Park Surgery

Quality Report

278 Stratford Road
Shirley
Solihull
West Midlands
B90 3AF
Tel: 0121 241 1700
Website: www.parksurgery-shirley.co.uk

Date of inspection visit: 6 November 2014
Date of publication: 31/03/2015

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

Ratings

Overall rating for this service	Requires improvement
Are services safe?	Inadequate
Are services effective?	Requires improvement
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Requires improvement

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We completed a comprehensive inspection at the Park Surgery on 6 November 2014. Overall the practice is rated as required improvement.

We found that the practice was rated good for caring and responsive. However, we identified that the practice required improvement in providing an effective and well-led service. It was inadequate in respect of providing safe services.

We found the care provided to the six population groups (people with long term conditions, families, children and young people, working age people, older people, people in vulnerable groups and people experiencing poor mental health) also required improvements. The ratings for the population groups are due to the provider rating of requires improvement for effective and well-led and an inadequate rating in safe. The concerns that led to these ratings apply to everyone using the practice, including these population groups.

Our key findings were as follows:

- Systems in place to manage and monitor the delivery of a safe service were in place but not robust.
- The practice provided effective services to patients overall but required improvement to demonstrate valid consent was given for minor surgery and effective use of audit to deliver service improvement.
- Patients were satisfied with the service overall and told us that they were treated with dignity and respect.
- Access to appointments was in line with other practices nationally although patients raised this as their main concern.
- Governance arrangements were not clearly defined resulting in inconsistent and ineffective management of risks.

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

Importantly, the provider must:

- Ensure that robust systems are put in place to identify, monitor and manage risks to patients and others who use the service by undertaking assessment of

Summary of findings

potential risks and implementing appropriate monitoring in areas such as infection control, the safety of the premises and emergency equipment. Review the clinical audit process to ensure the outcome and findings support service improvement.

- Ensure appropriate recruitment checks are undertaken to ensure that suitable staff are employed at the practice.
- Ensure appropriate systems are in place to protect patients and others from the risks of health care associated infection.
- Ensure consent for treatment is appropriately documented to demonstrate that risks, benefits and complications associated minor surgery have been explained and understood by the patient.

In addition the provider should:

- Review how they gain assurance that staff have the necessary knowledge, skills and understanding in relation to their roles and responsibilities in the absence of training.
- Ensure new staff have an effective induction programme so that they are aware fully of practice policies and procedures and location of equipment. Maintain up to date, practice specific policies and procedures in which staff can refer to in order to ensure consistency in the provision of services.
- Ensure that all patients have easy access to details of the complaints process.

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 a safe service.

The systems and processes to manage and address risks and managing safety alerts were not implemented well enough to ensure patients were always kept safe. We found areas relating to patient information, staff recruitment checks, infection control, equipment and management of emergency medicines that were not adequate.

Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned from incidents and communicated as appropriate to support improvement.

Are services effective?

Requires improvement

The practice is rated as requires improvement for providing effective services.

Data showed patient outcomes were at or above average in comparison to other practices in the locality. Staff referred to guidance from NICE and demonstrated its use. However, systems for discussing and sharing best practice guidance and ensuring actions from audits were implemented were not robust. The practice had a positive approach to health promotion and prevention. Patients' needs were assessed and care was planned and delivered as appropriate. Staff worked with multidisciplinary teams to effectively support patient needs. Staff received appraisals and assessments of their training needs although records of training were not well maintained to demonstrate training received. Records relating to consent for treatment did not demonstrate that risks and benefits had been discussed enabling patients to fully give informed consent.

Are services caring?

Good

The practice is rated as good for providing caring services.

Data from the national patient survey showed that patients rated the practice similar to others practices in various aspects of care. The majority of patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Accessible information to help patients understand the services available to them. We saw that staff treated patients with respect, and maintained their confidentiality.

Summary of findings

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services.

It reviewed the needs of its local population and engaged with the NHS England local area team and the Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Access to appointments was an issue raised by some patients and the practice had tried to address this although had yet to review the impact of any changes. The practice had facilities and equipment needed to treat patients and meet their needs. Information about how to complain was available and easy to understand although patients needed to request the complaints leaflet which could prevent some patients from raising their concerns. Evidence showed that the practice responded quickly to issues raised and learning from complaints took place.

Are services well-led?

Requires improvement

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

The practice had a strategy to deliver improved services and staff were aware of this. Staff were aware of their individual responsibilities and felt supported. The practice had a number of policies and procedures to govern activity, but these did not cover all areas to ensure a consistent approach. Lead roles were not always clearly defined to ensure tasks required to maintain patient safety were carried out. There was evidence of meetings in relation to significant events and complaints but governance meetings to discuss other issues with all staff were usually informal and not documented. The practice performed well in comparison with other practices locally in relation to patient outcomes for those with long term conditions. The practice proactively sought feedback from patients and had an active patient participation group (PPG). New staff did not receive formal inductions for their role however, staff did receive annual performance 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

Requires improvement

The practice is rated as requires improvement for the care of older people.

The rating for older people is requires improvement. This is because the provider was rated as requires improvement for providing effective services and being well-led. The practice is rated inadequate for providing safe services. The concerns which led to those ratings apply to everyone using the practice, including this population group.

Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of this patient group and had identified those patients with complex care needs. An agreed care plan had been put in place and there was a named GP for co-ordinating their care as part of an enhanced service. The practice worked with other healthcare professionals to deliver end of life care. It was responsive to the needs of older patients, and offered home visits for those who were unable to attend the practice and invited patients to attend flu vaccination clinics.

People with long term conditions

Requires improvement

The practice is rated as requires improvement for the care of people with long-term conditions.

The rating for people with long term conditions is requires improvement. This is because the provider was rated as requires improvement for providing effective services and being well-led. The practice is rated inadequate for providing safe services. The concerns which led to those ratings apply to everyone using the practice, including this population group.

There were processes in place for managing patients with deteriorating health. For those patients with the most complex needs there was a named GP and a duty doctor each day to assist in an emergency. Patients were encouraged to attend for annual reviews to check that their health and medication needs were being met and to ensure their medicines remained relevant. A variety of health information was available to patients with long term conditions.

Summary of findings

Families, children and young people

Requires improvement

The practice is rated as requires improvement for the care of families, children and young people.

The rating for Families, children and young people is requires improvement. This is because the provider was rated as requires improvement for providing effective services and being well-led. The practice is rated inadequate for providing safe services. The concerns which led to those ratings apply to everyone using the practice, including this population group.

There were systems in place to identify and follow up children who were at risk of harm. Immunisation rates were relatively high for all standard childhood immunisations. Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with health visitors. Emergency processes were in place and referrals were made for children and pregnant women whose health was deteriorating. Young children were prioritised for appointments.

Working age people (including those recently retired and students)

Requires improvement

The practice is rated as requires improvement for the care of working-age people (including those recently retired and students).

The rating for the care of working-age people is requires improvement. This is because the provider was rated as requires improvement for providing effective services and being well-led. The practice is rated inadequate for providing safe services. The concerns which led to those ratings apply to everyone using the practice, including this population group.

The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, and flexible to those with working commitments. The practice was proactive in offering online services such as booking appointments. There was a full range of health promotion and screening services that reflected the needs for this age group. Those aged 40 to 74 were actively invited to attend NHS health checks. A range of travel vaccinations were also available including Yellow Fever at the practice.

People whose circumstances may make them vulnerable

Requires improvement

The practice is rated as requires improvement for the care of people whose circumstances may make them vulnerable.

Summary of findings

This is because the provider was rated as requires improvement for providing effective services and being well-led. The practice is rated inadequate for providing safe services. The concerns which led to those ratings apply to everyone using the practice, including this population group.

The practice had identified patients living in vulnerable circumstances which mainly included patients with learning disabilities and those in care and nursing homes. We received positive feedback from one home supported by the practice. The practice carried out annual health checks for people with a learning disability and carers could request longer or double appointments if required. The practice was accessible to patients who used wheelchairs and home visits were available to those who were housebound.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. Information about access to various support groups and voluntary organisations was available from the practice. 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.

People experiencing poor mental health (including people with dementia)

Requires improvement

The rating for the care of people experiencing poor mental health (including people with dementia) is requires improvement.

This is because the provider was rated as requires improvement for providing effective services and being well-led. The practice is rated inadequate for providing safe services. The concerns which led to those ratings apply to everyone using the practice, including this population group.

The practice offered people experiencing poor mental health annual physical health checks. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. The practice told us that they offered dementia screening and were able to demonstrate how they would identify, refer and support a patient once diagnosis was confirmed.

The practice supported patients experiencing poor mental health to access various support including local counselling services managed by the local NHS mental health service improving access to psychological therapies (IAPT). Information about this service was available on the practice website.

Summary of findings

What people who use the service say

Prior to the inspection we provided the practice with a comments box and cards inviting patients to tell us about their care. We received 42 responses the majority of these were positive and told us that the patients were happy with the care and treatment that they received at the practice. However, we also received comments from a small percentage of patients who whilst satisfied overall with the practice told us of difficulties obtaining appointments, sometimes long waits and of being unable to get and appointment with the same GP.

We spoke with a member of the patient participation group (PPG). PPGs are an effective way for patients and GP surgeries to work together to improve the service and to promote and improve the quality of the care. They told us that the practice had an active patient participation group that met regularly. The PPG member was satisfied that the group was listened to and that action was taken in response to issues raised at the meetings.

We also looked at data available from the national patient survey and in house practice survey. Results from the national patient survey found the proportion of respondents to the GP patient survey who described the overall experience of their GP surgery as good or very good was similar to the national average. Results from the practice's own in-house survey of 127 patients undertaken in 2013 found 98% of patients described their overall experience as satisfactory or better.

Areas for improvement

Action the service MUST take to improve

- Ensure that robust systems are put in place to identify, monitor and manage risks to patients and others who use the service by undertaking assessment of potential risks and implementing appropriate monitoring in areas such as infection control, the safety of the premises and emergency equipment. Review the clinical audit process to ensure the outcome and findings support service improvement.
- Ensure appropriate recruitment checks are undertaken to ensure that suitable staff are employed at the practice.
- Ensure appropriate systems are in place to protect patients and others from the risks of health care associated infection.
- Ensure consent for treatment is appropriately documented to demonstrate that risks, benefits and complications associated minor surgery have been explained and understood by the patient.

Action the service SHOULD take to improve

- Review how they gain assurance that staff have the necessary knowledge, skills and understanding in relation to their roles and responsibilities in the absence of training.
- Ensure new staff have an effective induction programme so that they are aware fully of practice policies and procedures and location of equipment. Maintain up to date, practice specific policies and procedures in which staff can refer to in order to ensure consistency in the provision of services.
- Ensure that all patients have easy access to details of the complaints process.

Park Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector supported by a GP specialist advisor to CQC.

Background to Park Surgery

Park Surgery is registered for primary medical services with the Care Quality Commission (CQC) and provides services to patients under the General Medical Services contract (GMS) with NHS England. A GMS contract requires the practice to provide essential services to patients who are ill and includes chronic disease management and end of life care. The practice is part of NHS Solihull CCG Clinical Commissioning Group (CCG).

The practice is open Mondays to Fridays 8.15am until 6.30pm. Extended opening hours are available every Tuesday until 7.15pm and every third Saturday each month the practice opens between 8.30am and 11.30am. When the practice is closed patients are able to receive primary medical services during out-of-hours through another provider (BADGER).

The practice has a registered list size of just under 7000 patients. It is located in purpose built premises in Shirley, an area with low levels of deprivation and among one of the least deprived areas nationally. The practice population is slightly older than the national average.

There are three full time GP partners and two salaried GPs who work at the practice. One GP is male and four are female. The practice has two practice nurses, a practice manager and a team of administrative staff.

The practice was previously inspected in October 2013 under our old methodology and was found compliant in the areas inspected. The CQC intelligent monitoring placed the practice in band 6. 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.

Why we carried out this inspection

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

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

How we carried out this inspection

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

- Is it safe?

Detailed findings

- 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)

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew about the service. We carried out an announced inspection on 6 November 2014. During our visit we spoke with a range of staff which included two GPs, two practice nurses and two administrative staff. We looked at a range of documents that were made available to us relating to the practice. We sent the practice a box with comment cards so that patients had the opportunity to give us feedback. We received 42 completed cards where patients shared their views and experiences of the service. We also observed the way the service was delivered but did not observe any aspects of direct patients care or treatment.

Inadequate

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve quality in relation to patient safety. For example reported incidents, complaints and feedback from patients. Staff were aware of their responsibilities to raise concerns, and how to report incidents and near misses. For example we reviewed one reported incident in which the diagnosis of a patient had led the practice to review the care of this patient to determine whether an earlier diagnosis could have been made.

The GPs we spoke with told us that they routinely received national patient safety alerts. Patient safety alerts are issued when potentially harmful situations are identified and need to be acted on. The practice did not have a formal system for discussing and recording any action required in response to safety alerts and ensuring relevant information was disseminated to all staff as appropriate. The GPs we spoke with told us that they discussed these with other GPs at the practice during lunchtime meetings and we did see information about the Ebola virus from Public Health England had been displayed in the practice. However these meetings were not formally documented to ensure information and actions needed were not missed.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. Records of significant events that had occurred during the last two years were made available to us. The GPs we spoke with told us that significant event meetings were held twice each year with all staff but any major issues would be discussed earlier at informal meetings with the GP partners held over lunch. We saw records of meetings in which significant events were discussed however the last recorded meeting related to October 2014.

Staff were aware of the need to report any safety incidents or near misses that occurred and told us they were encouraged to do so. They told us that they would notify the practice manager who would complete the relevant forms. We saw copies of the significant event forms. We found that individual incidents were thoroughly investigated and action identified where needed. For example and investigation took place after medicine prescribed to a patient interacted with other medicine they were taking. This led the practice to discuss their processes when prescribing for patients on this particular medicine.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable adults and children. Practice training records were made available to us. These showed that some but not all staff had received relevant role specific training on safeguarding. Staff spoken with knew how to recognise the signs of abuse in vulnerable adults and children. They were aware of their responsibilities regarding information sharing and referring concerns to relevant authorities responsible for investigating safeguarding concerns and were able to give examples where they had made referrals.

The practice had a dedicated GP lead for safeguarding children and vulnerable adults who had been trained to a level 3, the appropriate level required for the lead GP. Most staff we spoke with were aware of who the safeguarding lead was at the practice if they had a safeguarding concern they wished to discuss.

Staff told us that alerts were placed on the patient's electronic records to highlight if they were vulnerable or at risk. This enabled staff to be more vigilant if the patient attended the practice for an appointment, we saw an example of this. Staff told us that they would contact parents of children that had not attended immunisation clinics to encourage attendance.

The practice held meetings with the health visitor to discuss vulnerable children and a communication book was in place to ensure information where relevant was shared between the health professionals. The GPs who we spoke with told us that the health visitor would make entries into the patient's records if a child was at risk.

The practice had a chaperone policy and information was displayed in the waiting area advising patients that they could request a chaperone for their consultation. Reception staff told us that they sometimes acted as chaperones during patient examinations and had been given training in this role. We saw minutes of a staff meeting confirming this. Staff spoken with had a clear understanding of their responsibilities and knew where to stand.

Inadequate

Are services safe?

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring medicines were kept at the required temperatures. This was being followed by the practice staff, and the action to be taken in the event of a potential failure was understood.

We checked a sample of vaccines held in the medicines fridge and found these were within their expiry date. However, there was no evidence of checks being undertaken to ensure other medicines held at the practice were in date and fit to use. We found two items in the emergency medicine box which had passed their expiry date and two oxygen cylinders which were also out of date. The GP partners were informed of this so that appropriate action could be implemented to address this.

The practice took part in prescribing benchmarking with other practices in the local CCG. Prescribing data from May 2014 to July 2014 showed that the practice performed well against targets in the prescribing of antibiotics, hypnotics and non-steroidal anti-inflammatory drugs (NSAIDs). The practice had also participated in an audit of the management of patients on high risk drugs. Although there had been a re-audit, it was not evident that any impovements had been made. There had been no analysis of the results to determine whether a further audit was required as a result of actions identified. The GPs we spoke with were unable to provide us with any more information about this audit.

The nurses administered vaccines using directions that had been produced in line with legal requirements and national guidance. The practice nurse showed us up-to-date copies of directions in place for them to administer vaccines.

Staff described the system for repeat prescribing. Although this process had not been formally recorded to ensure consistency, the systems described by staff were appropriate. Repeat prescriptions requiring re-authorisation were seen by the GP, reception staff spoken with were aware of specific medicines that needed to be authorised by a GP at each request. All prescriptions were signed by the GP before being given to the patient.

Blank prescription forms were handled in accordance with national guidance. The GPs told us that these were locked in storage. The reception supervisor would record prescription numbers and which member of staff they had been given to, enabling an audit trail to be maintained. They also told us that they could print off a populated prescription script from the electronic patient record system when attending a home visit and shred if not required.

Cleanliness and infection control

We observed the premises to be visibly clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. Feedback received from patients about the practice did not raise any concerns about the cleanliness of the practice. We saw that staff had access to personal protective equipment such as gloves and aprons. There were appropriate hand washing facilities available and signage in hand washing techniques displayed. There was information displayed informing staff of action to take in the event of a needle stick injury. These arrangements help to minimise the risk of cross infection.

We saw from local CCG benchmarking data that the practice had an infection control audit carried out in February 2014. This had rated the practice as amber and below the CCG average. There had been an improvement from the previous audit carried out in July 2013 in which the practice was red rated. Although we did not see any completed action plans we were told about some of the actions that had been undertaken such as the labelling and closing of sharps bins between use. They had also changed cleaning provider who would undertake their own cleaning audit on a three monthly basis. We were provided with a copy of the cleaning audit that had been undertaken in October 2014 by the cleaning contractor. The audit scored 82% which the minimum target of 90% they had set. Evidence seen did not provide adequate assurance that the practice had put in place adequate systems and processes to make and sustain improvements in relation to infection prevention and control.

Staff told us that the new practice nurse was the infection control lead for the practice. However, the practice nurse had not received any guidance as to what was required or expected of this role.

We asked to see infection control policies and procedures. We saw related policies and guidance but these were not comprehensive or had been reviewed recently. Those seen included personal protective equipment and bodily fluid spillage procedures dating from 2009.

Inadequate

Are services safe?

The practice did not have a policy in place for the management, testing and investigation of legionella (a germ found in the environment which can contaminate water systems in buildings). No risk assessments or testing had been undertaken at the practice to identify the risk of and any actions needed to minimise the risk of legionella infection. Although we did see from the cleaning schedules that the running of taps was included in the cleaning tasks to help reduce the risk of legionella.

Equipment

Staff we spoke with were satisfied with the equipment available to enable them to carry out diagnostic examinations, assessments and treatments. The practice did not maintain any inventory of equipment that required electrical safety testing, servicing or calibration. This would ensure that when testing and calibration took place and that no equipment was missed. We saw evidence that electrical equipment had undergone portable appliance testing (PAT) within the last 12 months. However, there were no records to confirm that, where appropriate, equipment such as scales and fridge thermometers had routinely undergone servicing and calibration checks to ensure the accuracy of readings.

Staffing and recruitment

We found that the practice did not have robust recruitment processes in place to ensure only suitable staff worked at the practice. We asked the practice manager for three staff files including two permanent members of staff who had been recently recruited and a clinical member of staff who was a long term locum nurse. There was a lack of consistency in the checks undertaken. For example, we found no criminal records checks via the Disclosure and Barring Service (DBS) for one member of staff. The practice manager told us the DBS checks were not routinely undertaken for administrative staff and no risk assessments were completed to determine whether they were required. Proof of identification was not consistently sought. In one file the person's professional registration had expired but no checks had been undertaken to ensure they remained registered and had the right to practice in their professional capacity. In the case of the locum member of staff there was no checks of training they had received in relation to the tasks they were undertaking. We asked to see the practice's recruitment policy but the practice did not have one. The practice manager was not able to explain why these systems were not in place.

We spoke with two of the GP partners about the staffing of the practice and how staff absences were covered to ensure there were enough staff. There were currently no vacancies at the practice. The GPs we spoke with told us that recruitment of practice nurses was a recognised issue in the area and they had until recently been without a permanent practice nurse. They told us that the recruitment of two salaried GPs meant they did not require locum GPs. Administrative staff were required to help cover for each other during leave or sickness. There were restrictions on the number of staff on leave during the summer to ensure sufficient administrative cover. This expectation was written into the staff contracts.

Monitoring safety and responding to risk

The practice did not have robust systems and processes in place to manage and monitor risks to patients, staff and visitors to the practice such as routine checks of the building, the environment, equipment (including emergency equipment) and staffing. There were no risk logs in place for recording identified risks so that they could be assessed, rated and mitigating actions recorded to reduce and manage them. There were no formal arrangements for discussing risks and sharing findings as appropriate with the staff team for example fire, health and safety and risks identified through audits.

We saw that staff were able to identify and respond appropriately to changing risks to patients including deteriorating health and wellbeing. The GPs we spoke with were able to give us specific examples of how they had managed deteriorating health in patients with long term conditions, an acutely ill child, acute pregnancy complications and in a mental health crisis.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage medical emergencies. We were told that there had been a training event for all staff in basic life support during the last 12 months. We were unable to verify from training records seen that all staff had attended. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). With the exception of one new member of staff, everyone knew the location of the

Inadequate

Are services safe?

equipment. However there were no records confirming that the emergency equipment was checked regularly to ensure it was fit for use. Only one of the three oxygen cylinders seen was within date.

Emergency medicines were available in a secure area of the practice. These included medicines for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. However, these were not checked regularly to ensure items when required were in date. We found two items that were past their expiry date.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice such as loss of power, the incapacity of staff; an epidemic or pandemic. The plan contained guidance for staff to refer to such as the availability of temporary accommodation and essential equipment staff may need to take with them as well as a list of relevant contact details for various services. There was also a flow chart detailing the cascade of information to ensure all practice staff are made aware of the situation.

There had been no recent fire risk assessment undertaken at the practice or actions seen. The last fire risk assessment was undertaken in 2008. Records of staff fire training was dated prior to 2009. There had been no recorded alarm test or fire drill in the last 12 months. However, we did see evidence that fire equipment such as the fire extinguishers had been checked within the last 12 months.

Requires improvement

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice did not have robust processes in place for ensuring best practice guidance was followed. The two GP partners who we spoke with told us that the GPs discussed the implications for patients of new guidance between themselves at lunch time meetings. These meetings were not formally document with agreed actions identified. They were however able to demonstrate an awareness of best practice guidance for example from the National Institute for Health and Care Excellence (NICE) and from local commissioners.

The GPs we spoke with told us that each GP had specific areas of interest such as asthma or gynaecology conditions which allowed them to focus on particular conditions. They also attended update sessions to keep their knowledge up to date to support patients. We were told that the locum nurse who had worked at the practice over a number of years specialised in diabetes but practice staff were unable to provide any evidence of this. The locum nurse confirmed that they had received this training but did not have their training certificates with them.

The practice had opted to take part in the new enhanced service to follow up patients discharged from hospital. Enhanced services are services provided above what is normally required under the core GP contract. Patients with health conditions most likely to cause admissions were selected for this. We saw examples of care plans in place to help best support these patients.

Referral data showed the practice had lower elective and urgent referral rates and lower A&E attendance rates overall than other practices in the local CCG area. We saw that the practice reviewed this data and acted on it to improve performance. We saw an example where the practice had investigated and taken action to reduce referral rates for a particular specialty when this had shown as an outlier. This included reviewing differences in referral rates between the practice GPs and supporting GPs in the management of referrals where they were high.

Local CCG data of the practice's performance for prescribing showed the practice performing well compared to similar practices in the CCG area with lower antibiotic prescribing levels.

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 practice showed us six clinical audits that had been undertaken in the last two years. The audits seen included high risk drug monitoring, prescribing for patients with chronic obstructive pulmonary disease and minor surgery audits. Two of the audits seen were completed cycles. However, it was not always evident from the information provided from the audits what improvements had been achieved or what follow up action was taken in the absence of improvement. The GPs we spoke with agreed that they needed to review how they undertook audits to demonstrate improvement.

The practice used Quality Outcomes Framework (QOF), a national performance measurement tool, to monitor outcomes for patients. The latest information we held about the practice showed that the QOF points achieved were similar to other practices in the local CCG area and the national average. This demonstrated that the practice was meeting standards required for QOF.

The practice was participating in the new unplanned admissions enhanced service and had processes in place to follow up patients who were discharged from hospital. Enhanced services are services which require an enhanced level of service provision above what is normally required under the core GP contract. We saw examples of care plans and of reviews undertaken of patients for those identified as at risk of being admitted to hospital. The practice had undertaken an audit to ensure follow up of patients discharged from hospital were not missed. The patient record system identified when patient medication reviews and health checks were due so that staff could remind patients to attend the practice for them. This enabled the GPs to monitor and support patients with long term and complex conditions.

The practice participated in local benchmarking run by the CCG. This is a process of evaluating performance data from the practice and comparing it to similar practices in the area. The practice showed us data from the local CCG of the practice's performance across a number of areas such as

Requires improvement

Are services effective?

(for example, treatment is effective)

referrals, quality and prescribing. The benchmarking data showed the practice was generally lower for referrals to secondary care and prescribing. The GPs we spoke with told us that the CCG had asked them to run workshops to share best practice as a result of this.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We asked to see staff training records; we found these to be disorganised and it was difficult to determine what training staff had received. The practice manager was unable to confirm what training had been undertaken. In the absence of complete training records we were therefore unable to confirm that all staff were up to date with training such as annual basic life support and safeguarding children and adults. There were no records kept of the locum nurse's training or evidence of checks undertaken by the practice to verify the training they had received. Some of the staff had completed training in specific areas for example, we saw that two of the GPs had undertaken additional training and had certificates in Diabetes Care.

We looked at records for the three GP partners and saw that they had all been revalidated or had a date for revalidation. Every GP must be appraised annually and then every five years undertakes a fuller assessment called revalidation. Only when revalidation has been confirmed by NHS England can the GP continue to practice and remain on the performers list with NHS England.

We saw evidence of annual appraisals for administrative staff that had been carried out in the last 12 months but none for clinical members of staff. Staff we spoke with told us that the practice was receptive to training if they needed it. The practice nurse had only recently been employed and had therefore not yet had an appraisal at the practice.

The practice was a training practice for final year medical students. One partner told us that they were also an examiner for part of the final exam for medical students.

We spoke with the practice nurse who had been in post for three months. We asked the practice nurse about how they were supported and they told us that this was through the lead development nurse at the CCG. They were currently undertaking training in areas such as cervical cytology and immunisations to enable them to take on additional roles at the practice. These areas were currently being covered by the locum practice nurse and GPs. However we did not see that the practice nurse had received a formal induction at the practice to ensure they were familiar with the lay out and location of equipment and our discussions with the practice nurse confirmed this. For example they had not been shown the practice processes for incident reporting or the location of emergency equipment if needed. They did however feel they could ask for advice and support if needed and it would be given.

Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and manage complex cases. Blood results, x-ray results, letters from the local hospital including discharge summaries, and information from the out of hours providers and the NHS 111 service were received both electronically and by post. The practice had a process for reviewing and taking action on any issues arising from communications with other care providers. Two of the GPs took responsibility for reviewing incoming post and deciding on action, including allocating to the referring GP if more complex action was required. The GPs we spoke with told us that protected time was allocated for the management of communications received and that they tried to ensure all actions required were cleared on a weekly basis.

The practice held multi-disciplinary team meetings approximately every three months to discuss the needs of complex patients and share information to provide co-ordinated care, for example, those with end of life care needs. The meetings were attended by the practice staff, the community matron and palliative care nurse. The meetings were recorded and we saw copies of minutes from them. The practice also met with the health visitor to discuss vulnerable children and information was shared on an informal basis when needed.

Information sharing

The practice had systems in place to share information with other providers. Electronic systems were in place for making referrals. The practice manager told us that they managed the majority of their 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

Requires improvement

Are services effective?

(for example, treatment is effective)

Information was shared with the out of hours service provider about patients receiving end of life care who may need to access the service. We saw a copy of template that was used to share information to help ensure the patient received continuity of care when the practice was closed.

The practice was adopting the summary care record. Patients were currently being notified of this and whether they wished to opt out. Summary Care Records provide healthcare staff treating patients in an emergency or out-of-hours service with faster access to key clinical information about them.

The practice had systems in place to provide staff with the information they needed. An electronic patient record system (SystmOne) was used by staff to coordinate, document and manage patients' care. The software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference. However, not all communications received were routinely scanned for example letters relating to cytology screening invites which would enable staff to easily see if a patient had missed their last screening date.

Consent to care and treatment

The GPs we spoke with had an understanding of the Mental Capacity Act (2005) and the Gillick competency when supporting patients to make decisions where capacity may be an issue. They told us that patients such as those with a learning disabilities or dementia would be given longer appointments to help facilitate discussions about their treatment and they would try and explain in a way they could understand. The GPs told us that if they had difficult decisions they would discuss them with the practice team and gave an example in the case of a child where further guidance was obtained from a paediatrician to help ensure care and treatment was provided in accordance with legal requirements and national guidance.

The practice did not have in place appropriate arrangements for obtaining and documenting consent for specific interventions. Minor surgery such as excisions were carried out by all three of the GP partners. The practice also carried out family planning procedures such as the fitting of intrauterine devices (IUD). Written consent for treatment was not consistently obtained. We saw that there was a consent form used when fitting an IUD, however, we were advised that there was no formal written consent obtained for minor surgery. Verbal consent was recorded on the patient records but no evidence that risks, benefits and complications of the procedure had been discussed with the patient. The GPs told us that they did discuss risks with the patient and would direct them to appropriate websites for further information. This did not provide assurance that patients had given informed consent to their treatment as there was no documented evidence.

The practice staff were aware of the distinction between lawful and unlawful restraint and were able to give an example in which they had managed a potential situation without the need for physical restraint.

Health promotion and prevention

The practice met regularly with the local Clinical Commissioning Group (CCG) to discuss local priorities and share information about the needs of the local population.

The practice offered new patients on regular medication or existing health problems a health check with the practice nurse or GP. The GPs we spoke with told us how they had undertaken new patient health check as a home visit where the patient was housebound. The practice also offered NHS Health Checks to all its patients aged 40-74. The practice was proactive in inviting eligible patients to attend and we saw a copy of the letter that was sent out to patients. Practice data showed that the uptake of the NHS Health check was at 90%. These health checks help to identify the onset of disease. The practice nurse told us that if they had any concerns about a patient during a health check they would speak directly with the GP on call that day or book the patient in to see a GP depending on the urgency so that their health needs could be addressed in a timely manner.

The practice had systems for identifying patients who needed additional support. For example, the practice kept a register of all patients with a learning disability. There were 30 patients on the learning disabilities register and approximately half had received an annual physical health check so far this year. The practice had also identified the smoking status of 93% of patients over the age of 16. They did not currently offer smoking cessation services but planned to train the new practice nurse to do this. Currently the practice directed patients to a local smoking cessation service and information was available to patients about this.

A range of Information leaflets and posters were available in the patient waiting area on health promotion and prevention such as alcohol awareness, lowering

Requires improvement

Are services effective?

(for example, treatment is effective)

cholesterol, colds and flu. There was also advice for common illnesses and accidents included in the practice leaflet. The waiting area had a machine to enable patients to check their own blood pressure. The practice held open days for patients with guest speakers discussing issues such as smoking cessation. This helped patients to take responsibility for their own health.

Benchmarking data from the CCG showed the practice's current performance for cervical smear uptake was 76% which was just above the CCG average. CCG data for the uptake of other national screening programmes such as mammography and bowel screening were also similar to other practices in the CCG area.

The practice offered a full range of immunisations for children, travel vaccinations (including yellow fever) and flu vaccinations. Data available to us showed performance with child immunisations was slightly better than the CCG average. Reception staff told us that they followed up patients that did not attend and in some cases would notify the health visitor.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent patient survey data available for the practice. This included information from the latest national patient survey and an in-house patient survey of 128 patients undertaken in November 2013. The evidence from these sources showed patients were generally satisfied that they were treated with compassion dignity and respect. For example, data from the national patient surveys showed the practice was rated as similar to other practices nationally for patients rating the practice as good or very good. The practice was also similar to other practices nationally for its satisfaction scores on consultations with doctors and nurses with 84% of practice respondents saying the GP was good at listening to them and 89% saying the GP gave them enough time.

Patients completed CQC comment cards to provide us with feedback on the practice. We received 42 completed cards and the majority of patients were positive about the service experienced. Patients told us they were happy with the care and treatment that they received. Most patients described the practice as helpful and caring and that they were treated with dignity and respect. However, we also received comment cards from seventeen patients, who were generally satisfied with the service overall but raised issues mainly about appointments. The GPs we spoke with told us that they had tried to improve appointment system through online booking, extended working hours and telephone consultations and results from their own in house survey had rated their performance in line with other practices in this area.

We saw that consultations and treatments were carried out in the privacy of a consulting room. Privacy curtains were provided in consulting rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

None of the patients we spoke with or feedback received indicated that they had any concerns about patient confidentiality. Patients' right to confidentiality was displayed in the waiting room and staff spoke with demonstrated an awareness of protecting patient confidentiality. Reception staff told us that if patients wanted to speak in private they would offer a room away from the waiting area.

Care planning and involvement in decisions about care and treatment

The national patient survey information we reviewed showed patients responses to questions about their involvement in planning and making decisions about their care and treatment were similar to the CCG and national averages. For example, data from the national patient survey showed 73% of practice respondents said the GP involved them in care decision and 77% of practice respondents said the GP was good at explaining treatment and results.

Feedback received from patients through the comment cards indicated that most patients were satisfied with their involvement in decision making about the care and treatment they received. However, a small proportion of patients whilst happy with the service overall said they did not feel they were given enough time to discuss their health needs.

Staff told us that translation services were available for patients who did not have English as a first language. Reception staff told us that they did not often need to use this service but had the number for the service if needed.

The practice had developed care plans for some of its most vulnerable patients. This enabled these patients to participate in decisions about their care and treatment.

We received positive feedback from a home which cared for patients with a learning disability. They described the practice as helpful and good at involving the patients in their care.

Patient/carer support to cope emotionally with care and treatment

The practice had a wide range of information available in the waiting room and on the practice website to help patients access support services and find out more about their health condition. We saw information displayed about various support groups and services including cancer, multiple sclerosis and smoking cessation. There was also information about carer support groups and services for common mental health conditions such as anxiety and depression. The GPs we spoke with also told us that they

Good

Are services caring?

would help signpost patients to websites during consultations. They also recognised the risks of anxiety and depression in patients with long term conditions and told us that as part of the annual review would assess this and direct patients as needed to counselling services through improving access to psychological therapies.

The practice told us how they would support families who had suffered bereavement. The practice had information available about bereavement support and counselling services which they could direct patients to.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice had a slightly older population than the national average and was in an area with low levels of deprivation.

The practice had identified patients that due to the complexity of their condition were high risk of hospital admission. This enabled them to plan care to support the patients in their home and avoid the need for unplanned hospital admissions. The GPs we spoke with told us that these patients were identified through discussion and knowledge of patients on the practice list. This was part of the enhanced service to avoid unplanned hospital admissions. An enhanced service is a service that is provided above the standard general medical service contract.

The practice also kept registers of vulnerable patients such as those with a learning disabilities so that they could be identified for health reviews and allow for adjustments to be made to meet their needs. For example longer appointments.

The practice engaged with the local Clinical Commissioning Group (CCG) to deliver local priorities. For example we saw that they were engaged in the prescribing and other benchmarking activity which enabled the practice to identify areas for improvement.

The practice had in place the gold standards framework for end of life care. The gold standard framework is about improving the care for patients through co-ordinated and multidisciplinary working. The practice held a palliative care register and held regular multidisciplinary meetings to discuss patients' and their families' care and support needs.

The practice worked collaboratively with other agencies to help meet patient needs. The GPs described situations in which they had consulted with healthcare professions such as community paediatricians to help meet patient needs.

We spoke with a member of the Patient Participation Group who told us that they were listened to. They gave examples as to how the group had provided input into information displayed on the practice television screens.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example the majority of patients who attended the practice were English speaking but access to translation services were available if needed. Information on the practice website could be translated into a number of different languages helping patients to access the services provided by the practice. There was also an audible option on the website that enabled patients to listen to the contents and the practice had a hearing loop in place to support patients who were hard of hearing.

The practice was located in purpose built accommodation with access to patients who used wheel chairs and for pushchairs. Accessible parking spaces were available and access into the premises was via a ramp. A door bell had been installed which allowed patients to obtain assistance if needed. Most of the consulting rooms were situated on the ground floor and the reception desk was low so that patients who used a wheelchair could easily speak with reception staff.

The GPs we spoke with were able to give specific examples as to how they had supported vulnerable patients. For example there was a learning disability register and patients on the register were offered annual health checks. The practice told us that they had undertaken health reviews on 50% of the patients with a learning disability so far this year. There were also examples given where patients with no fixed abode and patients not registered with the practice (which was situated on the high street) had arrived at the practice unwell and were seen.

Access to the service

The practice was open between 8.15am to 1.00pm and 2.00pm to 6.30pm daily. Extended opening was available on a Tuesday evenings until 7.15pm and every third Saturday of each month between 8.30am and 11.30am. Patients could book appointments up to four weeks in advance and some appointments were released on the day including urgent appointments. Patients were able to see their preferred GP if they were able to wait.

Home visits and telephone consultations were also available for patients whose circumstances meant they were unable to attend the practice for an appointment.

Comprehensive information was available to patients about appointments on the practice website and in the practice leaflet. This included how to arrange urgent

Good

Are services responsive to people's needs?

(for example, to feedback?)

appointments and home visits. There was also information on the practice website on how to book appointments online. There were arrangements in place to ensure patients received urgent medical assistance when the practice was closed. Information was available to patients on how to contact the out of hours provider when the practice was closed and other services locally available in which patients could get help or support.

Some patients told us that they experienced difficulties obtaining appointments and having to wait a long time from their allotted appointment time The practice had taken action to try and improve the appointment in response to comments received. However, results from the national patient survey showed that patient satisfaction with the appointment system was similar to those of other practices nationally. These findings were supported by the practice's own patient survey.

Listening and learning from concerns and complaints

The practice has a system in place for handling complaints and concerns. Their complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. There was a designated responsible person who handled complaints at the practice.

We saw information was available to help patients understand the complaints process. The practice leaflet and website directed patients to the practice manager or to reception for a copy of the complaints procedure. As the complaints procedure was held behind the reception desk it had to be requested and this may prevent some patients from raising their concern or complaint.

The complaints leaflet set out the process for patients to follow and provided details about when patients could reasonably expect a response. It also provided details about what to do if the patient was not satisfied with the response received from the practice.

There had been 11 complaints received by the practice in the last 12 months. We found these had been managed appropriately. The practice reviewed complaints annually and we saw minutes from the meetings. Complaints received did not identify any specific themes but showed that information about the complaints had been shared with all staff and lessons learnt.

Are services well-led?

Requires improvement

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

Our findings

Vision and strategy

The practice had a future strategy for the practice and how it planned to deliver quality care and promote good outcomes for patients. There were plans to merge with five other practices in order to deliver future government proposals for primary care opening, increase efficiency and to deliver a wider range of services. Information had been shared with both staff and patients about this.

Governance arrangements

Staff told us that policies and procedures were available on their computers or in hard copies with the practice manager. We saw evidence of some policies in place but not in all areas of practice activity. For example comprehensive and up to date recruitment, infection control policies and repeat prescribing policies and procedures were not available to us when requested from staff.

Governance issues such as performance, quality and risks were discussed by the GP partners at lunch time meetings. However, these were not formally recorded meetings and there was no evidence available as to what was discussed, actions required and clear accountability for any actions identified. The practice did not have robust processes in place for managing risks and securing improvements to services. The practice did not maintain any risk logs. We found risks to the practice and actions to mitigate those risks had not been specifically identified and implemented. For example risks relating to fire safety, legionella and staffing.

The practice used Quality and Outcomes Framework (QOF) to measure their performance and benchmarking data through the local Clinical Commissioning Group (CCG). Information available showed the practice performed well and in line with national standards.

Leadership, openness and transparency

There were some elements of the practice in which leadership was clear such as safeguarding and involvement with external bodies. However, there were areas in which leadership was less clear such as the management of risks and monitoring of service provision. For example, there was a lack of robust systems in place for the maintenance of equipment, staff recruitment and fire safety. The role of infection control lead had recently been identified but training and guidance as to what this would involve had not been clearly identified. Staff spoken with did however feel clear about their own roles and responsibilities and who to go to at the practice if they had any questions. We saw copies of job descriptions for various staff roles.

Practice meetings were not routinely held and minutes from the last meeting were dated 12 months previously. Practice meetings provide an opportunity for staff to raise issues and for the dissemination of information consistently among practice staff.

The practice manager was unable to show us any human resource policies and procedures to support staff such as disciplinary procedures, induction policies and the management of sickness. We did not see evidence that new members of staff received formal inductions to their role.

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

The practice had gathered feedback from patients though the national GP patient survey and from an in house patient survey carried out on 128 patients in November 2013. Results from the practice survey showed issues relating to booking appointments and waiting times were commonly raised. An action plan had been put in place and an appointment audit carried out in response which had led to changes to the appointment system and raising awareness about the booking of appointments.

The practice had an active patient participation group (PPG) with approximately six members. PPGs are a way in which patients and practices can work together to improve the service. We spoke with one member who told us that they had actively tried to recruit a more representative age group. We saw notices for new members displayed in the practice and on the website. The PPG had been involved in the analysis of the patient survey data and agreeing actions to take forward. The PPG was attended by a GP and the practice manager who were able to influence change in the practice.

Practice staff told us that they were able to discuss any issues or concerns with colleagues and senior staff when they needed to. They also had appraisals in which they could raise issues. However there were no routine arrangements or meeting in place where staff were given opportunities to discuss issues or concerns formally.

Are services well-led?

Requires improvement

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

The practice did not have a whistle blowing policy in place and staff spoken with were not aware of one. Whistleblowing is the means by which staff can raise concerns about poor practice.

Management lead through learning and improvement

We saw from staff records that staff received annual appraisals which identified learning needs. Staff we spoke with told us that the practice was receptive to training if they needed it, although training records at the practice were not readily available to verify what training staff had received.

The practice was a training practice for final year medical students and additional training for students who require it.

The practice had completed comprehensive reviews of significant events and other incidents which were shared with staff. Meetings were held to discuss any learning and improve 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 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 **The registered person must protect service users, and others who may be at risk, against the risks of inappropriate or unsafe care and** **treatment, by means of the effective operation of systems designed to enable the registered person to identify, assess and manage risks relating to the health, welfare and safety of service users and others who may be at risk from them carrying on of the regulated activity.** **Regulation 10 (1)(a)(b)**

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 **The registered person must, so far as reasonably practical ensure that service users; persons employed for carrying on of the regulated activity; and others who may be at risk of exposure to a health care associated infection arising from the carrying on of the regulated activity are protected against identifiable risks of acquiring such an infection.** **Regulation 12 (1)(a)(b)(c) (2)(a)**

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures	Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers **The registered person must have robust recruitment process in order to ensure that persons employed for carrying on a regulated activity are of good character,**

This section is primarily information for the provider

Compliance actions

Treatment of disease, disorder or injury	have the qualifications, skills and experience which are necessary for the work to be performed and are physically and mentally fit for that work. Ensure that information specified in Schedule 3 is available and that a person employed for the purposes of carrying on a regulated activity is registered with the relevant professional body. Regulation 21(a)(i)(ii)(iii) (b) (c)(i)(ii)

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment The registered person must have suitable arrangements in place for obtaining, and acting in accordance with, the consent of service users in relation to the care and treatment provided for them. Regulation 18