## Review of compliance

### CareTech Community Services Limited

#### CareTech Community Services Limited - 68 West Park Road

<table>
<thead>
<tr>
<th>Region:</th>
<th>West Midlands</th>
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| Location address: | 68 West Park Road  
Smethwick  
Birmingham  
West Midlands  
B67 7JH |
| Type of service: | Care home service without nursing |
| Date of Publication: | July 2011 |
| Overview of the service: | 68 West Park Road is a care service that accommodates up to 12 adults with a learning disability. Nursing care is not provided by the service. |
Our current overall judgement

CareTech Community Services Limited - 68 West Park Road was not meeting one or more essential standards. Improvements are needed.

The summary below describes why we carried out this review, what we found and any action required.

Why we carried out this review

We carried out this review because concerns were identified in relation to:

Outcome 04 - Care and welfare of people who use services
Outcome 07 - Safeguarding people who use services from abuse
Outcome 09 - Management of medicines
Outcome 16 - Assessing and monitoring the quality of service provision

How we carried out this review

We reviewed all the information we hold about this provider, checked the provider's records, observed how people were being cared for, looked at records of people who use services, talked to staff, reviewed information from stakeholders and talked to people who use services.

What people told us

We met with five out of the nine people that live at West Park Road. Other people we heard were out with staff, this due to involvement with planned activities or health appointments. All the people who use services that we met looked clean and well dressed, reflecting their age and gender. None of the people living at West Park showed any concerns or reservations when it came to communicating with the inspector or the staff on duty at the home. Two of the people we met communicate by signing. We observed that some staff are using appropriate communication techniques such as signing; this meaning it is possible for people to communicate their views.

One person living at the home showed us their bedroom and told us what activities they enjoy. They showed us their favourite X box games and the range of audio and visual equipment they had for their own personal use. They told us how the bedrooms décor reflected their personal likes and interests.

We saw people living at the home have involvement in domestic routines such as doing their own washing, and have access to appropriate equipment to allow this.
Only one person that we spoke to had any dissatisfaction, these centring on a wish to live independently in the community, although they had changed their mind about this later in the day. They also expressed dissatisfaction about staff restricting access to their cigarettes.

We saw that an individual at the home was able to say what they thought about things that were important to them, so as to plan changes that were agreeable to them.

We saw that there is ample space in the building so that people living there have ready access to their own space when they want this.

The provider has made us aware that there have been a number of alleged or actual incidents that have compromised people's safety or well being. The local authority has also confirmed that there are a number of allegations that are to be investigated and we have heard that people at the home have spoken about abusive practices to professional visitors. Staff told us they have whistle blown on bad practice by their peers to protect people living at the home.

Professionals who have visited the home recently have told us that people living at the home are safe.

People we spoke to told us that staff give them their medication as needed.

Staff told us that they are positive about changes which they hope will improve the service to the benefit of people living there.

What we found about the standards we reviewed and how well CareTech Community Services Limited - 68 West Park Road was meeting them

Outcome 04: People should get safe and appropriate care that meets their needs and supports their rights

The planning of care and treatment for individuals living at the home has not always been followed by staff. This has resulted in a lack of consistency in the way care is provided, with an impact on their welfare and safety.

Outcome 07: People should be protected from abuse and staff should respect their human rights

There have been occasions where action has not been taken to identify and prevent abuse from happening, coupled with a lack of appropriate response from the service.

The arrangements for ensuring that people that use the service are safeguarded against the risk of abuse have not always been followed.

Outcome 09: People should be given the medicines they need when they need them, and in a safe way

Medicines have not always been handled safely, securely or appropriately this indicating
people’s health and welfare was compromised.

The providers auditing of medication has become more robust in response to identified concerns with medication management, thus making people safer.

**Outcome 16: The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care**

Quality monitoring systems at West Park Road have not maintained compliance with essential standards, and as a result risks to people’s health, welfare and safety have occurred.

**Actions we have asked the service to take**

We have asked the provider to send us a report within 28 days of them receiving this report, setting out the action they will take to improve. We will check to make sure that the improvements have been made.

Where we have concerns we have a range of enforcement powers we can use to protect the safety and welfare of people who use this service. Any regulatory decision that CQC takes is open to challenge by a registered person through a variety of internal and external appeal processes. We will publish a further report on any action we have taken.

**Other information**

Please see previous reports for more information about previous reviews.
What we found for each essential standard of quality and safety we reviewed
The following pages detail our findings and our regulatory judgement for each essential standard and outcome that we reviewed, linked to specific regulated activities where appropriate.

We will have reached one of the following judgements for each essential standard.

**Compliant** means that people who use services are experiencing the outcomes relating to the essential standard.

A **minor concern** means that people who use services are safe but are not always experiencing the outcomes relating to this essential standard.

A **moderate concern** means that people who use services are safe but are not always experiencing the outcomes relating to this essential standard and there is an impact on their health and wellbeing because of this.

A **major concern** means that people who use services are not experiencing the outcomes relating to this essential standard and are not protected from unsafe or inappropriate care, treatment and support.

Where we identify compliance, no further action is taken. Where we have concerns, the most appropriate action is taken to ensure that the necessary improvements are made. Where there are a number of concerns, we may look at them together to decide the level of action to take.

More information about each of the outcomes can be found in the *Guidance about compliance: Essential standards of quality and safety*
Outcome 04: Care and welfare of people who use services

What the outcome says
This is what people who use services should expect.

People who use services:
* Experience effective, safe and appropriate care, treatment and support that meets their needs and protects their rights.

What we found

Our judgement
There are moderate concerns with Outcome 04: Care and welfare of people who use services

Our findings

What people who use the service experienced and told us
We met with five out of the nine people that live at West Park Road. Other people we heard were out with staff, this due to involvement with planned activities or health appointments. All the people who use services that we met looked clean and well dressed, reflecting their age and gender. None of the people living at West Park showed any concerns or reservations when it came to communicating with the inspector or the staff on duty at the home. Two of the people we met communicate by signing. We observed communication between the individuals and their allocated worker and based on reactions we judged their to be clear understanding between them.

One person living at the home showed us their bedroom and told us what activities they enjoy. They showed us their favourite X box games and the range of audio and visual equipment they had for their own personal use. They told us how the bedrooms décor reflected their personal likes and interests.

We saw people living at the home have involvement in domestic routines such as doing their own washing, and have access to appropriate equipment to allow this.

Only one person that we spoke to had any dissatisfaction, these centering on a wish to live independently in the community, although they had changed their mind about this later in the day. They also expressed dissatisfaction about staff restricting access to their cigarettes.
We saw that there is ample space in the building so that people living there have ready access to their own space when they want this.

**Other evidence**

We sampled two of the care records for people living at West Park Road. We saw that these are easy to read and supported by care plans in alternative formats (such as pictorial cues). We saw that these are based on assessments carried out by the funding authorities. Based on what we observed and heard people's care plans on the whole reflected their needs and individual preferences. The interim management of the home also showed a very good understanding of individual people's needs as detailed in care plans and assessments.

We discussed the one individual's concerns in respect of access to their cigarettes and the interim manager confirmed that the risk assessment in place at present did need review. The current risk assessment indicated that cigarettes are withdrawn overnight (due to fire safety issues) and the interim manager express concerns as to how restrictive this was, as well as a possible trigger for behaviours. We were also told that staff did not always follow the risk assessment suggesting it was not workable in its current form.

A report produced following a visit in January 2011 from a local authority contract monitoring officer stated that 'It is essential care plans are reviewed and updated to reflect the (people who use services) changing health, personal and social needs'. This was stated by the same professional to be applicable to risk assessments as well. This supports what the provider told us about their plans to review care plans and associated records.

Staff we spoke to told us that care plans were not always followed by some of the staff. From meetings and discussion with other professionals we have heard that staff need to be aware of what care plans say, and follow these. The overall quality of the care plans people living at the home have is not so much an issue as is the need for staff to use these to ensure care is delivered in the way people need and wish. We have heard of staff not following behaviour management plans, this resulting in instances where people's safety was compromised (see Outcome 7).

We have had discussions with management and have seen that they are aware of these issues and have told us they are committed to addressing them. Regular staff meetings have been commenced, additional management support brought in and the current training for staff has been evaluated. The availability of the provider's management of behaviour specialist at the home, working alongside staff is seen as a positive step in applying theoretical training to practice. Discussion with this specialist when we visited showed that their time at the home had given them an insight into ways in which people's care and welfare can be enhanced through such as appropriate person centred activities. This follows on from the local authority contracts visit in January 2011 stating the need to 'ensure residents are encouraged to participate in meaningful activities which provide encouragement to spend less time on their own in their room'. The input of the provider's behaviour specialist was confirmed by staff as positive, helping them understand how to better interact with people living at the home so as to enhance their care and welfare.

**Our judgement**
The planning of care and treatment for individuals living at the home has not always been followed by staff. This has resulted in a lack of consistency in the way care is provided, with an impact on their welfare and safety.
Outcome 07:
Safeguarding people who use services from abuse

What the outcome says
This is what people who use services should expect.

People who use services:
* Are protected from abuse, or the risk of abuse, and their human rights are respected and upheld.

What we found

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<tr>
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<td><strong>What people who use the service experienced and told us</strong></td>
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<tr>
<td>The provider has made us aware that there have been a number of alleged or actual incidents that have compromised people's safety or well being. The local authority has also confirmed that there are a number of allegations that are to be investigated and we have heard that people at the home have spoken about abusive practices to professional visitors. Staff told us they have whistle blown on bad practice by their peers to protect people living at the home.</td>
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<td>Some people at West Park Road have communication needs that can make it more difficult for them to communicate how they are feeling, meaning the ability of staff to support them to express concerns is critical. A visiting professional commented in a report (following a visit in January 2011) that the home needed to 'to undertake relevant training in communication in order to meet (the needs of people living at the home)'. We observed that some staff are using appropriate communication techniques such as signing; this meaning it is possible for people to communicate their views.</td>
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<td>Professionals who have visited the home recently have told us that people living at the home are safe.</td>
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<td>The provider has told us in written submissions that a delay was identified in reporting an allegation of potential abuse to relevant bodies. The provider has since taken robust action to safeguard people living at the home since that has included suspending several staff and the registered manager.</td>
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We have heard from the provider that their policies identify the types and possible indicators of abuse and how the staff team should respond in the event of any evidence of allegations of abuse or harm. Information in respect of the same is available to staff within the home for them to follow in the event of an alleged abuse. Staff we spoke to confirmed that this was the case. They also told us that they are aware of the home’s whistle blowing policy, and have had occasion to use this to protect people living at the home.

Other visiting professionals have also confirmed that the home has a safeguarding and whistle blowing policy that meets with the expectations of Sandwell Local Authority's safeguarding policy.

There was an incident earlier this year where staff verbally and physically abused a person living at the home. The reporting of this incident was delayed by at least 12 days between the time of the incident and the report to social services. The staff involved were suspended and have since been dismissed. There have also been other incidents that the provider reported to us on 6 June 2011 that have involved alleged inappropriate restraint that did not follow the person's behaviour plans or the home's procedures (this including physical intervention and use of medication). Staff involved with the incident involving inappropriate physical intervention have been suspended pending a full investigation by the provider.

The people living at the home that have been subject of safeguarding referrals to social services, have received visits from social workers to ensure they are now safe. We are aware that the provider is working with the local authority learning disability/safeguard team in relation to safeguard matters, this including involvement in meetings when required.

The provider has since kept us up to date in respect of events that have occurred at West Park Road, telling us how they intend to protect people living at the home. This has included Care Tech's behavioural management specialist spending time at the home, working alongside people and staff to review their behaviour management plans, and assist staff in translating classroom training into practice. Staff we spoke to, whilst admitting this was challenging, also said that this approach was helpful in understanding how to apply behaviour management plans successfully, this so that any physical or chemical restraint is a last resort. We have been told that support plans and risk assessments are under review so as to promote positive intervention with people living at the home.

The management have also looked at staff training and are to provide this to staff in a number of topics (such as behaviour management, mental capacity, adult protection and such like). We have been told by the provider that more regular staff meetings are to be held where the responsibilities of staff in respect of safe guarding and whistle blowing are to be discussed. Staff we spoke to confirmed that this was the case, and also showed a clear understanding of what the homes safeguarding procedure expects of them.

**Our judgement**
There have been occasions where action has not been taken to identify and prevent abuse from happening, coupled with a lack of appropriate response from the service.

The arrangements for ensuring that people that use the service are safeguarded
against the risk of abuse have not always been followed.
Outcome 09:
Management of medicines

What the outcome says
This is what people who use services should expect.

People who use services:
* Will have their medicines at the times they need them, and in a safe way.
* Wherever possible will have information about the medicine being prescribed made available to them or others acting on their behalf.

What we found

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| **What people who use the service experienced and told us**
People we spoke to told us that staff give them their medication as needed.

A visiting professional from the local authority reviewed the homes medication management in January 2011 and at that time found no issues of concern with the records they sampled at the time.

**Other evidence**
The provider has told us, following a internal audit of medication records, that during the course of 2011 there have been numerous issues with the administration of ‘as needed’ medications (to sedate people) and staff not following protocols laid down by Care Tech. There has also been one incident where a person living at the home was refusing medication for diabetes, and this was not reported to their G.P. as the homes protocol stated should happen. We were told that there have been issues in respect of recording for some medication.

In response to the above concerns, we were told that medication administration of ‘as needed’ medication was only to be authorised by the service's managers. In addition the service has carried out competency assessments of all staff that administer medication, this as confirmed by staff that we spoke to.

We looked at medication records for a number of people living at the home when we visited West Park Road on 16 June 2011. These showed us that recent records are
well documented, showed no use of 'as needed' sedatives (use of such to be considered a form of restraint).

We also looked at the management of medication for diabetes for one individual and records showed that this medication had been refused recently. Records clearly showed that contact was made with the individual's G.P. in accordance with set out protocols. Appropriate follow up to this issue was in place, with staff monitoring the individual's blood sugars to ensure they were aware of any risk to their health. This contrasts with earlier concerns where staff did not do this.

Medication records for people living at the home we saw to be supported by individual protocols and discussion with staff showed that they have an awareness of these. Stock control sheets have also been audited and are available with the medication records.

The provider's behaviour management specialist told us that they are looking at the use of 'as needed' sedatives within the review of people's behaviour management plans. The desired outcome is less use of this medication, with use of more appropriate alternatives to manage challenges. The recent medication records we viewed indicated that this was happening.

Whilst the provider has responded to concerns that they have identified recently there were issues in respect of the homes medication management raised at the time we last visited in January 2010. We said at the time that the service needed to ensure medication balances are to be recorded and that medication sheets must record the drug regime as prescribed, with signatures to verify that medication is given.

We asked to see audits carried out by the home's contracted pharmacist or any external pharmacist and were told that these had not been carried out.

The management of the home have informed us that they will continue to audit and monitor medication on a weekly basis, and are forwarding copies of action plans to us so that we are aware of any issues arising and aware of their progress towards compliance. Based on what they are telling us there are still issues that prevent compliance, which they are identifying through their internal audits.

**Our judgement**

Medicines have not always been handled safely, securely or appropriately this indicating people's health and welfare was compromised.

The providers auditing of medication has become more robust in response to identified concerns with medication management, thus making people safer.
Outcome 16: Assessing and monitoring the quality of service provision

What the outcome says
This is what people who use services should expect.

People who use services:
* Benefit from safe quality care, treatment and support, due to effective decision making and the management of risks to their health, welfare and safety.

What we found

Our judgement
There are moderate concerns with Outcome 16: Assessing and monitoring the quality of service provision

Our findings

What people who use the service experienced and told us
We saw that an individual at the home was able to say what they thought about things that were important to them, so as to plan changes that were agreeable to them.

Staff told us that their morale is low, and confidence in previous management was questionable, although they are positive about changes which they hope will improve the service to the benefit of people living there.

Other evidence
The provider has told us that they have an established quality monitoring system that is overseen by their quality and performance team. This team carries out reviews based around the 16 essential standards of quality and safety as published by CQC. Where there are identified issues the provider's quality team will issue a service improvement plan with the aim of highlighting any non compliance and good practice issues. The service manager is then expected to complete a monthly monitoring report to demonstrate how the service is meeting these issues.

As there are a number of areas where non compliance has been identified it is clear that quality monitoring has not taken place as it should have. The provider has also recognised that this is the case. To this end West Park Road is now to receive far more scrutiny from the providers Quality and Performance team with the intention of bringing the service back to full compliance.

Due to concerns that have arisen following safeguarding alerts and the audits the
provider has carried out the manager has been suspended (without prejudice) subject
to further investigation. The current area manager has only had responsibility for West
Park Road for about three months and has through their actions to date shown honesty
as to the homes non –compliance. They have told us that recent work has improved the
quality of the service, and provided us with evidence of improvement.

There is currently a lack of evidence to show that the home has historically sustained
compliance over a period of time. The provider's current self assessment of their
performance has told us that there are moderate concerns in respect of this outcome.

The provider has told us that to progress improvements they are reviewing a number of
systems including the following:

• How staff are allocated to people on a one to one basis, this called a key worker
  system, this to promote communication and ensure people's preferences and needs are
  met.
• More robust medication checks on a daily and weekly basis.
• Review and update of people's support plans so that it is clear what people want, and
  how this can be provided. These are then to be reviewed on a regular basis.
• Surveys to be conducted with people who use the service, their relatives and other
  stakeholders to gain their views of the service.

We are told that findings will be condensed into an overarching service improvement
plan that will be monitored by the provider's management.

Our judgement
Quality monitoring systems at West Park Road have not maintained compliance with
essential standards, and as a result risks to people's health, welfare and safety have
occurred.
**Compliance actions**

The table below shows the essential standards of quality and safety that are not being met. Action must be taken to achieve compliance.

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<th>Regulated activity</th>
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<th>Outcome</th>
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<tr>
<td>Accommodation for persons who require nursing or personal care</td>
<td>Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010</td>
<td>Outcome 04: Care and welfare of people who use services</td>
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<tr>
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<td><strong>How the regulation is not being met:</strong></td>
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<td></td>
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The providers auditing of medication has become more robust in response to identified concerns with medication management, thus making people safer.

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**How the regulation is not being met:**
Quality monitoring systems at West Park Road have not maintained compliance with essential standards, and as a result risks to people's health, welfare and safety have occurred.

The provider must send CQC a report that says what action they are going to take to achieve compliance with these essential standards.

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider's report should be sent to us within 28 days of this report being received.

Where a provider has already sent us a report about any of the above compliance actions, they do not need to include them in any new report sent to us after this review of compliance.

CQC should be informed in writing when these compliance actions are complete.
What is a review of compliance?

By law, providers of certain adult social care and health care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The Care Quality Commission (CQC) has written guidance about what people who use services should experience when providers are meeting essential standards, called Guidance about compliance: Essential standards of quality and safety.

CQC licenses services if they meet essential standards and will constantly monitor whether they continue to do so. We formally review services when we receive information that is of concern and as a result decide we need to check whether a service is still meeting one or more of the essential standards. We also formally review them at least every two years to check whether a service is meeting all of the essential standards in each of their locations. Our reviews include checking all available information and intelligence we hold about a provider. We may seek further information by contacting people who use services, public representative groups and organisations such as other regulators. We may also ask for further information from the provider and carry out a visit with direct observations of care.

When making our judgements about whether services are meeting essential standards, we decide whether we need to take further regulatory action. This might include discussions with the provider about how they could improve. We only use this approach where issues can be resolved quickly, easily and where there is no immediate risk of serious harm to people.

Where we have concerns that providers are not meeting essential standards, or where we judge that they are not going to keep meeting them, we may also set improvement actions or compliance actions, or take enforcement action:

**Improvement actions:** These are actions a provider should take so that they maintain continuous compliance with essential standards. Where a provider is complying with essential standards, but we are concerned that they will not be able to maintain this, we ask them to send us a report describing the improvements they will make to enable them to do so.

**Compliance actions:** These are actions a provider must take so that they achieve compliance with the essential standards. Where a provider is not meeting the essential standards but people are not at immediate risk of serious harm, we ask them to send us a report that says what they will do to make sure they comply. We monitor the implementation of action plans in these reports and, if necessary, take further action to make sure that essential standards are met.

**Enforcement action:** These are actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers are set out in the law and mean that we can take swift, targeted action where services are failing people.
### Information for the reader

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<td>Care Quality Commission</td>
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### Care Quality Commission

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