

Eastwick Park Medical Practice

Quality Report

Eastwick Park Avenue
Bookham
Leatherhead
Surrey
KT23 3ND
Tel: 01372 452081
Website: www.eastwickpark.co.uk

Date of inspection visit: 10 September 2015
Date of publication: 19/11/2015

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?

Requires improvement



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

Summary of this inspection

	Page
Overall summary	2
The five questions we ask and what we found	4
The six population groups and what we found	6
What people who use the service say	9
Areas for improvement	9

Detailed findings from this inspection

Our inspection team	10
Background to Eastwick Park Medical Practice	10
Why we carried out this inspection	10
How we carried out this inspection	10
Detailed findings	12
Action we have told the provider to take	24

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Eastwick Park Medical Practice on 10 September 2015. Overall the practice is rated as requires improvement.

Specifically, we found the practice to require improvement for providing safe, effective, and well led services. It also required improvement for providing services for 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 and people experiencing poor mental health (including people with dementia). It was good for providing caring and responsive 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 staff, patients and visitors were not always formally assessed and monitored. The practice did not have a supply of oxygen and had not assessed the risks associated with their management of medical emergencies. The practice had not assessed the risks of potential exposure to Legionella bacteria.
- The practice had not ensured the safe and secure storage and distribution of prescription pads.
- Staff had not always received training appropriate to their roles and further training needs had not always been identified and planned.
- Staff had not received regular appraisal of their performance.
- Patients' needs were assessed and care was planned and delivered following best practice guidance.
- The practice worked closely with other organisations and with local community services in planning how care was provided to ensure that they met people's needs.

Summary of findings

- There were systems in place for completing clinical audit cycles and we saw that audits were driving improvement in performance to improve patient outcomes.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- Urgent appointments were usually available on the day they were requested. However patients said that they sometimes had to wait a long time for non-urgent appointments. There were no extended hours appointments available to patients.
- The practice had a number of policies and procedures to govern activity. The practice held regular governance meetings and issues were discussed but not always clearly recorded.
- The practice implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from patients and from the Patient Participation Group (PPG).
- Ensure all staff receive regular supervision and appraisal.
- Ensure criminal records checks via the Disclosure and Barring Service are undertaken for all staff who are assessed as requiring a check, such as staff who act as chaperones.
- Ensure there are formal arrangements in place for assessing and monitoring risks to staff, patients and visitors, including the management of medical emergencies and the risk of exposure to legionella bacteria.
- Ensure the security and tracking of blank prescription pads at all times.
- Ensure that records are maintained and circulated which accurately reflect the management of services provided, including records of clinical meetings, training activities, reviews of infection control audits and learning from safety incidents.

In addition the provider should:

- Improve signage to ensure patients are made aware of the chaperone service available.
- Improve access to extended hours appointments for patients.

Professor Steve Field (CBE FRCP FFPH FRCGP)

Chief Inspector of General Practice

The areas where the provider must make improvements are:

- Ensure staff undertake training to meet their needs, including training in the safeguarding of children and vulnerable adults, the Mental Capacity Act 2005, information governance, fire safety, health and safety and infection control.

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

The practice is rated as requires improvement for providing safe services. Staff understood their responsibilities to raise concerns, and to report incidents and near misses. Incidents were recorded, monitored, appropriately reviewed and addressed. However, some risks to patients and staff were not always assessed and well managed. For example, the practice had not formally assessed the risks associated with the management of medical emergencies or the risk of exposure of staff and patients to legionella bacteria. The practice did not have a supply of oxygen to enable them to respond to medical emergencies. The practice was clean and tidy, however infection control audit findings had not been reviewed and monitored. Some staff had not received training in the safeguarding of children and vulnerable adults.

Requires improvement



Are services effective?

The practice is rated as requires improvement 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 well planned and delivered in line with current legislation. This included assessing mental capacity and promoting good health. However, staff had not always received training appropriate to their roles. For example, staff had not received training in health and safety, the mental capacity act 2005, infection control and information governance. Staff who acted as chaperones within the practice had received training to support this role. Some staff had not undergone appraisals and did not have personal development plans. Further training needs had not always been identified.

Requires improvement



Are services caring?

The practice is rated as good for providing caring services. Data showed that patients rated the practice higher than others for several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information 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.

Good



Are services responsive to people's needs?

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the

Good



Summary of findings

NHS England Area Team and clinical commissioning group (CCG) to secure improvements to services where these were identified. The practice provided highly responsive services to meet the needs of specific vulnerable groups of patients within the local practice population, such as patients with learning disabilities and travelling families. Urgent appointments were available on the same day. The practice was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand.

Are services well-led?

The practice is rated as requires improvement 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. However, records of these meetings were not always clearly recorded to ensure actions were followed up. There were some systems in place to monitor and improve quality. However, risks to patients and staff were not always assessed and well managed. The practice sought feedback from staff and patients, which it acted on. The patient participation group (PPG) was active. Staff had received induction but some staff had not undergone regular appraisal of their performance. Staff had not always received training appropriate to their roles. Training was not well planned and training which had been delivered was poorly recorded.

Requires improvement



Summary of findings

The six population groups and what we found

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

Older people

The practice is rated as requires improvement for the care of older people. The practice was rated as requires improvement for providing safe, effective and well-led services. The concerns which led to these 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 continuity of care with a named GP. Elderly patients with complex care needs and those at risk of hospital admission all had personalised care plans that were shared with local organisations to facilitate the continuity of care. The practice was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs. The practice supported residents within three residential and nursing homes including a home which was located next to the practice. The practice nominated a lead GP for each care home who provided weekly ward rounds within the homes. The practice organised a voluntary car service for patients who required transport in order to attend the practice. Following the death of a patient the practice sent a condolence card inviting the carer to attend the practice in order that ongoing support could be provided.

Requires improvement



People with long term conditions

The practice is rated as requires improvement for the care of people with long term conditions. The practice was rated as requires improvement for providing safe, effective and well-led services. The concerns which led to these ratings apply to everyone using the practice, including this population group. Nursing staff had lead roles in chronic disease management such as diabetes and respiratory conditions and patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. All these patients had a named GP and a structured annual review to check that their health and medicine needs were being met. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care. All patients were routinely collected from the waiting room by their GP. GPs told us this provided the GP with the opportunity to begin their assessment of each patient's condition prior to their arrival in the consulting room.

Requires improvement



Summary of findings

Families, children and young people

The practice is rated as requires improvement for the care of families, children and young people. The practice was rated as requires improvement for providing safe, effective and well-led services. The concerns which led to these ratings apply to everyone using the practice, including this population group. The practice offered continuity of care with a named GP. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances and those who were carers. Immunisation rates were good 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. However, some staff had not received training in the safeguarding of children. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with midwives and health visitors.

Requires improvement



Working age people (including those recently retired and students)

The practice is rated as requires improvement for the care of working age people. The practice was rated as requires improvement for providing safe, effective and well-led services. The concerns which led to these ratings apply to everyone using the practice, including this population group. The practice provided some services to meet the needs of the working age population, those recently retired and students. The practice had recently increased the availability of urgent and pre-bookable appointments by recruiting an additional GP partner. However, there were no extended hours appointments available to working age people. The practice was proactive in offering online services and patients were able to opt to have their prescriptions delivered using the electronic prescription service to a pharmacy of their choice. Installation of an improved telephone system meant that patients were able to cancel appointments using an automated system. The practice provided temporary residents status for students returning from university. Practice staff carried out NHS health checks for patients between the ages of 40 and 74 years.

Requires improvement



People whose circumstances may make them vulnerable

The practice is rated as requires improvement for the care of people whose circumstances may make them vulnerable. The practice was rated as requires improvement for providing safe, effective and well-led services. The concerns which led to these ratings apply to everyone using the practice, including this population group. The practice offered continuity of care with a named GP. The practice

Requires improvement



Summary of findings

held a register of patients living in vulnerable circumstances including those with a learning disability. It offered longer appointments and carried out annual health checks for people with a learning disability. Care was provided to patients with a learning disability living within one residential facility and to those living independently who received support from that facility. The lead GP partner provided flu vaccination clinics within the facility and worked closely with the staff team to carry out medicine reviews. The practice regularly worked with multi-disciplinary teams in the case management of other vulnerable patients. Information was provided to support vulnerable patients in accessing support groups and voluntary organisations. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours. However, some staff had not received training in the safeguarding of vulnerable adults.

People experiencing poor mental health (including people with dementia)

The practice is rated as requires improvement for the care of people experiencing poor mental health. The practice was rated as requires improvement for providing safe, effective and well-led services. The concerns which led to these ratings apply to everyone using the practice, including this population group. The practice held a register of patients experiencing poor mental health and offered continuity of care with a named GP. Patients with severe mental health needs were supported by care plans and received annual physical health checks. The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those with dementia. The practice undertook dementia screening of patients and ensured early referral to memory assessment services. The practice held regular meetings with a consultant psychiatrist to review those patients receiving secondary care and those in primary care whose treatment outcomes could be improved by the input of specialist advice. The practice provided information to patients experiencing poor mental health about how to access various support groups and voluntary organisations. It had a system in place to follow up patients who had been discharged from secondary care where they had been experiencing poor mental health.

Requires improvement



Summary of findings

What people who use the service say

Patients told us they were satisfied overall with the practice. Comments cards had been left by the Care Quality Commission (CQC) before the inspection to enable patients to record their views on the practice. We received 10 comment cards all of which contained positive comments about the practice. We also spoke with five patients on the day of the inspection.

The comments we reviewed were all extremely positive about the care and support provided to them by GPs and nurses within the practice. Patients said they felt the practice offered a caring service and staff were efficient, helpful and took the time to listen to them. They said staff treated them with dignity and respect. Two of the comment cards described the excellent care received in managing multiple or complex health problems. Two patients told us it could be difficult to obtain a routine

appointment. Patients we spoke with on the day of inspection told us that all staff were helpful, caring and professional. They told us they felt listened to and well supported.

We reviewed recent GP national survey data available for the practice on patient satisfaction. The evidence from the survey showed patients were satisfied with how they were treated and this was with compassion, dignity and respect. Data from the national patient survey showed that 82% of patients rated their overall experience of the practice as good, compared with a local and national average of 85%. We noted that 90% of patients had responded that the nurse was good at treating them with care and concern, compared with a national average of 90%. The survey also found that 81% of patients said the last GP they saw was good at involving them in decisions about their care, compared with a national average of 81%.

Areas for improvement

Action the service **MUST** take to improve

- Ensure staff undertake training to meet their needs, including training in the safeguarding of children and vulnerable adults, the Mental Capacity Act 2005, information governance, fire safety, health and safety and infection control.
- Ensure all staff receive regular supervision and appraisal.
- Ensure criminal records checks via the Disclosure and Barring Service are undertaken for all staff who are assessed as requiring a check, such as staff who act as chaperones.
- Ensure there are formal arrangements in place for assessing and monitoring risks to staff, patients and visitors, including the management of medical emergencies and the risk of exposure to legionella bacteria.

- Ensure the security and tracking of blank prescription pads at all times.
- Ensure that records are maintained and circulated which accurately reflect the management of services provided, including records of clinical meetings, training activities, reviews of infection control audits and learning from safety incidents.

Action the service **SHOULD** take to improve

- Improve signage to ensure patients are made aware of the chaperone service available.
- Improve access to extended hours appointments for patients.

Eastwick Park Medical Practice

Detailed findings

Our inspection team

Our inspection team was led by:

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

Background to Eastwick Park Medical Practice

Eastwick Park Medical Practice provides general medical services to approximately 7,400 registered patients. The practice delivers services to a higher number of patients who are aged 65 years and over, when compared with the national average. Care is provided to patients living in residential and nursing home facilities and a local hospice. Data available to the Care Quality Commission (CQC) shows the number of registered patients suffering income deprivation is lower than the national average.

Care and treatment is delivered by four GP partners and two salaried GPs. Four of the GPs are female and two are male. At the time of our inspection the practice was in the process of amending their registration to reflect the addition of the fourth partner who had very recently joined the practice. The practice employs a team of two practice nurses and two healthcare assistants. GPs and nurses are supported by the practice manager and a team of reception and administration staff.

The practice is a GP training practice and supports undergraduates and new registrar doctors in training.

The practice is open from 8.30am to 6.30pm on weekdays.

Services are provided from:

Eastwick Park Avenue, Bookham, Leatherhead, Surrey, KT23 3ND.

The practice has opted out of providing out of hours services to its own patients and uses the services of a local out of hours service.

Why we carried out this inspection

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

How we carried out this inspection

Before visiting the practice we reviewed a range of information we hold. We also received information from local organisations such as NHS England, Health watch and the NHS Surrey Downs Clinical Commissioning Group (CCG). We carried out an announced visit on 10 September 2015. During our visit we spoke with a range of staff, including GPs, practice nurses and administration staff.

We observed staff and patient interaction and spoke with five patients. We reviewed policies, procedures and operational records such as risk assessments and audits. We reviewed ten comment cards completed by patients, who shared their views and experiences of the service in the two weeks prior to our visit.

Detailed findings

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 living in vulnerable circumstances
- People experiencing poor mental health (including people with dementia)

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts, as well as comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses.

We reviewed safety records, incident reports and minutes of meetings where these were discussed. This showed the practice had managed these consistently over time. However, we noted that these meetings were not always attended by key staff and therefore information was not consistently shared with staff.

Learning and improvement from safety incidents

The practice had processes in place for reporting, recording and monitoring significant events, incidents and accidents. There were records of significant events that had occurred and we were able to review these. We saw that records of incidents were completed in a comprehensive and timely manner and that there was appropriate action taken as a result. Significant events were discussed at weekly clinical governance meetings. We saw evidence of those meetings. Although the majority of GPs and nurses attended those meetings, the practice did not have systems in place to ensure that the findings were shared with relevant staff who were not present at the meetings. For example, one nurse was only able to attend the meetings on an occasional basis. Staff, including receptionists, administrators and nurses, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

National patient safety alerts were disseminated to practice staff. Staff we spoke with were able to give examples of recent alerts relevant to the care they were responsible for. They also told us alerts were discussed at the weekly clinical meetings to ensure that staff were aware of any that were relevant to the practice and where they needed to take action.

Reliable safety systems and processes including safeguarding

The practice had some systems in place to safeguard children and adults. One GP partner was the practice lead for safeguarding children and vulnerable adults. All of the staff we spoke with knew who the practice safeguarding lead was and who to speak to if they had a safeguarding concern. The GP lead had undertaken training in the safeguarding of children and vulnerable adults at a level appropriate to their role. Other GPs within the practice had completed training in the safeguarding of children at a level appropriate to their role. However, the majority of staff had not received training in the safeguarding of children and vulnerable adults.

We saw that safeguarding flow charts and contact details for local authority safeguarding teams were easily accessible within the practice.

Staff described the open culture within the practice whereby they were encouraged and supported to share information within the team and to report their concerns. Information on safeguarding and domestic abuse was displayed in the patient waiting room and other information areas.

There was a system to highlight vulnerable patients on the practice computer system and patient electronic records. This included information to make staff aware of specific actions to take if the patient contacted the practice or any relevant issues when patients attended appointments. For example, children subject to child protection plans.

Patients' individual records were written and managed in a way to help ensure safety. Records were kept on an electronic system, which collated all communications about the patient including clinical summaries, scanned copies of letters and test results from hospitals.

There was a chaperone policy in place, however we noted there were no visible signs promoting this service within the practice to ensure patients were aware they could request a chaperone. Reception staff told us they were sometimes required to act as chaperones and training had been provided to support those staff. However, staff undertaking chaperone duties had not been subject to a criminal records check via the Disclosure and Barring Service and the practice had not undertaken a risk assessment to support this decision.

Medicines management

Are services safe?

We checked medicines stored in the treatment rooms and medicine refrigerators. We found they were stored securely and were only accessible to authorised staff. There was a clear process for ensuring medicines were kept at the required temperatures. We reviewed records which confirmed this. The correct process was understood and followed by the practice staff and they were aware of the action to take in the event of a potential power failure.

The practice had processes to check medicines were within their expiry date and suitable for use. Expired and unwanted medicines were disposed of in line with waste regulations.

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

The practice implemented a protocol for repeat prescribing which was in line with national guidance. The protocol complied with the legal framework and covered all required areas. For example, how staff who generate prescriptions were trained and how changes to patients' repeat medicines were managed. The practice had identified a dedicated prescriptions clerk who ensured monitoring of all prescription requests. This helped to ensure that patients' repeat prescriptions were still appropriate and necessary. Reviews were undertaken for patients on repeat medicines. All prescriptions were reviewed and signed by a GP before they were given to the patient. Electronic prescribing services enabled patients to request repeat prescriptions and have them sent directly to a pharmacy of their choice.

However, blank prescription forms were not handled in accordance with national guidance and were not kept securely at all times. Blank prescription pads were left in unlocked rooms which could potentially have been accessed by patients or visitors to the practice. The practice did not keep records of the distribution of prescription form stock including the serial numbers, where, when and to whom the prescriptions had been distributed.

The practice had identified a lead GP for medicines management. The practice prescribing lead worked closely in conjunction with the local clinical commissioning group (CCG) and the practice participated in prescribing audits and reviews.

Cleanliness and infection control

Some systems were in place to reduce the risks of the spread of infection. We observed the premises to be clean and well maintained. We saw there were cleaning schedules in place and that daily cleaning records were kept. Patients we spoke with told us they always found the practice to be clean and had no concerns about cleanliness or infection control.

The practice had identified a practice nurse as the lead nurse for infection control. Infection control policies and procedures were in place. An audit of infection control processes had been carried out by the lead nurse in February 2015. However, the practice had not developed an action plan to address the findings of the audit. We saw that some areas identified as requiring action had been followed up, such as the wall mounting of liquid soap. However, the practice had not recorded whether other areas requiring action and been reviewed or appropriate action taken. For example the laundering of privacy curtains and the provision of hand hygiene training for staff.

We spoke to one nurse who told us they had recently undertaken training in infection control with the clinical commissioning group (CCG). However, the practice did not hold records to demonstrate that any staff had received training infection control.

Hand washing notices were displayed in all consulting and treatment rooms. Hand wash solution, hand sanitizer and paper towels were available in each room. Disposable gloves were available to help protect staff and patients from the risk of cross infection. Spillage kits were available within the practice.

We saw that the practice had arrangements in place for the segregation of clinical waste at the point of generation. Colour coded bags were in use to ensure the safe management of healthcare waste. An external waste management company provided waste collection services. Sharps containers were available in all consulting rooms and treatment rooms, for the safe disposal of sharp items, such as used needles.

The practice had not considered the risks associated with potential exposure to legionella bacteria which is found in some water systems. There were no processes in place to ensure regular checks were carried out to reduce the risk of exposure of legionella bacteria to staff and patients.

Equipment

Are services safe?

Staff we spoke with told us they had sufficient 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. A schedule of testing was recorded. We saw evidence that testing of electrical items and calibration of relevant equipment had been carried out in March 2015. For example, digital blood pressure machines and weighing scales.

Records showed essential maintenance was carried out on the main systems of the practice. For example the boilers and fire alarm systems were serviced in accordance with manufacturers' instructions. Fire extinguishers had been serviced in July 2015.

Staffing and recruitment

Staff told us there were enough staff to maintain the smooth running of the practice and there were always enough staff on duty to ensure patients were kept safe. There was a system for members of staff, including GPs and administrative staff, to cover annual leave.

We examined personnel records and found that the practice had ensured that appropriate recruitment checks were undertaken prior to employment. For example, proof of identification, references, qualifications and registration with the appropriate professional body. The practice had a recruitment policy which set out the standards it followed when recruiting clinical and non-clinical staff.

The practice had not undertaken a risk assessment of all roles within the practice to determine the need for criminal records checks through the Disclosure and Barring Service (DBS). As a result, some staff, such as those reception staff who were required to act as chaperones, had not been subject to a criminal records check. We saw evidence that nurses within the practice had been subject to criminal records checks.

Monitoring safety and responding to risk

We observed the practice environment was organised and tidy. Safety equipment such as fire extinguishers and the defibrillator were checked regularly and sited appropriately.

The practice had some systems and processes to manage and monitor risks to patients, staff and visitors to the practice. We saw that the latest health and safety risk

assessment had been carried out in August 2015. The practice had a health and safety policy which had last been reviewed in March 2015. Health and safety information was readily available to staff. However, the practice had not assessed the risks associated with exposure to legionella bacteria which is found in some water supplies.

We saw that staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies. For patients with long term conditions and those with complex needs there were processes to ensure these patients were seen in a timely manner. Staff told us that these patients could be urgently referred to a GP and offered longer appointments when necessary.

Arrangements to deal with emergencies and major incidents

There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency. All staff told us they had received annual basic life support training. However, the practice did not hold records of this training. Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the emergency medicines we checked were in date and fit for use.

The practice had defibrillator which was checked regularly by one practice nurse. The practice did not have a supply of oxygen and had not carried out a risk assessment to identify the risks associated with managing emergencies which required access to oxygen. One GP partner told us they felt a supply of oxygen was unnecessary due to the close proximity of the practice to an ambulance station. They told us the ambulance station was a five minute drive away from the practice. The practice had pulse oximeters available which enabled them to assess breathless patients within the practice, such as those experiencing an acute asthma attack. However, the practice was unable to demonstrate how they would respond to such an emergency without a supply of oxygen. There was a first aid kit and accident book available.

The practice had a comprehensive business continuity plan in place for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff were familiar with current best practice guidance, accessing guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. The staff we spoke with and evidence we reviewed confirmed these actions were aimed at ensuring that each patient was given support to achieve the best health outcome for them. We found from our discussions with the GPs and the nurses that staff completed, in line with NICE guidelines, thorough assessments of patients' needs and that these were reviewed when appropriate.

All patients were routinely collected from the waiting room by their GP. GPs told us this provided the GP with the opportunity to begin their assessment of each patient's condition prior to their arrival in the consulting room.

GPs within the practice held lead roles in specialist clinical areas such as diabetes and mental health. We spoke to one nurse who was the nurse lead for diabetes within the practice. They told us that they worked closely with a diabetes specialist nurse who provided support to the practice in managing the care of patients with the most complex needs. The diabetes specialist nurse attended regular clinics within the practice which meant that some patients' care was managed by the practice team rather than requiring hospital clinic attendance. The lead nurse also worked closely with the GP lead for diabetes within the practice. The GP lead was available to provide support during each diabetes clinic and met with the nurse lead at the end of each clinic to further discuss the care and management of patients.

National data showed the practice was in line with referral rates to secondary and other community care services for all conditions. GPs used national standards and best practice for all referrals to secondary care. For example, patients requiring a referral into secondary care with suspected cancers were referred and seen within two weeks.

The practice ensured that patients had their needs assessed and care planned in accordance with evidence based best practice. We saw that patients received appropriate treatment and regular review of their condition. For example, the practice nurses managed the

care of a number of patients with venous leg ulcers. The nurses worked closely with the local tissue viability nurse in the ongoing assessment and management of those patients. One nurse we spoke with had recently received updated training in wound management.

The practice held a register of patients receiving end of life care and held monthly palliative care meetings with the local hospice and multi-disciplinary teams. Patients with palliative care needs were supported using the Gold Standards Framework.

The practice used computerised tools to identify and review registers of patients with complex needs. For example, patients with learning disabilities or those with long term conditions. The practice worked closely with the community teams to identify those patients most at risk of deteriorating health and unplanned hospital admissions. The practice nurses told us that the practice provided support and review of patients with long term conditions according to their individual needs. The practice sent invitations to patients for review of their long term conditions.

Management, monitoring and improving outcomes for people

Staff across the practice held key roles in the monitoring and improvement of outcomes for patients. These roles included data input and quality, clinical review scheduling, long term condition management and medicines management.

The practice participated in the Quality and Outcomes Framework (QOF). (This is a system intended to improve the quality of general practice and reward good practice). The practice used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. Current results were 90.2% of the total number of points available, compared with a national average of 94.2%. Data from 2013/2014 showed:

- Performance for those patients with a diagnosis of diabetes related indicators was similar or slightly below the CCG and national average. For example, 88.63% of patients with diabetes had received a flu immunisation in the preceding 1 September to 31 March, compared

Are services effective?

(for example, treatment is effective)

with a national average of 93.46%; the percentage of patients with diabetes whose last measured cholesterol was 5/mmm0l/l or less was 83.19% compared with a national average of 81.61%.

- Performance for those patients with a diagnosis of mental health related indicators was slightly below the national average. For example: 75.76% of patients with schizophrenia, bipolar affective disorder and other psychoses had a record of their alcohol consumption in the preceding 12 months compared with a national average of 88.65%; The percentage of patients diagnosed with dementia whose care had been reviewed in the preceding 12 months was 70.59% compared with a national average of 83.82%.

There were systems in place for completing clinical audit cycles. For example the practice had undertaken a prescribing audit of one medicine prescribed to patients for specific heart conditions. The practice had carried out the audit in response to local and national prescribing guidelines in order to monitor the number of patients prescribed the medicine and the correlation between the dose they were given and their kidney function. The practice had repeated the audit 10 months later and had reviewed their processes for the ongoing management of those patients as a result. We saw evidence of other completed audit cycles relating for example to the administration of influenza vaccines to patients with diabetes and the complication rates of fitting of intrauterine contraceptive devices.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that some staff were not up to date with training in key areas. Where staff told us they had completed training in some areas, record keeping was poor. For example, staff told us they had received regular training in basic life support. However, no records of this training were held by the practice. The practice manager told us that individual staff had been provided with their training certificates. Nurses told us they had received training in the safeguarding of children and vulnerable adults at a level appropriate to their role and the practice manager confirmed this. However no records of this training were available. Administration and reception staff had not received training in the safeguarding of children and vulnerable adults. Staff within the practice had not received

training in fire safety, health and safety, infection control, information governance or the Mental Capacity Act 2005. Reception staff were required to act as chaperones within the practice and had received appropriate training to undertake this role. The practice manager was aware of the shortfall in training and had identified a suitable programme for staff to follow, although this had not yet been implemented.

We spoke with one practice nurse who told us the practice supported education and ongoing professional development. The nursing team were able to attend training in specialist areas such as spirometry, cervical screening and immunisations. Those nurses with extended roles had undertaken training in the management of conditions such as chronic obstructive pulmonary disease, asthma and diabetes. One practice nurse told us they had recently undertaken updated training in diabetes management and wound care. They told us they were scheduled to attend training in cervical screening, smoking cessation and childhood immunisations within the next few months.

All GPs were up to date with their yearly continuing professional development requirements and all had been revalidated. (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).

Nurses within the practice told us they had recently undergone appraisal which gave them the opportunity to discuss their performance and to identify future training needs. We saw evidence of those appraisals. However, other staff we spoke with had not recently participated in appraisal. The practice manager told us that administration and reception staff had not undergone appraisals since February 2013. For some staff this meant that objectives they had previously been set were out of date and had not been reviewed.

Working with colleagues and other services

Staff worked together and with other health and social care services to understand and meet the range and complexity of people's needs and to assess and plan ongoing care and treatment. This included when people moved between services, including when they were referred, or after they

Are services effective?

(for example, treatment is effective)

were discharged from hospital. We saw evidence that regular multi-disciplinary team meetings took place within the practice and that care plans were routinely reviewed and updated. These included monthly meetings with palliative care nurses from the local hospice and three monthly meetings with community mental health teams.

The practice worked closely with a consultant psychiatrist to review those patients receiving secondary care and those in primary care whose treatment outcomes could be improved by the input of specialist advice.

Blood results, hospital discharge summaries, accident and emergency reports and reports from out of hours services were seen and actioned by a GP on the day they were received. In the absence of a patient's named GP, the duty GP within the practice was responsible for ensuring the timely processing of these reports. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting upon any issues arising from communications with other care providers on the day they were received.

Information sharing

The practice used several electronic systems to communicate with other providers and for making referrals. 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.

The practice had systems to provide staff with the information they needed. Staff used the electronic patient record to coordinate, document and manage patients' care. All staff were fully trained on the system. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

Consent to care and treatment

The practice had a written policy for consent. Patients' consent to care and treatment was always sought in line with legislation and guidance. Staff understood some of the relevant consent and decision-making requirements of legislation and guidance. When providing care and treatment for children and young people, assessments of capacity to consent were also carried out in line with relevant guidance. However, staff including nurses, told us they had not received training in the Mental Capacity Act 2005.

Health promotion and prevention

Patients who may be in need of extra support were identified by the practice. These included patients receiving end of life care, carers, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation. Patients were then signposted to the relevant service.

The practice had a comprehensive cervical screening programme. The practice's uptake for the cervical screening programme was 92.1%, which was above the national average of 81.89%.

Childhood immunisation rates for the vaccinations given were comparable to CCG averages. We reviewed our data and noted that 93.5% of children aged up to two years who attended the practice, had received their first dose of the measles, mumps and rubella vaccination, compared with a CCG average of 84.7%. Data we reviewed showed that 88.63% of patients with diabetes had a flu vaccination within the six month period between September and March. This was slightly lower than the national average of 93%.

Patients had access to appropriate health assessments and checks. These included health checks for new patients and NHS health checks for people aged 40–74.

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We observed throughout the inspection that members of staff were courteous and helpful to patients both attending at the reception desk and on the telephone and that people were treated with dignity and respect. Curtains were provided in consulting 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. Reception staff knew when patients wanted to discuss sensitive issues or appeared distressed they could offer them a private area to discuss their needs.

All of the 10 patient CQC comment cards we reviewed were extremely positive about the care and support provided to them by GPs and nurses within the practice. Comment cards highlighted that staff responded compassionately when they needed help and provided support when required.

They said staff treated them with dignity and respect. Patients we spoke with on the day of inspection told us that all staff were helpful, caring and professional. They told us they felt listened to and well supported. We spoke with one member of the patient participation group (PPG) on the day of our inspection. They also told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

Patients we spoke with and those who had completed comment cards were very happy with the way they were treated by reception staff within the practice. We were provided with several examples of ways in which reception staff had provided high levels of personal service to patients.

Results from the most recent national GP patient survey indicated that the practice was comparable or above average for its satisfaction scores on consultations with doctors and nurses. For example:

- 85% said the GP was good at listening to them compared to the CCG average of 91% and national average of 89%.

- 84% said the GP gave them enough time compared to the CCG average of 88% and national average of 87%.
- 97% said they had confidence and trust in the last GP they saw compared to the CCG average of 96% and national average of 95%
- 98% said they had confidence and trust in the last nurse they saw compared to the CCG average of 98% and national average of 97%.
- 90% said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 91% and national average of 90%.

Care planning and involvement in decisions about care and treatment

Patients we spoke with 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 available to them. Patient feedback on the comment cards we received was also positive and aligned with these views.

Results from the national GP patient survey we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and results were in line with local and national averages. For example:

- 84% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 87% and national average of 86%.
- 91% said the last nurse they saw was good at explaining tests and treatments compared to the CCG average of 89% and national average of 90%.
- 81% said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 83% and national average of 81%
- 84% said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average of 83% and national average of 85%

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

Patient/carer support to cope emotionally with care and treatment

The results of the national GP survey showed that 82% of patients said the last GP they saw or spoke to was good at

Are services caring?

treating them with care and concern and that 90% of patients said the nurses were also good at treating them with care and concern. Patients we spoke with on the day of our inspection and some of the comment cards we received gave examples of where patients had been well supported.

The practice ensured continuity of care for patients receiving end of life care and their carers. Although the practice used the services of a local out of hours provider, GPs provided support and visits out of hours to patients

who were receiving end of life care at home. Following the death of a patient the practice sent a condolence card inviting the carer to attend the practice in order that ongoing support could be provided.

The practice held a register of patients who were carers and new carers were encouraged to register with the practice. The practice computer system then alerted GPs and nurses if a patient was also a carer. We saw written information was available for carers to ensure they understood the various avenues of support available to them. Notices in the patient waiting room and patient website signposted patients to a number of support groups and organisations.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patients' needs. The needs of the practice population were well understood and systems were in place to address identified needs in the way services were delivered.

The practice worked closely with local residential and care homes to provide care and support to the residents. For example, the practice was located next door to one residential care home and provided care to those residents. The practice had identified a named GP partner as the lead for providing care and support to residents. The GP partner carried out weekly ward rounds and worked closely with staff and relatives to plan and review care.

The practice told us they provided support to travelling families and non-travelling settled communities. The practice had reviewed research undertaken by the University of Sheffield which had explored the health status of travellers in England, in order to improve their understanding of the needs of this group of patients. The practice worked closely with these patients to encourage them to make informed decisions about childhood immunisations and to ensure the effective management of their chronic conditions.

The practice worked collaboratively with other agencies and regularly shared information to ensure good, timely communication of changes in care and treatment. The practice held monthly multidisciplinary team meetings to discuss the needs of complex patients, for example those with end of life care needs. The practice invited representatives from social services, mental health, district nursing, the community matron and local hospice teams.

Patients with learning disabilities were well supported by the practice. Care was provided to patients with a learning disability living within one residential facility and to those living independently who received support from that facility. The lead GP partner provided flu vaccination clinics within the facility and worked closely with the staff team to carry out medicine reviews. The practice utilised information booklets with simple text and images in order to improve levels of understanding of their care and conditions for those patients.

The practice had implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from patients. The practice had an active patient participation group (PPG) which met regularly and with whom the practice worked closely. The practice manager showed us the analysis of the last patient survey, conducted in January 2015 which was considered in conjunction with the PPG. The results and actions agreed from the survey were available on the practice website.

Overall, there was a positive response to the survey with 95.68% of respondents rating their overall satisfaction with the quality of service provided by the practice as good, very good or excellent. In response to the feedback gathered the practice had noted a number of improvements they had made. Online prescription services had been enhanced and an increase in the availability of online appointment bookings had been implemented. The practice had also refurbished the waiting area as a result of patient feedback. Waiting room chairs had been replaced to provide an increased number of high legged chairs for less mobile patients. A flat screen monitor had been purchased in order to reduce the number of waiting room notices and provide updated information to patients via rotating notices on a flat screen. The practice had recently increased the number of urgent and non-urgent appointments available to patients by the recruitment of an additional GP partner.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. Vulnerable patients were well supported. The practice provided care and support to patients with a learning disability and worked closely with community services to support their needs.

The practice was located in premises which provided limited access for patients with disabilities. The practice could be approached via a ramp to the main door. However, patients were required to pass through two further manual doors to access the waiting area. Space within the waiting area was limited and was restrictive for patients with wheelchairs and prams. The practice had recognised the limitations imposed by the practice layout and practice staff provided assistance to patients when

Are services responsive to people's needs?

(for example, to feedback?)

required. We noted there were car parking spaces for patients with a disability. Toilet facilities were accessible for all patients and contained grab rails for those with limited mobility and an emergency pull cord.

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

Access to the service

The practice was open from 8.30am until 6.30pm on weekdays. There were no extended hours appointments available for patients. There were online facilities for patients to book appointments. The practice had also introduced an automated telephone system which enabled patients to cancel an appointment. Appointments could be booked up to four weeks in advance for routine appointments. A number of urgent appointments were available on the day.

The results from a recent GP patient survey indicated that 81% of respondents said they found it easy to get through to the practice by phone. This was compared with a CCG average of 68% and a national average of 73%.

Information was available to patients about appointments on the practice website. This included how to arrange home visits, how to book appointments and the number to call outside of practice hours. There were arrangements in place to ensure patients received urgent medical assistance when the practice was closed. Patients were advised to call the out of hours' service.

Patients spoken with and comments left on CQC comment cards confirmed that patients were mainly happy with the appointment system. Patients told us they were happy with the practice's appointment system and GP led triage

system and were usually able to obtain an appointment to meet their needs. The results from a recent GP patient survey indicated that 67% of patients described their experience of making an appointment as good compared with a CCG average of 68% and a national average of 73%.

Listening and learning from concerns and complaints

The practice had a system for handling complaints and concerns. Their complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. The practice manager handled all complaints in the practice.

We saw that information was available to help patients understand the complaints system. There were posters in the waiting rooms to describe the process should a patient wish to make a compliment, suggestion or complaint. Complaint forms and a patient information leaflet about the complaints process were available to patients. Information was also advertised on the practice website. Patients we spoke with were aware of the process to follow should they wish to make a complaint. None of the patients spoken with had ever made a complaint about the practice.

We looked at the complaints log for those received in the last twelve months and found these were all discussed, reviewed and learning points were noted. Complaints were discussed at clinical meetings and partners meetings. The practice reviewed complaints on an annual basis to detect themes or trends. Staff we spoke with knew how to support patients wishing to make a complaint and told us that learning from complaints was shared with the relevant team or member of staff.

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 clear vision to deliver high quality care and promote good outcomes for patients. The practice was clinically well led with a core ethos to deliver the best quality clinical care whilst maintaining a high level of continuity.

We spoke with thirteen members of staff and they all knew and understood the vision and values and were clear about what their responsibilities were in relation to these.

The practice had recognised the needs of the local population and the increasing demand for appointments. They had recently recruited an additional GP partner in order to support their succession planning.

Governance arrangements

Arrangements were in place to ensure that responsibilities were clear and that quality and performance were regularly considered. Some risks were identified and well managed. The practice and staff were able to demonstrate the use of data, audits and benchmarking information on how they minimised risks to care quality by early warnings, proactive practice and performance management. However, the practice had not assessed the risks associated with some aspects of safety within the practice. The practice had not considered the risks associated with potential exposure to legionella bacteria which is found in some water systems. The practice did not have a supply of oxygen and had not carried out a risk assessment to identify the risks associated with managing emergencies which required access to oxygen.

Clinical governance leads were identified and received appropriate professional development and training to support the role. The nursing team were well supported to attend training in specialist areas such as spirometry, cervical screening and immunisations. Those nurses with extended roles had undertaken training in the management of conditions such as chronic obstructive pulmonary disease, asthma and diabetes.

The practice had systems in place for completing clinical audit cycles. We saw completed audit cycles relating to one

medicine prescribed to patients for specific heart conditions, the administration of influenza vaccines to patients with diabetes and the complication rates of fitting of intrauterine contraceptive devices.

Leadership, openness and transparency

The partners in the practice had the experience, capacity and capability to run the practice and ensure high quality care. They prioritised safe, high quality and compassionate care. The partners were visible in the practice and staff told us that they were approachable and always took the time to listen to all members of staff. The partners encouraged a culture of openness and honesty.

The practice had developed a clear leadership structure which included named members of staff in lead roles. For example, there was a lead GP for prescribing and one GP partner was the lead for child and adult safeguarding. There were lead GPs and nurses for the management of patients with diabetes and asthma. Staff were aware of the leadership structure within the practice. Reception, administration staff and nurses we spoke with were clear about their own roles and responsibilities. Staff told us they felt respected, valued and supported.

A series of regular meetings took place within the practice which enabled staff to keep up to date with practice developments and facilitated communication between the GPs and the staff team.

These included weekly clinical meetings which were accessible to all staff, weekly GP partner meetings and quarterly reception team meetings. We looked at minutes from the most recent meetings and found that performance, quality and risks had been discussed. Significant events and incidents were discussed to ensure learning and continuous improvement. However, the practice did not have systems in place to ensure that essential information was shared with relevant staff who were not present at the meetings. Records of clinical meetings were very brief and did not include allocated actions which could be clearly followed up and reviewed.

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

The practice had systems in place to seek and act upon feedback from patients. We saw that the practice responded to issues or concerns raised by patients in a

Are services well-led?

Requires improvement 

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

positive way. We looked at the most recent patient satisfaction survey carried out in 2015 and the majority of patients were extremely positive about the service provided by the practice.

The practice gathered feedback from staff through informal discussions and via team meetings. Staff told us they felt able to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged within the practice to improve outcomes for both staff and patients.

The practice had a whistleblowing policy which was available to all staff. Staff we spoke with were aware of the policy and how they could whistleblow internally and externally to other organisations.

Management lead through learning and improvement

The practice had systems in place for reporting, recording and monitoring significant events, incidents and accidents. The practice kept records of significant events that had occurred and these were made available to us. Significant events were discussed at regular meetings. There was evidence that the practice had learned from these and that appropriate action had been taken as a result. However, we noted that these meetings were not always attended by key staff and therefore information was not consistently shared with staff.

GPs and nurses were supported to maintain their continued professional development. For example, those nurses with extended roles had undertaken training in the management of conditions such as chronic obstructive pulmonary disease, asthma and diabetes. However, the majority of staff were not up to date with training in key areas. The planning and recording of staff training was generally poor. For example, staff within the practice had not received training in the safeguarding of children and vulnerable adults, fire safety, health and safety, infection control, information governance or the Mental Capacity Act 2005. Where staff told us they had completed training in areas such as basic life support, there was a lack of record keeping to support this.

Nurses within the practice told us they had recently undergone appraisal which gave them the opportunity to discuss their performance and to identify future training needs. We saw evidence of those appraisals. However, administration and reception staff had not undergone appraisals since February 2013. For those staff this meant that objectives they had previously been set were out of date and had not been reviewed.

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	<p>Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment</p> <p>We found that the registered provider had not always ensured that effective systems were in place to assess the risks to the health and safety of service users of receiving care or treatment and had not always done all that was reasonably practicable to mitigate such risks.</p> <p>We found that the registered provider had not ensured the proper and safe management of medicines.</p> <p>We found that the registered provider had not ensured that effective systems were in place to assess the risk of, and prevent, detect and control the spread of infections, including those that are healthcare associated.</p> <p>This was in breach of regulation 12 (1) (2) (a) (b) (g) (h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.</p>
Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	<p>Regulation 18 HSCA (RA) Regulations 2014 Staffing</p> <p>We found that the registered provider had not ensured that persons employed in the provision of a regulated activity had received appropriate support, training, professional development and appraisal to enable them to carry out the duties they were employed to perform.</p> <p>This was in breach of regulation 18 (1) (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.</p>
Regulated activity	Regulation
Diagnostic and screening procedures Family planning services	<p>Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed</p>

This section is primarily information for the provider

Requirement notices

Maternity and midwifery services

Surgical procedures

Treatment of disease, disorder or injury

We found that the registered provider had not ensured that persons employed for the purposes of carrying on a regulated activity were of good character.

We found that the registered provider had not ensured that information specified in Schedule 3 was available in relation to each person employed.

This was in breach of regulation 19 (1) (a) (3) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity

Diagnostic and screening procedures

Family planning services

Maternity and midwifery services

Surgical procedures

Treatment of disease, disorder or injury

Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

We found that the registered provider had not always ensured that records were kept in relation to the management of the regulated activity.

This was in breach of regulation 17 (1) (2) (d) (ii) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.