Urmston Group Practice

Quality Report

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

Ratings

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

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Urmston Group Practice on 21 January 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing effective, caring, responsive and well led services. It was also good for providing services for all the population groups. It required improving for providing safe services.

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

- The practice were moving to new updated premises. Plans to move have been under consideration for a number of years and were finally coming to a head in September 2015. All plans for improvements to the practice such as infection control requirements and the implementation of some policies and procedures had been deferred until the move.
- One of the GPs at the practice had been nominated and awarded for 'Going the Extra Mile'.
- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Risks to patients were assessed and well managed, with the exception of some training aspects and the availability of some equipment to deal with emergency situations such as patients with difficulty breathing or fainting.
- Patients' needs were assessed and care was planned and delivered following best practice guidance.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment and information about services and how to complaint was available and easy to understand. Most patients found access to the service acceptable and the practice were continually reviewing access to see if it could be improved.

Summary of findings

The areas where the provider must make improvements are :

- Ensure that all staff are appropriately trained in infection control and ensure infection control issues highlighted in the infection control audit are addressed.

The areas where the provider should make improvements are :

- Ensure that there is equipment available for patients who may present with breathing difficulties or suffer from fainting spells.
- Ensure that all staff are appropriately trained and receive regular updates in safeguarding.
- Ensure recruitment arrangements include all necessary employment checks, such as Disclosure and Barring Service checks (or evidence and reason if it is felt these are not required) for all staff.

Professor Steve Field (CBE FRCP FFPH FRCGP)
Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

The practice is rated as requires improvement for providing safe services as there are areas where it must make improvements. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Although risks to patients who used services were assessed, the systems and processes to address these risks were not implemented well enough to ensure patients were kept safe. Areas of concern related to safeguard training, disclosure and barring service checks, infection control and dealing with emergencies.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from National Institute for Health and Care Excellence and used it routinely. Patient's needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received most training appropriate to their roles. Some further training needs had been identified and arrangements were made to implement them in the future. Appraisals were undertaken in the past and although overdue, arrangements were in place for 2015. Staff worked with multidisciplinary teams and we saw evidence that information was shared appropriately to improve outcomes for patients.

Are services caring?

Good

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 to help patients understand the services available was easy to understand. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS England and Trafford Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients said they mostly found it easy to make an appointment

Summary of findings

with a named GP and that there was continuity of care, with urgent appointments available the same day. The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. Learning from complaints was discussed with staff and other stakeholders.

Are services well-led?

Good

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

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in dementia and end of life care. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. Nursing staff had lead roles in chronic disease management 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 medication 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.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. Immunisation rates were relatively high for all standard childhood immunisations. Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with midwives, health visitors and school nurses.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered

Summary of findings

to ensure these were accessible, flexible and offered continuity of care. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including homeless people and those with a learning disability. It had carried out annual health checks for people with a learning disability if requested but did pro-actively offer all learning disability patients an annual health check. The practice did not feel equipped to offer an effective service and had therefore opted out of this enhanced service. The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. It had told vulnerable patients about how to access various support groups and voluntary organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). People experiencing poor mental health had received an annual physical health check when required. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. It carried out advance care planning for patients with dementia. The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations such as MIND and SANE. It had a system in place to follow up patients who had attended accident and emergency (A&E) where they may have been experiencing poor mental health.

Summary of findings

What people who use the service say

We received 19 completed Care Quality Commission (CQC) comment cards and comments were all positive with only one mentioning difficulty getting through over the telephone and one mentioning difficulty obtaining a same day appointment. We spoke to ten patients between both the locations, three who were members of the patient participation group (PPG). The patients' overall opinion of the service was very good with no problems reported. However half of the patients spoken with said they were not regularly asked for their opinion and had never received any survey to complete. None of the patients expressed any concerns with regards to the cleanliness or hygiene at the practice and all were happy with the staff and the care and treatment offered to them. Staff were described as helpful, friendly, always happy and very thorough. Patients said they were treated with dignity and respect. One of the GPs had been nominated by a patient for 'going the extra mile' and had received the award. Patients felt involved in planning their care and treatment.

Most patients expressed satisfaction about the ease with which they could get an appointment. They told us urgent appointments were always available and they were sure they would be 'slotted in' even if all appointments were taken should they need it. Several patients commented on the environment saying it felt safe and hygienic.

We looked at the results of the 2014/15 GP patient survey. This is an independent survey run by Ipsos MORI on behalf of NHS England. These are the three areas where the practice scored best :

- 85% of respondents usually wait 15 minutes or less after their appointment time compared to the local CCG average of 70%
- 98% said the last nurse they saw or spoke to was good at explaining tests and treatments compared to the local CCG average of 91%
- 98% of respondents said the last nurse they saw or spoke to was good at treating them with care and concern compared with the local CCG average of 93%.

The three results where the practice came lowest compared with other practices in the CCG were as follows :

- 73% of respondents found it easy to get through by phone – compared to the CCG average of 81%
- 74% described their experience of making an appointment as good – compared to the CCG average of 78% and
- 84% of respondents said the last GP they saw or spoke to was good at giving them enough time- compared to the CCG average of 88%

Areas for improvement

Action the service MUST take to improve

- Ensure that all staff are appropriately trained in infection control and ensure infection control issues highlighted in the infection control audit are addressed.

Action the service SHOULD take to improve

- Ensure that there is equipment available for patients who may present with breathing difficulties or suffer from fainting spells.
- Ensure that all staff are appropriately trained and receive regular updates in safeguarding.
- Ensure recruitment arrangements include all necessary employment checks, such as Disclosure and Barring Service checks (or evidence and reason if it is felt these are not required) for all staff.

Urmston Group 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 adviser, specialist nurse adviser and an expert by experience. Experts by Experience are members of the public who have direct experience of using services.

Background to Urmston Group Practice

Urmston Group Practice has provided services to the local community for 75 years and does so under a PMS contract. There are currently two surgeries, one at Church Road and one at Woodsend and the practice population is 11,709 with a slightly higher percentage of females. Approximately 25% of the patients are aged over 60 and 18% are aged below 19. There are three male and four female GPs, a female advanced practitioner and three female nurses. In addition the practice employs approximately 24 reception and administration staff across the two sites.

Regulated activities are provided from both 154-156 Church Road, Urmston and 6 Woodsend Circle, Flixton. Both sites were visited as part of this inspection. The practice has opted out of providing out-of-hours services to their own patients and patients are directed to the out-of-hours service when the surgery is closed.

The practice is preparing to move to new updated premises. Plans to move have been under consideration for a number of years and are finally coming to a head in September 2015. All plans for improvements to the practice such as infection control requirements and the implementation of some policies and procedures have been deferred until the move.

The surgery doors are open at both sites on a Monday to Friday between 8.30am and 6.00pm. At Church Road the doors close half an hour later at 6.30pm. The telephone lines are open from 8.30am until 6.00pm at both sites. Extended opening hours are offered at Church Road on a Monday evening from 6.30pm until 9.30pm. Appointments are pre-bookable up to one month in advance and urgent on-the-day appointments are allocated on a first-come-first-serve basis by telephone in the morning for a morning appointment and in the afternoon for an afternoon appointment.

The CQC intelligent monitoring placed the practice in band 4. The intelligent monitoring tool draws on existing national data sources and includes indicators covering a range of GP practice activity and patient experience including the Quality Outcomes Framework (QOF) and the National Patient Survey. Based on the indicators, each GP practice has been categorised into one of six priority bands, with band six representing the best performance band. This banding is not a judgement on the quality of care being given by the GP practice; this only comes after a CQC inspection has taken place.

Why we carried out this inspection

We inspected this service as part of our comprehensive inspection programme. This provider had not been inspected before and that was why we included them.

Detailed findings

How we carried out this inspection

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

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

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

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

Before visiting we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 21 January 2015 and visited both branches (Woodsend and Church Road) of the practice. During our visit we spoke with a range staff including GPs, nurses, administration and reception staff. We also spent the day with the practice manager who assisted us with the inspection by providing information and evidence relating to the key lines of enquiry which we followed. We held a listening event with some members of the patient population group (PPG) and reviewed 19 CQC comment cards where patients and members of the public shared their views and experiences of the service.

Requires improvement

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 looked at the last six significant events which had been recorded. These related to prescription errors and patient treatment. Full details of the incidents and action to be taken had been documented. We followed these up during inspection and saw that the action recorded had been implemented.

We reviewed safety records, incident reports and minutes of meetings over the previous six months where these incidents were discussed. We also reviewed the significant event log which had been kept for the previous years. This showed the practice had managed these consistently over time and evidenced a safe track record over the long term.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. There were records of significant events that had occurred over previous years and we were able to review these. Significant events were discussed at clinical meetings if and when they occurred. Partners' meetings were held weekly on a Wednesday morning and other clinicians met weekly on a Friday. The GPs also met with the practice manager daily and any safety issues would be discussed. Not all these meetings were formally minuted but we saw that an agenda was created for relevant items. For example if there were any safeguarding issues or significant events or complaints then these would be reviewed. We saw that information from any learning was passed on.

There was evidence that the practice had learned from incidents and that the findings were shared with relevant staff. A member of staff told us of an incident which prompted a discussion with all staff about how and when to use the emergency alarm on their computers. We saw that training specifically about the "little green button" alarm was implemented because of this incident. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

Staff used incident forms on the practice intranet and sent completed forms to the practice manager. We saw the system used to manage and monitor incidents. We tracked three incidents and saw records were completed in a comprehensive and timely manner. We saw evidence of action taken as a result of such training on existing protocols, changes to existing practice and mentorship with relevant staff. Where patients had been affected by something that had gone wrong, in line with practice policy, they were given an apology and informed of the actions taken.

There was a policy within the practice for distribution of national patient safety alerts. These were disseminated by the practice manager, the deputy manager, and nursing and medical staff to other relevant practice staff. Staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for. Updates from the National Institute for Health and Care Excellence (NICE) were actioned through the medicines management team and the Medicines and Healthcare products Regulatory Agency (MHRA) updates were sent either in the post or via email. The GPs told us alerts were discussed at clinical practice meetings to ensure all 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 systems to manage and review risks to vulnerable children, young people and adults. We looked at the practice training records which suggested that only one clinical and one non clinical member of staff required training in the safeguarding of vulnerable adults. When we queried this, the practice manager explained that this training could be cascaded to other staff by those trained. Non clinical staff were logged as receiving safeguarding training in the first year of their employment and then as required or five yearly. The deputy practice manager was in the process of updating safeguarding training for all staff.

We asked members of medical, nursing and administrative staff about their most recent training and knowledge. Staff knew how to recognise signs of abuse in older people,

vulnerable adults and children. We spoke with four members of administration staff some who thought they had completed safeguarding training and others who were not sure. Staff we spoke with understood the term safeguarding and what it meant and were able to describe the different forms of abuse. The nurse we spoke with had completed e-learning level 1 and 2 in child and adult safeguarding and gave an account about how she had raised a concern with a health visitor and a GP at the practice.

Staff were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. We saw that the practice had a safeguarding policy for children and vulnerable adults which provided good explanation for staff on what to do in any case of concern. However, although there was a guide of how to escalate a concern there were no contact numbers in the policy for any of the agencies outside of the practice.

The practice had appointed a dedicated GP as the lead in safeguarding vulnerable adults and children. They had undertaken on-line and face to face training to the appropriate level three and could demonstrate they had the necessary training to enable them to fulfil this role. Not all staff were aware who the lead was but said they would escalate any concerns to the practice manager or any one of the partners.

There was a system to highlight vulnerable patients on the practice's electronic records. They used read codes and a "watch list" to share information about patients subject to child protection plans or other areas of vulnerability. Sensitive patients and safeguarding were standing items for discussion at practice meetings. Routine baby immunisations were undertaken only in scheduled baby clinics when either two nurses or a GP and a nurse were present. This was to safeguard against incorrect immunisations being given.

There was a chaperone policy, which was visible on the waiting room noticeboard and in consulting rooms. (A chaperone is a person who acts as an advocate for a patient and health care professional during a medical examination or procedure). Reception and nursing staff would act as a chaperone when requested. However, not all staff had received training in their responsibilities as a chaperone such as where to stand to be able to observe the examination. Neither had they had Disclosure and Barring Service (DBS) checks to ensure they were of suitable character. This had been acknowledged prior to our visit by the practice and reception staff were no longer being asked to chaperone until they had completed the required training and received appropriate DBS checks.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. The practice staff followed the policy. Medicines in the GPs bags were also checked and they were found to be in date. Medicines were not routinely stored in GP bags but were collected to be taken on home visits when thought necessary. Some medicines were stored in the GPs rooms and these were kept in locked drawers. On inspection these were also found to be appropriately kept, regularly checked and in date.

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

We saw an audit which had been carried out to see whether the practice were adhering to guidelines in respect of the prescription of Diclofenac which is a drug used in the management of pain, swelling and inflammation caused by arthritis. We saw that actions were identified and prescribing reduced where appropriate.

The nurses administered vaccines using directives that had been produced in line with legal requirements and national guidance. We saw up-to-date copies of directions and evidence that nurses had received appropriate training to administer vaccines.

There was a system in place for the management of high risk medicines, which included regular monitoring in line with national guidance. Appropriate action was taken based on the results. We discussed these processes with the GPs we interviewed.

All prescriptions were reviewed and signed by a GP before they were given to the patient. We saw that blank

prescription pads were kept in surgeries. At one of the sites we noticed a prescription pad on the desk of one the consulting rooms and we were told that the rooms were kept locked when they were not in use. Prescriptions should always be stored securely when not in use.

We discussed the cold chain policy with the nursing staff. This ensures that medicines such as vaccinations are stored at a particular temperature at all times to keep them safe for use. We saw that there were three fridges in total between the two sites and these were audited and checked regularly to make sure the contents were managed appropriately and kept safe. The fridges were not hard wired to ensure that they could not be switched off in error, but we saw that there were signs instructing that they should not be switched off at any time. Vaccines were stored in their original packaging and were in date.

On review of patient records we saw that patients were receiving the right medicines at the right time for the right conditions.

Cleanliness and infection control

We observed the premises to be clean and tidy but the fixtures and fittings were tired and required updating. The waiting room chairs and couches were covered in material and looked worn and unclean. We saw there were cleaning schedules in place and cleaning records were kept. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

The practice had a lead for infection control but we were unable to speak to them as they were not at work on the day of the inspection. We saw that there was an infection control policy and supporting procedures which staff could refer to and staff spoken with told us they were responsible for their own areas. We saw that disposable tips for thermometers and auroscopes were used and we saw a cleaning log for mouthpieces and spirometers was in place. Disposable gloves were available in each treatment room.

Infection control was an agenda item at practice meetings and hand washing signs and infection control guidance was seen in each of the treatment rooms. Control of substances hazardous to health (COSHH) training had been added to the training schedule and was organised for June 2015. Infection control training was part of induction when new staff were employed but we did not see evidence that this training was updated for existing staff on a regular basis. Existing reception and administration staff we spoke with said they had not undertaken infection control training although some thought it was due to be done in the future.

The practice had declared non compliance with infection control when they registered in 2011. An infection control audit had been undertaken by Trafford CCG in 2012 and repeated in August 2014. A number of actions were required and some had been addressed. However there were still a number of outstanding items and although the practice had deferred these because they were moving to new premises we found some areas which required immediate attention. For example privacy curtains in clinical rooms were not disposable, specifically in the treatment room where minor ops were undertaken and although we were told they were laundered there were no specific cleaning regimes with documented dates. We saw that the chairs and couches in the nurses' room were non wipeable and some consulting rooms were carpeted. In one of the consulting rooms we noticed that the carpet was stained.

The practice had a protocol for the management, testing and investigation of legionella (a bacterium that can grow in contaminated water and can be potentially fatal). We saw records that confirmed the practice had undertaken a risk assessment and identified that legionella checks were not required.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. For example the practice manager had a plan in place to ensure all equipment was effectively maintained in line with manufacture guidance and calibrated where required. We saw maintenance contracts were in place for all equipment including fridges, spirometers and blood pressure measuring devices and these had last been tested in July 2014. New pulse oximeters had been purchased for all GPs.

All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. The next

testing date was overdue. However the practice manager explained that this had been deferred until the implementation of new computers expected in January 2015.

The computers in the reception and consulting rooms had a panic alert system for staff to call for assistance and all staff had been trained in its use.

Staffing and recruitment

Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks through the Disclosure and Barring Service (DBS). The practice had identified prior to our inspection that some staff undertaking chaperone duties had not received a DBS check. Those staff had been removed from this duty until DBS had been undertaken. The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff.

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

There was a good mix of male and female staff to meet the needs of the patient population.

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. The practice had acknowledged that the services of a health care assistant would be beneficial but due to a lack of room space this was not currently possible. A plan to recruit a health care assistant was proposed when the practice moved to new premises.

A discussion with the practice manager highlighted that there had been an influx of around 600 new patients, registering at a rate of approximately 50 per month. The list size was now stable at approximately 11,709. Although there were a large number of GPs working at the practice the clinical staffing level amounted to just over five and a half whole time equivalents. Department of health guidance recommends one whole time equivalent GP per approximately 1900 patients.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included annual and monthly checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy.

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 example, the practice maintained a 'watch list' of patients who were vulnerable, chronically ill and/or terminally ill. The list was reviewed three or four times during each week with clinicians and district nurses and the information updated and shared. Any risks were discussed at GP partners meetings and within team meetings. We saw evidence of discussions in minutes we reviewed.

We were told of an incident where a receptionist shared a concern that a patient recently discharged from hospital was not answering the telephone. The information was escalated and actions discussed. Interrogation into the matter identified that the patient had been discharged to a nursing home rather than their own home as stated in the hospital discharge letter. A GP visit was therefore arranged to that place of residence.

We also saw that the practice monitored repeat prescribing for people receiving long term medicines. In particular patients on antidepressant medicines were requested to attend a medicine review after a specific number of repeat prescriptions had been administered.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that staff had received training in basic life support. We spoke with four members of administration staff and two clinicians who confirmed their training was up to date and regularly reviewed. Emergency equipment was available such as an automated external defibrillator (used to attempt to restart

Requires improvement

Are services safe?

a person's heart in an emergency) was available. When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly.

There was no oxygen or nebulisers available at the premises. This equipment is used in the event of any patient having difficulty breathing and may be required for patients undergoing minor surgery or having contraception implants. Following a discussion in 2013 the partners at the practice had assessed the requirement for oxygen and agreed it was not required. Contrary to this a patient told us of a time when they were referred to the walk in centre to access a nebuliser when suffering a severe asthma attack. We discussed this with the partners who said they would review their policy.

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

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to. We saw that the continuity plan had been utilised recently when IT systems had failed.

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

Risks associated with service and staffing changes (both planned and unplanned) were monitored by the practice manager. We saw that locum staff were used when necessary and that appropriate checks were made to ensure they were fit to practice.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We saw minutes of practice meetings where new guidelines were disseminated, the implications for the practice's performance and patients were discussed and required actions agreed. The staff we spoke with and the evidence we reviewed confirmed that these actions were designed to ensure that each patient received support to achieve the best health outcome for them. We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate.

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

The senior GP partner showed us data from the local CCG of the practice's performance for antibiotic prescribing, which was comparable to similar practices. The practice used read coding to identify patients with complex needs. We were shown the process the practice used to review patients recently discharged from hospital and saw that checks were made via a 'watch list' on patients who were vulnerable, at risk or near the end of their life.

Discrimination was avoided when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were cared for and treated based on need and the practice took account of patient's age, gender, race and culture as appropriate. The practice had a number of gender re-assignment patients registered at the practice and one of the clinicians had received training specific to lesbian, gay, bisexual and transsexual patients. However there was no specific policy or procedure in place for other staff to refer to and we discussed this during feedback. Gender re-assignment patients from female to male were at risk of 'falling off' the cytology recall lists once they had changed their name, so a different system was in place to protect those patients and ensure they were re-called if necessary.

Management, monitoring and improving outcomes for people

The practice maintained a 'watch list' of patients who were vulnerable, chronically and/or terminally ill who they felt needed to be on the practice 'radar'. The list was reviewed regularly and included discussion with multi-disciplinary health and social care professionals, such as district nurses, palliative care nurses and health visitors. It ensured that patient care was continual and that patients did not 'slip through the net'.

The practice had a system in place for completing clinical audit cycles. They showed us four clinical audits that had been completed during the course of the last two years. Following each audit changes to treatment or care were made where needed and the audit was repeated to ensure outcomes for patients had improved. One example of this was an alcohol audit which was undertaken following a learning event. It was done to identify the provision of follow up for patients with problematic drinking habits. The audit identified a scoring system and a check to ensure that patients had been given appropriate advice and received appropriate treatment in relation to their alcohol intake. A re-audit identified that the scoring system helped to identify patients who needed further treatment or advice and that clinical staff needed to be more aware of the process and on the look-out for Audit-C results in new cases.

Other examples included audits to confirm that the GPs who undertook minor surgical procedures were doing so in line with their registration and National Institute for Health and Care Excellence guidance.

The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). (QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). For example, we saw an audit

Good

Are services effective?

(for example, treatment is effective)

regarding the prescribing of analgesics and nonsteroidal anti-inflammatory drugs. Following the audit, the GPs carried out medication reviews for patients who were prescribed these medicines and altered their prescribing practice, in line with the guidelines. GPs maintained records showing how they had evaluated the service and documented the success of any changes.

There was a protocol for repeat prescribing which was in line with national guidance. In line with this, staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also checked that all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines. We saw evidence to confirm that, after receiving an alert, the GPs had reviewed the use of the medicine in question and, where they continued to prescribe it outlined the reason why they decided this was necessary. The evidence we saw confirmed that the GPs had oversight and a good understanding of best treatment for each patient's needs.

The practice had protocols for external peer review such as the review of referrals by the Clinical Commissioning Group (CCG) and in-house utilisation reviews with each specialist at the practice. We saw that the last reviews had taken place in 2014 as part of the peer appraisal assessment.

Effective staffing

All the staff apart from one had been with the practice in excess of five years, some for over 10 years or more. There was an induction process for any new staff which covered administration matters such as references, bank details and proof of identification. It also explained the practice ethos and training required. We looked at the staff file of the person most recently employed and saw that induction was provided.

Three of the reception staff we spoke with said they felt confident in their roles and felt they were adequately trained. The training matrix showed that staff had completed or should complete training in basic life support, manual handling, equality and diversity, fire safety, health and safety and infection prevention and control. However on speaking with staff and the practice managers we identified that not all training had been undertaken or was up to date. For example, training such as safeguarding, chaperoning, and infection control. Training such as basic life support and fire safety were up to date for all staff.

We discussed other training and education for staff in areas such as the Mental Health Act, mental capacity, dementia, dealing with aggressive behaviour, and medicines management. Some staff spoken with did not feel this type of education was appropriate to their role. However patients in the practice included people with mental health issues, old age, confusion, dementia and challenging behaviour and reception and administration staff reviewed and issued repeat prescriptions. There was an annual appraisal policy and some staff appraisals had taken place but training needs such as these had not been identified. The practice managers were aware of this and there was a plan in place to make sure that all staff training and education was up to date and appropriate to their requirements.

Practice nurses were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties. For example, on administration of vaccines, cervical cytology and smoking cessation. Those with extended roles received training, for example nurses were specifically trained in asthma and family planning to ensure a good skill mix and provide safe services to patients.

Staff files we reviewed showed that where poor performance had been identified appropriate action had been taken to manage this.

Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and manage those of patients with complex needs. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from communications with other care providers on the day they were received. The GP who saw these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well. An incident about a patient's attendance at the accident and emergency department

Good

Are services effective?

(for example, treatment is effective)

(A&E) was identified, and a significant event was documented with appropriate action and learning undertaken by the practice to minimise the likelihood of the event reoccurring in the future.

The practice held multidisciplinary team meetings at least weekly to discuss the needs of complex patients, for example those with end of life care needs or children on the at risk register. These meetings were attended by district nurses, social workers, palliative care nurses and decisions about care planning were documented on a 'watch list' held by the practice. Where health care professionals could not attend the meetings were managed by telephone. Staff felt this system worked well and remarked on the usefulness of the forum as a means of sharing important information.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. Electronic systems were also in place for making referrals, and the practice made referrals through the Choose and Book system. (Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital). Staff reported that this system was easy to use.

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

Consent to care and treatment

We found that clinical and medical staff were aware of the Mental Capacity Act 2005, the Children's Acts 1989 and 2004 and their duties in fulfilling it. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice. For some specific scenarios where capacity to make decisions was an issue for a patient, the practice had drawn up a policy to help staff, for example with making do not attempt resuscitation orders. This policy highlighted how patients should be supported to make their own decisions and how these should be documented in the medical notes.

Patients with a learning disability and those with dementia were supported to make decisions through their carers or advocates. Implied consent was utilised in some cases by the patient's attendance at the clinic for their appointment. Informed consent was utilised for patients requiring procedures such as cytology or gynaecology.

Carers were involved in decisions where appropriate and the practice kept a copy of any Do Not Attempt Resuscitation (DNACPR) on patient's records. These were identified by 'pop ups' generated by the electronic system. Staff spoken with about the subject were able to provide examples of how a patient's best interests were taken into account if they did not have capacity to make a decision.

Clinical and medical staff spoken with demonstrated a clear understanding of Gillick competencies. (These are used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions).

There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures and child vaccinations, a patient's (or their parent or guardian's) verbal or written consent was documented in the electronic patient notes with a record of the relevant risks, benefits and complications of the procedure.

Health promotion and prevention

Health checks were carried out opportunistically and the GPs were informed of all health concerns detected. We saw good communication exchanges between the nurses and GPs in the management of specific conditions such as COPD and asthma. Communications were followed up in a timely manner and referred back to the nurse when the situation was controlled. We noted a culture among the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering weight advice or smoking cessation advice to smokers. A new system had recently been implemented for the recall of patients referred for cytology.

Good

Are services effective?

(for example, treatment is effective)

The practice had numerous ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example the 'watch list' identified vulnerable patients and patients requiring end of life support. Practice nurses who specialised in diabetes carried out visits to housebound patients with the condition and communication between the health visitors and the practice meant that potentially vulnerable families were monitored.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance for all immunisations was above average for the CCG, and again there was a clear policy for following up non-attenders by the named practice nurse.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the 2014 national patient survey. A survey of 117 patients identified that 98% of respondents said the last nurse they saw or spoke to was good at treating them care and concern compared to the local (CCG) average of 93%. said the last nurse they saw or spoke to was good at explaining tests and treatments compared with the local (CCG) average of 91%. 88% say the last GP they saw or spoke to was good at treating them with care and concern and 97% had confidence and trust in the last GP they saw or spoke to. (The local CCG average was not available).

We spoke with three members of the patient participation group (PPG). Comments received by all of them were very complimentary about the practice, the staff and the services provided. These and another seven patients spoken with reported that they were always treated with dignity, compassion and respect by clinical, medical and administration staff. They gave us specific examples where continuity of care was implemented and help and support was provided for themselves either as patients, or as carers of patients with learning disabilities and/or other long term conditions. One patient (and carer) told us that their child with learning disabilities was spoken to in an appropriate manner, made to feel part of the consultation and not discriminated against in any way.

Twenty one patients completed CQC comment cards to tell us what they thought about the practice and all were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring.

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

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. Data from the 2014 national patient survey showed that 98% of respondents said the last nurse they saw or spoke to was good at treating them with care and concern, 90% said the last GP they saw or spoke to was good at explaining tests and treatments and 97% had confidence and trust in the last GP they saw or spoke to.

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

We heard evidence that children and young people were treated in age appropriate way, recognised as individuals and their preferences considered.

One of the GPs had been nominated by a patient for 'Going the Extra Mile' and had received a reward for the care he had provided. The nomination had been sent because the patient felt the GP had gone over and above any requirements to ensure he received the care and treatment he needed and to co-ordinate all the aspects of his long term conditions.

Patient/carer support to cope emotionally with care and treatment

Patients spoken with were positive about the emotional support provided by the practice and rated it well in this area. They told us they had received help to access support services to help them manage their treatment and care when it had been needed. The CQC comment cards we received were also consistent with this information. For example, they highlighted that staff responded compassionately when they needed help and provided support when required.

Notices in the patient waiting room and patient website told patients how to access a number of support groups

Good

Are services caring?

and organisations. The practice's computer system alerted GPs if a patient was also a carer. We were shown the written information available for carers to ensure they understood the various avenues of support available to them.

Good

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 patient's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered.

The practice engaged regularly with the Clinical Commissioning Group (CCG) and with other practices to discuss local needs and service improvements that needed to be prioritised. The practice took part in the Salford Lung Study the purpose of which was to test the safety and effectiveness of a new treatment for asthma. We saw minutes of meetings where this had been discussed and actions agreed to implement service improvements and manage delivery challenges to its population. The practice were moving to a new health centre and patients had been notified and asked for their views on the move. The patient participation group survey had identified the patient priorities should the practice move to new premises and had identified how patients preferred to be communicated with to provide updates about the move.

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG). These included an improved telephone system, improved waiting areas, improved privacy, ease of access to a pharmacy, improved clinical facilities and improved disabled access which were all to be addressed following the move to new premises.

Tackling inequity and promoting equality

The practice were aware of the different groups of people within their population and they recognised they had differing needs and they used information about their patients in the planning of their services. They gave an example of a homeless person able to use the surgery as their home address and interpretation services available for a family who spoke little English. The practice also had access to online and telephone translation services for other languages if required. There was very little diversity within the practice population with only nine who were not White British.

The practice provided equality and diversity training through e-learning. Staff we spoke with confirmed they had completed training and were aware of what was meant by the term equality and diversity and were able to give examples.

We visited both locations of the practice and saw that they met the needs of patients with disabilities. We saw disabled access at both locations and noted that the doors and corridors were wide enough for wheelchair and pushchair users. The hallways and corridors were clear and patients were not seen on upper floors. Building work was taking place outside the practice at Woodsend for the new surgery but this was not affecting access and inside was clean and tidy.

The waiting room at Woodsend was large and spacious but there was little privacy which the practice were aware of. They provided a corridor adjacent to the reception desk in the event of patients wishing to speak to someone in private. The toilet at Woodsend was locked at all times and there were no baby changing facilities. These issues would be addressed when the practice moved to the new premises, but this still some way off.

Access to the service

The surgery doors were open at both sites on a Monday to Friday between 8.30am and 6.00pm. At Church Road the doors closed half an hour later at 6.30pm. The telephone lines were open from 8.30am until 6.00pm at both sites. Routine appointments were pre-bookable up to one month in advance and urgent on-the-day appointments were allocated on a first-come-first-serve basis by telephone in the morning for a morning appointment and in the afternoon for an afternoon appointment. Surgery times were staggered so that there were appointments available all day and a rota system was in place to manage 'extra' patients who were divided equally between the GPs. Extended opening hours were offered at Church Road on a Monday evening from 6.30pm until 9.30pm. Two GPs were available for a total of six hours.

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits and how to book appointments through the website. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If

Good

Are services responsive to people's needs?

(for example, to feedback?)

patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients.

Longer appointments were available for patients who needed them and those with long-term conditions. This also included appointments with a named GP or nurse specifically for older patients who were seen regularly in order to deal with their complex needs. Continuity of care for those patients was managed in this way. Home visits were made to all patients when required.

Patients were generally satisfied with the appointments system. They confirmed that they could see a doctor on the same day if they needed to. They also said they could see another doctor if there was a wait to see the doctor of their choice and they could be seen at any one of the locations. Comments from patients showed that those in urgent need were able to make appointments on the same day. One patient fed back that it is sometimes difficult to get through on the telephone when trying to make an appointment. Call backs and telephone consultations were also available.

Listening and learning from concerns and complaints

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

We saw that information was available to help patients understand the complaints system. There was a practice leaflet, notices in reception and advice on the surgery website. Patients we spoke with were aware of the process to follow if they wished to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice although they told us they would speak to the practice manager or one of the doctors without hesitation and felt their issues would be acted upon.

We looked at four complaints received in the last 12 months and found that they were dealt with in a timely way. The practice reviewed complaints annually to detect themes or trends. We looked at the report for the last review and no themes had been identified. However, lessons learned from individual complaints had been acted on and we saw that all complaints were discussed openly at team meetings so that all staff could learn from them.

Are services well-led?

Good

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

Our findings

Vision and strategy

It was clear from speaking with all staff at the practice that they shared the practice vision to strive to continually improve the range of services offered to patients. They welcomed input from their patients and acted upon it when they could. The vision and values were part of the practice's strategy and five year business plan. However the practice had been planning a move to new premises for some years and a lot of improvements such as better infection control management and better facilities to meet diversities were being put off until the move.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the practice. We looked at eight of these policies and procedures and staff we spoke with knew where they were, how to access them and how to find information within them. The policies and procedures we looked at had been reviewed and were up to date. The practice manager and new deputy were in the process of reviewing all policies and looking for ways to have everything available electronically, saving space and paper.

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead nurse for infection control and one of the partners was the lead for safeguarding. We spoke with eight members of staff and they were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed it was performing in line with national standards. We saw that QOF data was regularly discussed at monthly team meetings and action plans were produced to maintain or improve outcomes.

The practice nurse told us about a local peer review system they took part in with neighbouring GP practices where she had the opportunity to measure her performance and that of the practice against others and identify areas for improvement. The practice manager also attended a practice manager forum across a core of eight other surgeries where they shared good practice. The practice manager gave us an example of an action she had taken from one of the meetings to improve communication within her own practice.

The practice held monthly governance meetings. We looked at minutes from the last three meetings and found that performance, quality and risks had been discussed.

Leadership, openness and transparency

The practice manager undertook appraisals for the reception and administration staff and the nursing/clinical staff were appraised by one of the GPs. This gave staff an opportunity to discuss their objectives, any improvements that could be made and training that they needed or wanted to undertake. Clinicians received appraisal through the revalidation process.

We saw from minutes that team meetings were held regularly, at least monthly. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example disciplinary procedures, induction policy, management of sickness and whistleblowing which were in place to support staff. Staff spoken to were aware of the policies and knew how to access them when required.

Seeking and acting on feedback from patients, public and staff

The practice had gathered feedback from patients through their patient participation group (PPG), the friends and family test, the national GP survey and comments and complaints received. We reviewed the 2014 action plan which was based on the PPG questionnaire responses and group opinion. We saw that areas for improvement relating to access were actioned. For example the practice now offered patients the facility to book Monday evening appointments in advance. Patients also expressed a preference as to how they could best be kept informed about progress of the move to new premises and the practice had arranged leaflets, kept communication lines open and arranged an open day.

We spoke with three members of the PPG who were very complimentary about the service. They said that meetings

Are services well-led?

Good

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

were held regularly (perhaps three times a year) with the practice manager and one of the partners from the practice. However they were not fully aware that they were the voice of all the patients at the practice and they did not know how information from their meetings was regularly fed back all the patients or if it was. They did not know that patients could come to them with issues or suggestions. We did not see any minutes on the practice website but there was a copy of the survey and action plan.

The practice had an open culture and staff said they would be happy to make suggestions and thought they would be listened to. There was no annual staff survey. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients. One member of staff said they had fed back a suggestion about appointments and this had been actioned.

The practice had a whistleblowing policy and staff knew what to do if they had any concerns. Staff spoken with told us they would not hesitate to raise any concerns either with the practice manager or with one of the partners.

Management lead through learning and improvement

Staff we spoke with felt supported and encouraged to maintain their clinical professional development through training and mentoring. The nursing staff in particular told us they felt well supported and were able to access informal supervision from any of the GPs whenever they needed it. We looked at staff files and saw that appraisal took place but we noted that some training needs for staff although identified had not been addressed.

The practice had completed reviews of significant events, complaints and other incidents and these were shared with staff at meetings to ensure the practice improved outcomes for patients.

The practice had a study and training policy in place providing staff with an opportunity to develop their education as long as the increased knowledge benefited the practice and it's population. Study leave and the cost would be provided at the employer's discretion.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control **The provider did not comply with the requirements of regulation 12 with regard to the Code of Practice for health and adult social care on the prevention and control of infections and related guidance.**