We found that staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. All the clinical staff we spoke to understood the key parts of the legislation and were able to describe how they implemented it in their practice.

Staff described 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 help clinicians to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment).

There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures a patient's written consent was obtained and then documented in the electronic patient notes. We saw the consent form outlined the relevant risks, benefits and complications of the procedure and there was space for both the clinician and patient to sign the form. Staff told us how they explained procedures to patients and checked their understanding before any procedure or treatment was carried out.

Health promotion and prevention

The provider offered all new patients a consultation to assess their past medical and social histories and care needs. Following the assessment care would be arranged that met the patients' individual needs. Staff used their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering opportunistic chlamydia screening to patients aged 18-25 and offering smoking cessation advice to smokers.

We saw there was information about carers support groups available in the waiting area for patients. The practice did not identify which patients attending the practice had a caring role.

There was a good range of health promotion information in the waiting room and on the practice web site. We saw that there were posters around the practice promoting services that may help support patients, such as smoking cessation and support with mental health.

The practice had numerous ways of identifying patients who needed additional support, for example, the practice kept a register of all patients with a learning disability and they were offered an annual physical health check. The QOF data showed that the practice was performing well in identifying the smoking status of patients over the age of 16 and was actively offering smoking cessation support and advice to these patients. Similar mechanisms of identifying 'at risk' groups were used for patients who were obese and those receiving end of life care. These groups were offered further support in line with their needs.

The practice's performance for cervical smear uptake was 80.7%, which was in line with others in the CCG area. There was a policy to offer telephone reminders for patients who did not attend for cervical smears and the practice audited patients who do not attend annually.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. The practice was up to date with childhood immunisations. However not all patients in at risk groups had received a flu immunisation. For example only 88% of patients with COPD (a respiratory condition), had received their flu immunisation in 2013/14 which was 8.3% below the CCG average.

Requires improvement

Are services caring?

Our findings

Respect, dignity, compassion and empathy

Staff were familiar with the steps they needed to take to protect patient's dignity. Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Privacy 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 reviewed the most recent data available from the national patient survey for the practice on patient satisfaction. This showed 66% of respondents stated that the last GP they saw or spoke to was good at treating them with care and concern, the local CCG average was 83% and 74% said the GP was good at listening to them, the local CCG average was 85%. The satisfaction rates for the nurses for these two areas was 91%, the local CCG average was 92% for both areas.

We spoke with 20 patients during the inspection and received 15 completed CQC comment cards. Feedback received from patients was mixed with 14 patients making positive comments about the staff being good and helpful and treating them with dignity and respect. Feedback from six patients was negative and said that some staff were rude.

We observed reception staff treating patients with respect and being extremely tactful when triaging requests. The practice had an open plan reception area and we observed that reception staff were discreet and quiet when speaking with patients. There was a room available if patients wished to discuss a matter with the reception staff in private. Patients were able to check in using an electronic screen which assisted in maintaining their confidentiality.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed mixed responses from patients to questions about their involvement in planning and making decisions about their care and treatment. For example, the most recent data from the national patient survey showed 65% of respondents said the GP involved them in care decisions, the local CCG average was 79% and 71% felt the GP was good at explaining treatment and results, the local CCG average was 83%. Patient responses regarding the nurses was positive in these areas with 83% of respondents saying the nurse involved them in care decisions, the local CCG average was 87% and 88% felt the nurse was good at explaining treatment and results, the local CCG average was 91%.

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

Staff told us that translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patents this service was available. One of the GPs and the nurse both gave examples of when an interpreter had been used to support a patient during a consultation so the patients could be involved in decisions about their care.

Patient/carer support to cope emotionally with care and treatment

The survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. Feedback from the comment cards and the patients we spoke with on the day said they had received help to access support services to help them manage their treatment and care when it had been needed. For example, these highlighted that staff responded compassionately when they needed help and provided support when required.

Notices in the patient waiting room and the practice website also told people how to access a number of support groups and organisations. Written information was available for carers to ensure they understood the various avenues of support available to them. However the practice did not identify which of their patients had a caring role.

Requires improvement

Are services caring?

Staff told us that if families had suffered bereavement they would be offered an appointment to see the GP and the GP would contact relatives of patients who had died to offer their sympathy and support.

Information was available to signpost people to support services. This included MIND for help with mental health issues, the Macmillan service for support following bereavement and carers support groups.

Inadequate

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice was not always able to respond effectively to people's needs and demands. The practice had implemented some suggestions for improvements and made some changes to the way it delivered services as a consequence of feedback from the Patient Participation Group (PPG). For example, they had employed locum GPs after feedback said it was difficult to get an appointment.

The staff composition of GPs had not remained stable over the past 12 months and this impacted on continuity of care for patients. The practice was using locum GPs to cover appointments and the one GP partner currently working was providing cover for urgent appointments and administration tasks. Also, as there was only one nurse practitioner patients told us it was difficult to get an appointment with them. This was confirmed by the nurse and reception staff. Feedback from patients we spoke with and on the CQC comment cards reflected these findings.

Longer appointments were available for people who needed them. Twenty minute appointments were offered to patients with long term conditions or mental health issues. Home visits were made to local care homes by the GP and to those patients who could not attend the surgery.

The practice struggled to maintain the level of service required. The needs of the practice population were not clearly understood by staff and systems were not in place to effectively address identified needs. There was no evidence that the practice used any risk tools to help the practice detect and prevent unwanted outcomes for patients.

The NHS England (North Yorkshire and Humber) Area Team had visited the practice recently to discuss local needs and prioritisation of service improvements. We saw records of the visit where actions to implement service improvements had been identified. However, there was little evidence to show that these actions had been taken forward.

The practice manager told us that they did attend Clinical Commissioning Group (CCG) meetings with other practices to discuss local needs and any service improvements that needed to be made.

Tackling inequity and promoting equality

The practice had recognised the needs of some different groups in the planning of its services. For example they gave longer appointment times for patients with learning disabilities. The practice had access to online and telephone translation services if they were needed and three members of staff spoke other languages and had supported patients during appointments.

The premises and services had been designed to meet the needs of people with disabilities. We found that the practice was accessible to patients with mobility difficulties as facilities were on the ground floor or accessible by a lift. The consulting rooms were accessible for patients with mobility difficulties and there was also access enabled toilets. There was a large waiting area with plenty of space for wheelchairs and prams. This made movement around the practice easier and helped to maintain patients' independence.

Staff told us that they did not have any patients who were of "no fixed abode" but they did have people attending the practice when the 'Hull Fair' was in progress. The practice manager told us that they did see these people as temporary patients.

The three partners in the practice were all male and as the practice was using locum GPs it was not possible for patients to choose to see a male or female doctor.

Access to the service

Patients could make appointments either by telephone or by coming to the practice. The practice was open from 9.00am to 12.00pm and 4.00pm to 6.00pm Monday to Friday. National Patient survey data for 2014 indicated 67% of patients were satisfied with the surgery opening hours, the CCG average was 79%. Patients who did not need an urgent appointment could book them in advance which freed up slots for patients who needed to be seen quickly. However due to the use of locum GPs patients could only book an appointment a week in advance and patients were unable to see a GP of their choice. The national GP Patient survey data for 2014 showed that only 32% of respondents with a preferred GP could usually get to see or speak to that GP, the local CCG average was 54%.

Patients we spoke with, feedback from CQC comment cards and the national patient survey confirmed that patients found it difficult to get appointments when they needed them, this included same day appointments. We found that patients were not satisfied with the appointment system at

Inadequate

Are services responsive to people's needs?

(for example, to feedback?)

the practice. The GP said if a patient needed an urgent appointment during the afternoon and all the slots had been taken then they spoke with the patient on the telephone to determine if they needed to be seen that day. Reception staff told us they were unable to offer patients' appointments when they wanted them as locums were only booked a week in advance. Appointments were available outside of school hours for children and young people.

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. This was observed on the day of the inspection, with priority given to vulnerable groups such as children.

Longer appointments were also available for older people, those experiencing poor mental health and patients with long-term conditions. Home visits were made to local care homes by the GP and to those patients who could not attend the surgery.

The practice did not provide telephone consultation appointments and patients could not make appointments on line so patients who worked during the day or were unable to get to the practice did not have a choice of how they made their appointment and how and when they wanted to see the GP or nurse.

Patients we spoke to on the day of the inspection raised concern about the appointment waiting times and getting through to the practice on the telephone. Survey data showed only 37% of patients said it was easy to get through to the practice on the phone compared to the CCG local average of 73%.

Information about appointments was available to patients on the practice website, in the waiting area and in the practice leaflet. This included what to do in an emergency, in hours and out of hours, how to arrange urgent appointments and home visits and how to book appointments. 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. Copies of the practice information leaflet were not available for patients in the waiting area and the inspector had to ask for a copy.

Patients could order repeat prescriptions via their local pharmacy, in person or on line. This meant the practice was using different methods to enable patients' choice and ensure accessibility for the different groups of patients the practice served.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Their complaints policy was in line with recognised guidance and contractual obligations for GPs in England and there was a designated responsible person who handled all complaints in the practice. The policy needed to be updated to reflect current organisational arrangements in the area. Information on how to make a complaint was on the practice website, in the patient information leaflet but was not displayed in the waiting room. We saw that the complaints policy had details of who patients should contact and the timescales they would receive a response by.

Patients we spoke with told us they were not aware of the complaints procedure but if they were not happy with something they would raise it with a member of staff. One of the patients we spoke had made a complaint about the practice and told it was investigated and resolved to their satisfaction. Staff we spoke with were aware of the practice complaints procedure and described how they would support someone who was not happy with the service.

The practice had received five complaints in 2014 and we saw that they had investigated the complaints and responded to the complainant in a timely manner

Are services well-led?

Inadequate

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

Our findings

Vision and strategy

The practice staff told us they wanted to deliver good quality care. However, it was evident the practice lacked any vision or strategy about how it would deal with current and future changes and demand. There were no details of the practices vision and practice values displayed in the waiting area or on the practice website, although there was a patient charter on the website.

Governance arrangements

There was no clear leadership structure with named members of staff in lead roles. For example, the nurse practitioner told us responsibility for Infection Prevention and Control (IPC) fell to her but it was not clear what her responsibilities were. However the practice manager told us there no one was identified as the IPC lead. The GP said they were the lead for safeguarding but the staff we spoke with told us it was the practice manager. We spoke with eight members of staff and seven of them told us that there was a lack of clarity about aspects of staff roles and responsibilities.

There were a number of policies and procedures in place to govern activity, for example infection control, medicines management and incident reporting, but it was evident that these were not being followed. We looked at 12 policies and protocols and found six of these had not been reviewed when required.

All of the staff we spoke with knew who to go to in the practice if they had any concerns and said they felt supported by the practice manager. However they all commented on the lack of communication and poor relationships between staff in the practice. For example staff told us that when meetings were held and minutes taken they were not shared with staff so if they were not at the meeting they were unaware of any changes required.

The practice did make use of the Quality and Outcomes Framework (QOF) and data from the CCG to measure its performance and identify areas for improvement. The QOF data for this practice showed it was performing below the CCG average in a number of areas. The practice did not have an on-going programme of clinical audits which it used to monitor quality or systems to identify where action should be taken.

The practice had not carried out risk assessments and did not monitor risks on a regular basis to identify any areas that needed addressing.

Leadership, openness and transparency

Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings and report incidents. The GP and practice manager told us that informal meetings were held each day. These were used for management to share information and disseminate lessons learned from incidents and for staff to raise concerns. Staff confirmed that they could raise issues however they told us that they did not feel they were kept informed about issues and lessons learned were not shared. Minutes were not kept of these meetings to demonstrate that lessons learned or information was shared with staff. There were no regular practice meetings and when they were held the minutes taken were not shared with staff. We did not see any minutes from the practice meetings.

The practice manager was responsible for human resource procedures. We saw that there was an induction procedure in place and policies for disciplinary issues and whistleblowing. The practice had access to an external HR company to support them with staff issues and promote their positive wellbeing. Staff we spoke with told us they felt bullied and were not always valued, although there was no evidence from staff surveys to support this. In the absence of a clear vision, strategy and suitable governance arrangements the practice failed to demonstrate effective leadership.

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

The practice had established a Patient Participation Group (PPG) and they had held three meetings. We saw minutes from the meetings which demonstrated that feedback was used to improve services. For example patients had raised the issue of access to appointments and the practice had employed more locums. There was information on the practice website encouraging patients to become involved in the PPG.

We found that the practice had not undertaken surveys to gather feedback from patients. Also there was no evidence

Are services well-led?

Inadequate

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

that they had reviewed its' results from the national GP survey to see if there were any areas that needed addressing. The practice had also not responded to patients' comments on the NHS Choices website.

The practice did not have a comments or suggestion box in the waiting area and no information on display on how to raise comments or suggestions.

We did not see any evidence that staff surveys were undertaken but staff told us they could raise any issues at team meetings or with the GPs and practice manager.

Management lead through learning and improvement

The practice had an understanding of the need to ensure staff had access to learning and improvement opportunities. Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. Staff told us they had access to training. The appraisal process gave staff the opportunity to develop a personal development plan and staff told us that the practice supported them to undertake training. However only two staff confirmed they had been appraised in the past 12 months.

The practice had completed reviews of significant events and other incidents and but there was no evidence that the lessons learned were shared with staff at meetings to ensure the practice improved outcomes for patients.

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 Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records **Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010** **The registered person must ensure that service users are protected against the risks of unsafe or inappropriate care and treatment arising from a lack of proper information about them by means of the maintenance of—** **(a) an accurate record in respect of each service user which shall include appropriate information and documents in relation to the care and treatment provided to each service user; and** **(b) such other records as are appropriate in relation to—** **(ii) the management of the regulated activity.**

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff **Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010** **The registered person must have suitable arrangements in place in order to ensure that persons employed for the purposes of carrying on the regulated activity are appropriately supported in relation to their responsibilities, to enable them to deliver care and treatment to service users safely and to an appropriate standard.**

This section is primarily information for the provider

Enforcement 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 Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services **Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010** **The registered person must take proper steps to ensure that each service user is protected against the risks of receiving care or treatment that is inappropriate or unsafe. Regulation 9(1) (a) and (b) (i) (ii)**

Regulated activity	Regulation
Diagnostic and screening procedures 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 provision **Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010** **The practice did not have suitable arrangements in place for assessing and monitoring the quality of service provision. Regulation 10(1)(a)(b), 10(2)(a), 10(2)(b)(i)(ii)(iii), 10(2)(c)(i) and 10(2)(e)**