Victor Street Surgery

Quality Report

Victor Street
Shirley
Southampton
Hampshire
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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	Good
Are services safe?	Requires improvement
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Victor Street Surgery on 21 April 2015. Overall the practice is rated as good .

Specifically, we found the practice to be, it was good for providing responsive, effective, caring and well-led and services for older people, people with long term conditions, families, children and young people, working age people, people whose circumstances may make them vulnerable and people experiencing poor mental health.

It required improvement for providing safe services.

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Risks to patients were not effectively assessed and monitored. These included recruitment checks, medicines management, staffing, fire safety and infection control.
- Patients' needs were assessed and care was planned and delivered following best practice guidance.
- Most staff received training appropriate to their roles and any further training needs had been identified and planned.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- A recent survey showed 94% of patients said they had confidence and trust in the GP treating them;
- Information about services and how to complain was available and easy to understand.
- Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.

Summary of findings

- There was a clear leadership structure and staff felt supported by management.
- The practice proactively sought feedback from staff and patients, which it acted on.

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

Importantly the provider must:

- Ensure recruitment arrangements include all necessary employment checks for all staff;
- Carry out fire and legionella risk assessments;
- Ensure safeguarding, basic life support and fire safety training is undertaken for relevant staff;
- Service medicine/vaccination refrigerators and calibrate their temperature gauges;
- Ensure prescriptions are kept securely and only accessible to authorised people; and
- Identify, manage and monitor effective infection prevention and control systems.

In addition the provider should:

- Have a consent policy available for staff to refer to.

Professor Steve Field (CBE FRCP FFPH FRCGP)

Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

The practice is rated as requires improvement for providing safe services as there are areas where it should make improvements. Staff understood their responsibilities to raise concerns, and to report incidents and near misses. When things went wrong, reviews and investigations were thorough and lessons learned were communicated to support improvement. Risks to patients who used services were not assessed which meant that any systems and processes required to address these risks were not implemented to ensure patients were kept safe. Areas of concern found were recruitment, infection control, medicine management and management of unforeseen circumstances.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from the National Institute for Health and Care Excellence and used it routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Not all staff had received training appropriate to their roles.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice higher than other GPs both locally and nationally for several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information for patients about the services available was easy to understand and accessible. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the clinical commissioning group to secure improvements to services where these were identified. Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day. The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.

Summary of findings

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings. There were some systems in place to monitor and improve quality. The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group (PPG) was active. Staff had received inductions, performance reviews and attended staff meetings and events.

Summary of findings

The six population groups and what we found

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

Older people

Good

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

Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services. For example, in dementia and end of life care. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs. All of the patients over 75 had a named GP. Staff were able to recognise signs of abuse in older people and knew how to escalate or refer these concerns. The practice had a good working relationship with local community services and district nurses were based at the practice. Discussions took take place regularly between the district nurses and GPs. Monthly Multi-Disciplinary Team Meeting (complex care) were held which where attended by GPs, district nurses, community matrons and the over 75's nurse.

People with long term conditions

Good

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

The practice held a number of nurse led clinics to support patients with long term conditions such as diabetes, coronary heart disease, asthma and chronic obstructive pulmonary disease. GPs supported patients with care plans that they regularly reviewed. Care plans also formed part of the practice's hospital admissions avoidance. Complex Care meetings were held which reviewed hospital admissions and assessed whether admission could have been avoided and whether staff could have done anything differently. Notes of these meetings were made within patient notes as part of the review process. Minutes of the complex care meeting were taken and circulated to all GPs, district nurses, community nurses, over 75s nurse to ensure those not in attendance at the meeting were aware of discussions and subsequent actions.

Families, children and young people

Good

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

There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk. For example, children and young people who had a high number of Accident and Emergency attendances. Appointments were available outside of

school hours and the premises were suitable for children and babies. Emergency processes were in place and referrals were made for children and pregnant women whose health deteriorated suddenly. Weekly family planning, antenatal and baby clinics were also available. We saw examples of joint working with midwives, health visitors and school nurses.

Working age people (including those recently retired and students)

Good

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

The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. Access to GP advice was provided through telephone consultations as well as face to face appointments. There was an online booking system which enabled patients to book, change and cancel appointments and request repeat prescriptions without the need to visit or telephone the practice. NHS health checks were available for those aged between 40 and 74 and extended hours were available from 7.30am on four weekday mornings, until 8.00pm one weekday evening and one Saturday morning a month.

People whose circumstances may make them vulnerable

Good

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

The practice held a register of patients living in vulnerable circumstances including those with a learning disability. It offered annual health checks for patients with a learning disability and 70% of these patients had taken this up. It also offered longer appointments for patients with a learning disability.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. Staff sign-posted vulnerable patients to various support groups and voluntary organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff had undertaken training on domestic abuse and sexual violence and were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

Summary of findings

People experiencing poor mental health (including people with dementia)

Good

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

The practice achieved good outcomes in relation to meeting the needs of patients with mental health needs. The practice kept a register of these patients which they used to ensure they received relevant checks and tests. Where appropriate, a comprehensive care plan had been completed for patients who were on the register. Care plans were written and agreed with patients and their carers. The practice hosted in house weekly counselling sessions and worked with multi-disciplinary teams to help meet the needs of patients experiencing poor mental health. For example, primary care mental health team counselling services.

Summary of findings

What people who use the service say

We received 16 completed patient comment cards and asked 20 patients for their views at the time of our inspection visit. These included older patients, mothers with babies, vulnerable patients and patients of working age.

All of the patients we spoke with and who completed Care Quality Commission comment cards were very positive about the care and treatment provided by the GPs and nurses and other members of the practice team. Everyone told us that they were treated with dignity and respect and that the care provided by the GPs, nursing staff and administration staff was of a very high standard. Comments included reference to the practice being caring, staff being friendly, willing to help and polite.

The practice had an active patient participation group who improved communication between the practice and its patients. This group was a way for patients and the practice to listen to each other and work together to improve services, promote health and improve the quality of care.

Results of surveys were available to patients on the practice website alongside the actions agreed as a result of the patient feedback.

We also looked at the results of the 2014 GP patient survey which was published in January 2015. This is an independent survey on behalf of NHS England. The survey showed that the practice achieved better than average results for the local area and nationally, these results included;

• 88% of respondents said the last GP they saw or spoke to was good at giving them enough time

• 94% of respondents said they had confidence and trust in the GP treating them.

Areas for improvement

Action the service MUST take to improve

- Ensure recruitment arrangements include all necessary employment checks for all staff;
- Carry out fire and legionella risk assessments;
- Ensure safeguarding, basic life support and fire safety training is undertaken for relevant staff;
- Service medicine/vaccination refrigerators and calibrate their temperature gauges;
- Ensure prescriptions are kept securely and only accessible to authorised people; and
- Identify, manage and monitor effective infection prevention and control systems.

Action the service SHOULD take to improve

- Have a consent policy available for staff to refer to.

Victor Street Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a GP specialist advisor and a practice manager specialist advisor.

Background to Victor Street Surgery

Victor Street Surgery is a training practice situated in Shirley, Southampton.

The practice has an NHS general medical services contract to provide healthcare and does this by providing health services to approximately 12,300 patients.

Appointments are available between 8.00am to 6.30pm from Monday to Friday. In addition early morning appointments are available between 7.30am and 8am on Monday, Tuesday, Thursday and Friday. Evening appointments are also available on Tuesday evenings between 6.30pm and 8.00pm and one Saturday per month between 8.30am and 11.30am. The practice has opted out of providing out-of-hours services to its patients and refers them to Care UK out-of-hours service via the 111 service.

The mix of patient's gender (male/female) is almost half and half. The practice is located in an area of average deprivation. Victor Street Surgery treats a number of patients who have high intake of drug and alcohol and/or experience poor mental health.

The practice has eight GP partners and one salaried GPs and a GP registrar who together work an equivalent of eight full time staff. In total there are three male and seven female GPs. The practice also has three practice nurses and a phlebotomist and a health care assistant. The GPs and the nursing staff are supported by a team of 16 administration staff, the finance manager and practice manager.

We carried out our inspection at the practice's only location which is situated at;

Victor Street Surgery

Victor Street

Shirley

Southampton

Hampshire

SO15 5SY

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme.

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.

Detailed findings

How we carried out this inspection

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

We asked the practice to send us some information before the inspection took place to enable us to prioritise our areas for inspection. This information included; practice policies, procedures and some audits. We also reviewed the practice website and looked at information posted on the NHS Choices website.

During our visit we spoke with a range of staff which included GPs, nursing and other clinical staff, receptionists, administrators, secretaries and the practice manager. We also spoke with patients who used the practice. We reviewed comment cards and feedback where patients and members of the public shared their views and experiences of the practice before and during our visit.

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

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

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

The population groups are:

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

Requires improvement

Are services safe?

Our findings

Safe track record

The practice had a system in place for managing alerts received from agencies such as the Medicines and Healthcare Regulatory Agency. A GP partner received alerts and routed them to clinical staff as appropriate. The practice also used a range of information to identify risks and improve patient safety. For example, reported incidents as well as comments and complaints received from patients. This showed the practice had managed these consistently over time and evidence of a safe track record over the long term.

For example, staff reported incidents to the practice manager who then escalated them as appropriate. All significant events were discussed at GP meetings. Records we viewed confirmed this. This provided senior staff with the opportunity to discuss incidents and to record any learning points. We saw evidence of discussion and formal reviews.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. Staff, including receptionists, administrators and nurses, knew how to raise an issue for consideration at meetings and they felt encouraged to do so. They completed incident forms on the practice intranet and sent completed forms to the practice manager.

We reviewed records of five significant events that had occurred during the last six months and saw this system was followed appropriately We tracked three significant events in depth and saw records were completed in a comprehensive and timely manner. We saw evidence of action taken as a result and that the learning had been shared. For example, GPs changed their protocol for examining and following up patients with abdominal pain issues. Significant events were a standing item on the practice meeting agenda and a dedicated meeting was held bi-monthly to review actions from past significant events and complaints.

Where patients had been affected by something that had gone wrong they were given an apology and informed of the actions taken to prevent the same thing happening again.

Reliable safety systems and processes including safeguarding

Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours.

The practice had a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments; for example children subject to child protection plans.

Two GP partners were the leads for safeguarding vulnerable adults and children. They had been trained in both adult safeguarding and child safeguarding to level three and could demonstrate they had the necessary competency to enable them to fulfil these roles. All staff we spoke with were aware who these leads were and who to speak with in the practice if they had a safeguarding concern. Of the remaining eight GPs, one had received level three safeguarding children training and four GPs had received level two training. Other staff working at the practice included nursing and administration staff. Of these, 12 out of 23 had received the appropriate level of safeguarding children training and four had received safeguarding adults training.

There was a chaperone policy in place for staff to refer to. A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure. We were told that both administration and nursing staff performed chaperone duties. Not all staff who undertook these duties had received a Disclosure and Barring Service (DBS) check or a documented rationale why a check should not be undertaken. A DBS check identifies whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable.

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 policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. Records showed room

temperature and fridge temperature checks were carried out which ensured medication was stored at the appropriate temperature. Fridges were not serviced or their thermometers calibrated to ensure they worked effectively.

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

All prescriptions were reviewed and signed by a GP before they were given to the patient. Both blank prescription forms for use in printers and those for hand written prescriptions were tracked through the practice but not kept secure.

Nurses used Patient Group Directions (PGDs) to administer vaccines and other medicines that had been produced in line with legal requirements and national guidance. We saw evidence that nurses had received appropriate training and been assessed as competent to administer the medicines referred to under a PGD.

Cleanliness and infection control

We observed the premises to be generally clean and tidy. We could that some carpets were stained in places. Cleaning schedules in place and cleaning records were kept. All of the 20 patients we asked told us they always found the practice clean and had no concerns about cleanliness or infection control.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these to comply with the practice's infection control policy.

Sharps boxes were provided and were positioned out of the reach of small children. There was also a policy for needle stick injury and staff knew the procedure to follow in the event of an injury. Clinical waste was stored safely and securely before being removed by a registered company for safe disposal. We examined records that detailed when such waste had been removed.

The practice had a lead for infection control. We asked the lead for the practice's annual infection control statement and any audits that had been carried out in the past 12 months. We were told that neither had been completed.

Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with liquid hand soap, cleansing hand gel and paper hand towel dispensers were available in consulting and treatment rooms.

A GP partner told us they had carried out a risk assessment for legionella in April 2015. Legionella is a bacterium which can contaminate water systems in buildings. This assessment did not include an inspection of water storage units or pipes within the building and therefore did not identify any potential risk to health or if an action plan was required.

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 routinely tested and a certificate indicated the last test was carried out in November 2014. We saw evidence of calibration of some equipment; for example weighing scales, spirometers, blood pressure measuring devices were all calibrated in the previous 12 months of our visit.

Staffing and recruitment

We looked at the staff recruitment files for three reception staff who started to work at Victor Street Surgery in May 2014 and found that two did not have evidence to confirm satisfactory conduct in their previous employment, eligibility to work in UK or proof of identity. The practice also had an induction policy, but there was no evidence to show that these members of staff had completed an induction. A risk assessment had been carried out for a person carrying out administration duties to determine whether a Disclosure and Barring Service (DBS) check should be made (this check identifies whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable) but no records were on file to confirm a risk assessment had been carried out for the remaining two staff.

Requires improvement

Are services safe?

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. There was also an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual leave.

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. The practice manager showed us records to demonstrate that actual staffing levels and skill mix met planned staffing requirements.

Monitoring safety and responding to risk

The practice had some systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. However, a number of risk assessments remained outstanding. These included, checks of the building, the environment, medicines management, dealing with emergencies and equipment. There was an accident book and staff knew its location. All incidents and accidents were recorded appropriately.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. We were shown a first aid policy which indicated that staff should be trained in basic life support annually. Records showed that 19 out of 33 staff had received training in basic life support in 2014.

Emergency equipment was available including access to oxygen and an automated external defibrillator (used in cardiac emergencies). Staff all knew the location of this equipment and records confirmed that it was checked regularly. We checked that the pads for the automated external defibrillator were within their expiry date.

Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

A business recovery plan was in place to deal with a range of emergencies that could impact on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to. For example, contact details of a telephone company to contact if the phone system failed. The plan was last reviewed in January 2015.

The practice had not carried out a fire risk assessment which would identify the actions required to maintain fire safety. Also monitoring of fire safety had not been carried out. Actions missing included testing of fire alarms, emergency lighting checks and fire drills.

Records provided to us showed that only four out of 33 staff had received fire training in the previous 12 months.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We saw that guidance from local commissioners was readily accessible in all the clinical and consulting rooms.

A GP told us how NICE guidance was received into the practice and disseminated to relevant staff. For example, the lead for a specific area would take responsibility for actioning the guidance. This could be e-learning or tutorials received from a local hospital. Staff we spoke with all demonstrated a good level of understanding and knowledge of NICE guidance and local guidelines.

Staff described how they carried out comprehensive assessments which covered all health needs and was in line with the national and local guidelines. They explained how care was planned to meet identified needs and how patients were reviewed at required intervals to ensure their treatment remained effective. For example, patients with diabetes were having regular health checks and were being referred to other services when required.

The GPs told us they lead in specialist clinical areas such as diabetes, heart disease and asthma and the practice nurses supported this work, which allowed the practice to focus on specific conditions. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support. GPs told us they supported all staff to review and discuss new best practice guidelines, for example, for the management of respiratory disorders.

The practice acknowledged that Accident and Emergency attendances and unplanned admissions were high and attributed this to the practice's proximity to the local hospital. To address this GPs met monthly to discuss patients' needs with community matrons and district nurses. These patients were reviewed regularly to ensure multidisciplinary care plans were documented in their records and that their needs were being met to assist in reducing the need for them to go into hospital. Patients care plans were written with the patients' involvement and shared with ambulance staff, the out of hours service and contained a patient's end of life wishes when appropriate. We saw that after patients were discharged from hospital they were followed up by a GP to ensure that all their needs were continuing to be met.

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

Management, monitoring and improving outcomes for people

Information about patients care and treatment, and their outcomes, was routinely collected and monitored and this information was used to improve care. Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, and managing child protection alerts and medicines management. The information staff collected was then collated by the practice manager and the data/IT administrator to support the practice to carry out clinical audits.

The practice showed us seven clinical audits that had been undertaken in the previous four years. All of these were completed, two cycle, audits where the practice was able to demonstrate the changes resulting since the initial audit. Following each clinical audit, changes to treatment or care were made where needed and the audit repeated to ensure outcomes for patients had improved. For example, in 2014 a search was carried out of female patients who took anti-epileptic medicines and were of childbearing aged (14-55). This followed a medical alert being received by the practice about the significant risk of foetal abnormalities for patients taking Sodium Valproate. An audit identified two patients who fell into this category and both were contacted to attend the practice with a view to reviewing their contraceptive methods and /or change their anti-epileptic medicines going forward. A second clinical audit was completed one year later which demonstrated that only one patient had not attended the practice for a review. Staff were alerted to call the patient into the practice for an urgent medicines review.

Other audits included those carried out by GPs who undertook contraceptive implants and the insertion of intrauterine contraceptive devices were doing so in line with their registration and National Institute for Health and Care Excellence guidance.

Good

Are services effective?

(for example, treatment is effective)

The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). For example, we saw an audit regarding antipsychotic prescribing in dementia patients. Following the audit, the GPs carried out medication reviews for patients who were prescribed these medicines and altered their prescribing practice to ensure it aligned with national guidelines.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. This practice was not an outlier for any QOF (or other national) clinical targets, It achieved 96.5% of the total QOF target in 2014, which was above the national average of 94.2%. Specific examples to demonstrate this included:

- Performance for diabetes related indicators was better than the national average.
- The percentage of patients with hypertension having regular blood pressure tests was better than the national average
- Performance for mental health related and hypertension QOF indicators was similar to the national average.
- The dementia diagnosis rate was above the national average

The practice was aware of the areas where performance was not in line with national or CCG figures and we were told about the arrangements the practice put into place to address these.

The team made use of clinical audit tools, clinical supervision and staff meetings to assess the performance of clinical staff. The staff we spoke with discussed how, as a group, they reflected on the outcomes being achieved and areas where this could be improved. Staff spoke positively about the culture in the practice around audit and quality improvement, noting that there was an expectation that all clinical staff should undertake at least one audit a year.

The practice's prescribing rates were similar to national figures. There was a protocol for repeat prescribing which followed national guidance. This required staff to regularly check patients receiving repeat prescriptions had been reviewed by the GP. They also checked that all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines. We saw evidence that after receiving an alert, 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 made use of the gold standards framework for end of life care. It had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss the care and support needs of patients and their families.

Effective staffing

We looked at the results of a national GP patient survey published in January 2015. The results showed a positive patient attitude towards the practice. For example, 94% of respondents had confidence and trust in the GP they saw or spoke to. This was higher than both the local average (89%) and national satisfaction average (92%). Also, all the patients who gave us feedback both before and during our visit indicated their complete satisfaction.

We noted a good skill mix among the GPs with a number having additional diplomas in sexual and reproductive medicine, mental health, children's health and obstetrics. All GPs were up to date with their yearly continuing professional development requirements and all either have been revalidated or had a date for revalidation. Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that not all staff were up to date with attending courses such as annual basic life support, fire safety and safeguarding. Infection control training records showed that five out of ten GPs and four out of five nursing staff had received infection control training.

Staff undertook annual appraisals that identified learning needs from which action plans were documented. As the practice was a training practice, doctors who were training to be qualified as GPs were offered extended appointments and had access to a senior GP throughout the day for support. Practice nurses were expected to perform defined duties and were able to demonstrate that they were trained

Good

Are services effective?

(for example, treatment is effective)

to fulfil these duties. For example, those with extended roles such as diabetes, asthma and immunisations were also able to demonstrate that they had appropriate training to fulfil these roles. Staff files we reviewed showed that where poor performance had been identified appropriate action had been taken to manage this.

Working with colleagues and other services

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

Emergency hospital admission rates for the practice were relatively higher at 19.7% compared to the national average of 13.6%. The practice was commissioned for the unplanned admissions enhanced service and had a process in place to follow up patients discharged from hospital. Enhanced services require an enhanced level of service provision above what is normally required under the core GP contract. We saw that the process for actioning hospital communications was working well in this respect.

The practice held multidisciplinary team meetings monthly to discuss patients with complex needs. For example, patients with multiple long term conditions and those with end of life care needs or children on the at risk register. These meetings were attended by district nurses, social workers, palliative care nurses and decisions about care planning were documented in a shared care record. Minutes of the complex care meeting were taken and circulated to all GPs, district nurses, community nurses, over 75s nurse to ensure those not in attendance at the meeting were aware of the discussions/actions. Staff felt this system worked well. Care plans were in place for patients with complex needs and shared with other health and social care workers as appropriate.

Information sharing

Patient information was stored on the practice's electronic record system which was held on practice computers that were all password protected. This information was only accessible to appropriate staff. All staff who worked at the practice were aware of information governance standards and worked in such a way to protect patient information.

Health records and patient administration information was collated and stored in patient's electronic records by staff at the practice. This was a critical role in the NHS due to the vast number of healthcare professionals involved in a patient's care who need access to this vital information at a moment's notice. Patient note summarising was carried out by appropriately trained staff.

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. We saw evidence there was a system for sharing appropriate information for patients with complex needs with the ambulance and out of hours services. For patients who were referred to hospital in an emergency there was a policy of providing a printed copy of a summary record for the patient to take with them to Accident and Emergency.

Consent to care and treatment

GPs were aware of the Mental Capacity Act 2005, and their duties in fulfilling it. We were told that training was cascaded down to staff who did not attend the training. Whilst there was not a formal consent policy in place all the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it.

GPs and staff explained the discussions that took place with patients, to help ensure they had an understanding of their treatment options. We reviewed data from the national patient survey published in January 2015. This showed the practice was rated below both the local and national patient satisfaction average by patients who were asked how good they felt the GP was at involving them in decisions about their care and treatment. Of the patients asked, 71% said they felt the GP was good or very good.

Good

Are services effective?

(for example, treatment is effective)

Staff demonstrated an understanding of the Gillick competence when asked about treating teenage patients. Gillick competence is a term is used in medical law to decide whether a child, 16 years or younger, is able to consent to their own medical treatment, without the need for parental permission or knowledge. We were told how the Gillick competence automatically flagged up on the notes of all patients aged under 18 notes every time they were seen.

The practice had not needed to use restraint in the last three years, but staff were aware of the distinction between lawful and unlawful restraint.

Health promotion and prevention

The practice used information about the needs of the practice population identified by the Joint Strategic Needs Assessment (JSNA) undertaken by the local authority to help focus health promotion activity. The JSNA pulls together information about the health and social care needs of the local area.

We saw a large range of health promotion information available at the practice and on its website. This information included preventative health care services available. For example, cervical smears and vaccinations for influenza (flu) and shingles.

We were shown a new patient registration form which included a request for information about their medical history, exercise habits, alcohol intake, smoking status and cared for or caring responsibility. These patients were also offered a health check. This check included height, weight and blood pressure level together with a urine sample test. The GP was informed of all health concerns detected and these were followed up in a timely way. We noted a culture among the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering opportunistic chlamydia screening to patients aged 18 to 25 years and offering smoking cessation advice to smokers.

The practice also offered NHS Health Checks to all its patients aged 40 to 75 years. Practice data showed that 53% of patients in this age group took up the offer of the health check.

The practice had many ways of identifying patients who needed additional support, and was pro-active in offering additional help. For example, the practice had identified the smoking status of 56% of its patients over the age of 16 and actively offered nurse-led smoking cessation clinics to 100% of these patients. There was evidence these were having some success as 12 patients were reported to have stopped smoking in the last 12 months. Similar mechanisms 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. For example, the practice identified 806 patients who were obese and 39 came forward for weight loss support. The practice kept a register of all patients with a learning disability and 34 were offered an annual health check. Practice records showed 24 had received a check up in the last 12 months.

The practice's performance for the cervical screening programme was 90%, which was above the national average of 81%. There was a policy to offer telephone reminders for patients who did not attend for their cervical screening test. A practice nurse had responsibility for following up patients who did not attend. The practice also encouraged its patients to attend national screening programmes for bowel cancer and breast cancer screening.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance was above average for the majority of immunisations where comparative data was available. For example:

- Flu vaccination rates for the over 65s were 73%, and at risk groups 41%. These were similar to national averages.
- Childhood immunisation rates for the vaccinations given to under twos and five year olds were comparable to clinical commissioning group averages.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey, published in January 2015, a survey of 641 patients undertaken by the practice's patient participation group (PPG) and patient satisfaction questionnaires sent out to patients by each of the practice's partners. A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care.

The evidence from all these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the national patient survey showed the practice was rated 'in line with other local practices' for patients who rated the practice as good or very good. The practice was also above average locally and nationally for its satisfaction scores on consultations with GPs and nurses. For example:

- 88% said the GP was good at listening to them compared to the clinical commissioning group (CCG) average of 86% and national average of 87%.
- 85% said the GP gave them enough time compared to the CCG average of 83% and national average of 85%.
- 94% said they had confidence and trust in the last GP they saw compared to the CCG average of 89% and national average of 92%

Patients completed Care Quality Commission comment cards to tell us what they thought about the practice. We received 16 completed cards and all were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. We also asked 20 patients for their opinion of the service and all 20 said they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. 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 and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard. We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. The practice switchboard was located away from the reception desk which helped keep patient information private. Additionally, 88% said they found the receptionists at the practice helpful compared to the CCG average of 86% and national average of 87%.

Staff told us that if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected, they would raise these with the practice manager. The practice manager told us they would investigate these and any learning identified would be shared with staff. There was a clearly visible notice in the patient reception area stating the practice's zero tolerance for abusive behaviour. Receptionists told us that referring to this had helped them diffuse potentially difficult situations.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example:

- 80% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 81% and national average of 82%.
- 71% said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 74% and national average of 75%.

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

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

Good

Are services caring?

saw notices in the reception areas informing patents this service was available. We saw that the electronic patient 'sign in' display was available in alternative languages and two reception staff spoke Polish.

Patient/carer support to cope emotionally with care and treatment

The patient survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. For example:

- 77% said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 81% and national average of 78%.
- 77% said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 78% and national average of 78%.

The patients we asked on the day of our inspection and the comment cards we received were also consistent with this survey information. For example, these highlighted that staff responded compassionately when patients needed help and provided support when required. We were told that all patients who were discharged from hospital were contacted by their GP and a home visit was offered if appropriate.

Notices in the patient waiting room and patient website told patients how to access a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer. We were told that the practice actively identified carers and offered support if requested. This was particularly aimed at carers of patients who had dementia.

Staff told us that if families had suffered bereavement, their usual GP contacted them. This call was either followed by a patient consultation or by giving them advice on how to find a support service. Support services included Cruse, and Talking Therapies. The practice also worked closely with district nurses and sign-posted patients to organisations such as the Befriending Service to support patients who felt isolated.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice had met with the Public Health team from the local authority and the clinical commissioning group (CCG) to discuss the implications and share information about the needs of the practice population identified by the Joint Strategic Needs Assessment (JSNA). The JSNA pulls together information about the health and social care needs of the population in the local area. This information was used to help focus services offered by the practice. A GP partner was the CCG lead in the locality group which consisted of a number of practices.

We found the practice was responsive to patient's needs and had systems in place to maintain the level of service provided. For example, the practice offered a variety of appointments which were based on need. Appointment options ranged from five to twenty minutes and a sit and wait appointment service was also available.

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group. For example, the recruitment of a full time practice manager, more frequent updates to health information in waiting areas and introduction of a patient newsletter.

Tackling inequity and promoting equality

The practice recognised the needs of different groups in the planning of its services. For example, longer appointment times were available for patients with learning disabilities. There were three male and seven female GPs in the practice; therefore patients could choose to see a male or female GP. We were told this was particularly helpful for patients who wished to see a same gender GP for cultural reasons. Staff told us that they had a number of patients who were of "no fixed abode" and would register the patients so they could access services. There was also a system for flagging vulnerability in individual patient records.

The majority of the practice population were English speaking patients but access to online and telephone translation services were available if they were needed. Staff were aware of when a patient may require an advocate to support them and there was information on advocacy services available for patients. Two reception staff spoke Polish, one GP spoke German, another GP spoke Swedish and two nursing staff spoke Hindi and Farsi respectively..

The premises were accessible to patients with mobility difficulties. Facilities were based on the ground and first floor and a lift was available. Both the consulting and treatment rooms were accessible for patients with mobility difficulties and there were wheelchair accessible toilet and baby changing facilities. 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.

Access to the service

Appointments were available from 8.00am to 6.30pm on all weekdays. In addition the practice offered extended open hours from 7.30am on Monday, Tuesday, Thursday and Friday and Tuesday evenings between 6.30pm and 8.00pm as well as one Saturday per month between 8.30am and 11.30am. The practice's extended opening hours on these days was particularly useful to patients with work commitments and older patients who were taken to the practice by working relatives.

We looked at the results of the most recent GP patient survey, published in January 2015. It reported that 73% of respondents said they were satisfied with the practice opening hours. This was in line with local and national patient satisfaction.

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits and how to book appointments. Patients could make appointments on line, by telephone and in person to ensure they were able to access the practice at times and in ways that were convenient to them.

All appointments were booked with the patient's registered GP unless they requested a different GP. For patients who had urgent issues the practice offered same day appointments.

There were arrangements in place to ensure patients received urgent medical assistance when the practice was closed. This was provided by an out-of-hours (OOH) service. If patients called the practice when it was closed, the answerphone message gave the telephone number they

Good

Are services responsive to people's needs?

(for example, to feedback?)

should ring depending on their medical symptoms. Information about the OOH service was also provided on the practice front door and via the patient information booklet and the practice website.

Longer appointments were also available for older patients, those experiencing poor mental health, patients with learning disabilities and those with long-term conditions. This also included appointments with a named GP or nurse. Home visits were made to 19 patients living at a local care home on a specific day each week, by a named GP and to those patients who needed one.

The patient survey information we reviewed showed how patients responded to questions about access to appointments. Results showed they were generally lower than local and national results for making an appointment and ease of getting through by phone:

For example:

- 61% described their experience of making an appointment as good compared to the CCG average of 73% and national average of 74%.
- 50% said they could get through easily to the practice by phone compared to the CCG average of 69% and national average of 72%

Opening hours feedback was more positive:

- 73% were satisfied with the practice's opening hours compared to the CCG average of 75% and national average of 76%.

Patients we spoke with were satisfied with the appointments system and said it was easy to use. They confirmed that they could see a GP on the same day if they felt their need was urgent although this might not be their GP of choice. They also said they could see another GP if there was a wait to see the GP of their choice. Routine appointments were available for booking six weeks in advance. Comments received from patients also showed that patients in urgent need of treatment had often been able to make appointments on the same day of contacting the practice. For example, one patient told us about an occasion when they telephoned the practice and requested an emergency appointment on a Monday morning which was provided straight away.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its 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 all complaints in the practice.

We saw that information was available to help patients understand the complaints system. Information was seen in the practice foyer, on its website and in the practice leaflet. Of the 20 patients we asked, 16 were aware of the process to follow if they wished to make a complaint, two were not sure and two didn't know. None of these patients had ever needed to make a complaint about the practice.

We were shown a spread sheet which contained the details of seven complaints received by the practice in the previous six months and was told that full details of complaints and resulting investigations were kept separately. We reviewed the complaints folder that contained details of all complaints raised. All of these complaints had been dealt with appropriately; investigated and the complainant responded to in a timely manner.

For example, a parent contacted the practice and requested that their child was seen as an emergency appointment. They were not happy with the way their request was responded to by staff. As a result of this the patient complained. We saw evidence of a full investigation plus an apology which was sent to the complainant. As a result of the complaint the practice changed its protocol to prioritise appointments for ill children.

Staff reported that complaints which were relevant to them were relayed either at practice meetings or via individual feedback if this was appropriate.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. We saw an organisation development plan which included plans to improve interactions with patients, workforce planning and review contractual requirements.

The practice vision and values included supporting patients and healthcare professionals to work together to ensure the most appropriate care was provided. Staff all knew and understood the

vision and values and knew what their responsibilities were in relation to these.

Governance arrangements

GPs and practice management took an active leadership role for overseeing that the systems in place to monitor the quality of the service were consistently being used and were effective. This included using the Quality and Outcomes Framework to measure its performance. The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the practice. We looked at eight of these policies and procedures and all were up to date.

The QOF data for this practice showed it in 2013/14 they had met 96.5% of the outcomes. This was higher than the national average for GP practices. However, there were no arrangements for identifying, recording and managing some risks. For example, fire safety, infection control and legionella.

We saw a number of clinical audits which GPs completed to monitor quality and systems. For example, one audit identified the need for a prescribing protocol for patients who took medicines to lower their blood pressure. A pop up window reminded GPs of the need for a kidney function test when repeat medicines were requested. Evidence from other data from sources, including incidents and complaints was used to identify areas where improvements could be made. Additionally, there were processes in place to review patient satisfaction and that action had been taken, when appropriate, in response to feedback from patients or staff. The practice regularly submitted governance and performance data to the clinical commissioning group.

Leadership, openness and transparency

We saw a clear leadership structure in place with named members of staff in lead roles. For example, there was a lead nurse for infection control and two partner GPs were leads for safeguarding. We spoke with seven members of staff and they were all clear about their own roles and responsibilities.

The GP partners in the practice were visible in the practice and staff told us that they were approachable and always took the time to listen. All staff were involved in discussions about how to run the practice and how to develop the practice and the GP partners encouraged all members of staff to identify opportunities to improve the service delivered by the practice.

The practice held staff meetings where governance issues were discussed. We looked at minutes from these meetings and found that practice performance had been discussed. The practice manager was responsible for human resource policies and procedures. We reviewed eight policies which were in place to support staff. These included recruitment, equality and diversity, disciplinary, grievance and sickness and absence policies. We found these to be fit for purpose.

Seeking and acting on feedback from patients, public and staff

We looked at the results of the most recent GP patient survey, published in January 2015. Of those who responded, 76% said they would recommend the practice to someone new to the area. We asked 20 patients about this and 18 said they would recommend the practice and two were not sure.

The practice encouraged and valued feedback from its patients. It had gathered feedback through the patient participation group (PPG), surveys and complaints received. The practice had an active patient participation group (PPG) of 19 patients.. The PPG met every three months and was made up of older patients who were semi-retired or retired. The practice manager chaired the group and a GP always attended meetings. We met with two members of the PPG who each told us that they felt supported and involved. Changes made as a result of PPG input included, length and wording of patient surveys, introduction of a patient newsletter and up to date and relevant patient health promotion notice boards in waiting areas.

Are services well-led?

Good

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

Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients. We interviewed three staff who all told us those meetings were generally informal but appreciated. They told us that they felt well supported and there was an open culture and friendly atmosphere at the practice.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. Regular staff appraisals took place and included a personal development plan. Systems were in place to review significant events and complaints records confirmed that each occurrence was seen to be investigated and resolved on an individual basis and learning shared with staff.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control We found that the registered person did not ensure that effective systems were in place to assess the risk of, and prevent, detect and control the spread of infections. Procedures missing included infection control audits, an annual infection control statement and a legionella risk assessment. This was in breach of regulation 12 (2)(h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The registered person must – Ensure the effective operation of systems designed to assess the risk of and to prevent, detect and control the spread of a health care associated infection.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed We found that the registered person had not ensured that persons employed for the purposes of carrying on a regulated activity were of good character and that information specified in Schedule 3 was available in relation to each such person employed and such other information as appropriate. Checks missing included; conduct in previous employment, eligibility to work in the UK and photographic identification. Staff that performed chaperone duties did not have either a criminal records check or documented rationale why such a check was not required.

This section is primarily information for the provider

Requirement notices

This was in breach of regulation 19(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered person must –

Operate effective recruitment procedures in order to ensure that no person is employed for the purposes of carrying on a regulated activity unless that person is of good character.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance We found that the registered person had not assessed, monitored and mitigated the risks relating to the health safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity. A risk assessment had not been carried out for fire safety, tests and fire drills were also not completed. This was in breach of Regulation 17(2)(b)of the Health Act 2008 (Regulated Activities) Regulations 2014. The registered person must – Identify, assess and manage risks relating to the health, welfare and safety of service users and others who may be at risk from the carrying out of the regulated activity.

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 (RA) Regulations 2014 Safe care and treatment We found that the registered person did not protect people against the risks associated with the management of medicines by means of making appropriate arrangements for the obtaining, recording, handling, using, safe keeping, dispensing, safe administration and disposal of medicines used for the purpose of the regulated activity. Blank prescription forms were not stored securely.

This section is primarily information for the provider

Requirement notices

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 (RA) Regulations 2014 Staffing We found that the registered person did not have suitable arrangements in place to ensure the persons employed for the purposes of carrying on the regulated activity were appropriately supported by means of receiving appropriate training. Not all staff were up to date for fire safety, basic life support and safeguarding training. This was in breach of Regulation 18(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The registered person must – (1) Have suitable arrangements in place to ensure that persons employed for the purposes of carrying out 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 by – (a) receiving appropriate training, professional development and appraisal.
	Medicines/vaccination refrigerators had not been serviced or temperature gauges calibrated. This was in breach of Regulation 12 (f)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The registered person must – Make appropriate arrangements for the obtaining, recording, handling, using, safe keeping, dispensing, safe administration and disposal of medicines used for the purposes of the regulated activity.