Sandown Health Centre

Quality Report

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Date of inspection visit: 24/03/2015
Date of publication: 16/07/2015

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Sandown Health Centre on 25 March 2015.

Overall the practice is rated as good.

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

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed;
- Risks to patients were assessed and managed, with the exception of some aspects infection control;
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment;
- A recent survey showed 95% of patients said they had confidence and trust in the GP treating them;
- Information about services and how to complain was available and easy to understand;
- Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day;
- The practice had good facilities and was well equipped to treat patients and meet their needs; and
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.

We saw areas of outstanding practice including:

Summary of findings

- The practice had a proactive patient participation group (PPG). We met with two members of the PPG who were extremely positive about the practice and told us they felt welcomed and involved in the development of the practice;
- GPs supported an alcohol rehabilitation unit, a mental health recovery unit, temporary housing for vulnerable families and other vulnerable groups. Homeless patients who were registered at the practice, were able to use the practice address for correspondence; and
- Patients had access to fact sheets from the practice and on the practice website. These had been written to explain the role of the NHS to newly-arrived individuals seeking asylum. The fact sheets were available in a choice of 20 different languages which included; Polish Albanian, Urdu, Somali and Croatian.

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

Importantly the provider must:

- Produce an action plan after each infection control audit.

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 their responsibilities to raise concerns, and to report incidents and near misses. 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.

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 training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. There was evidence of appraisals and personal development plans for all staff. Staff worked with multidisciplinary teams.

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

Are services responsive to people's needs?

Outstanding

The practice is rated as outstanding for providing responsive services. It reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group to secure improvements to services where these were identified. Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day.

The practice supported patients whose circumstances made them vulnerable. Services for these patients included adult and young

Summary of findings

people's alcohol, drug and mental health recovery support. The practice had a patient participation group were actively involved in the running of the service and the practice reacted positively to suggestions and feedback from the patients the group represented.

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. There was learning from complaints 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 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.

The practice employed a dedicated nurse and health care assistant for patients over the age of 75. They carried out health and social care checks for these patients giving advice and support.

Patients were given a card with names and contact details for the over 75 team. The practice fostered a close relationship with care homes they had patients living in. There was a dedicated GP for each of the care homes with weekly visits.

People with long term conditions

Good

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

The practice diabetes service supported 650 patients with diabetes. This service comprised of active detection and monitoring of pre-diabetes symptoms, comprehensive in-house education for patients, commencing appropriate treatment for diabetes, twice-yearly reviews and blood sugar monitor quality control checks. This service was complemented by weekly podiatry (foot care) and lower limb assessment clinics and monthly eye health screening clinics. GPs held personal patient lists and had a close working relationship with the community matron and community nursing team and offered longer appointments and home visits to this patient group if required.

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. Immunisation rates were good for all standard childhood immunisations. We saw good examples of joint working with midwives, health visitors and school nurses.

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. The practice offered daily urgent sit and wait appointments and scheduled appointments were available outside of school hours. The premises were suitable for children and babies.

The practice provided an all Isle of Wight, drop-in, 'You're Welcome' accredited Young Person's Sexual Health Clinic for under 25 year olds. This included outreach visits to a local high school, youth club

and girl guides by their family planning nurse with enhanced take up of contraceptive and sexual health services. Four GPs carried out contraceptive device fitting and provided emergency coil fitting for their own and patients registered at other practices. Patients were encouraged to attend the practice with minor injuries rather than going to A&E.

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). Online services were available for patients to book and cancel appointments and request repeat prescriptions. The practice also accepted communication from patients via e-mail. Various appointment times were available including evening appointments and a sit and wait urgent surgery at 5.15pm daily. Extended evening appointments were available on two evenings per week. Patients could also request telephone consultations.

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 used the 'Gold Standard Framework' for palliative care and held bi-monthly multi-disciplinary team meetings with the local hospice. Staff had designed an 'End of Life' care pathway and documentation was agreed between GPs, District and Macmillan nurses.

Staff had received training and knew how to recognise signs of abuse in vulnerable adults and children

Staff used a system for annual health checks for people with learning disabilities and longer appointments were given when required.

Practice staff had access to interpreting services, via language line and there were facilities for patients to translate the practice website into 90 different languages. Patients had access to fact sheets from the practice and from the practice website. These had been written to explain the role of the NHS to newly-arrived individuals seeking asylum. They covered issues such as the role of GPs, their function as gatekeepers to the health services, how to register and how to access emergency services. Sheets were available in a choice of 20 different languages which included; Polish Albanian, Urdu, Somali and Croatian.

Isle of Wight recovery and integration service adult and young people's alcohol and drug recovery services were held a weekly clinic at the practice. GPs supported an alcohol rehabilitation unit, a

Summary of findings

mental health recovery unit, temporary housing for vulnerable families and other vulnerable groups. Homeless patients were who were registered at the practice, were able to use the practice address for correspondence.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for people experiencing poor mental health (including people with dementia). GPs carried out active screening for dementia which ensured a high diagnostic rate (92%) this was the best performing practice on the Isle of Wight by over 15%. 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.

Of patients with a diagnosis of psychosis 90% had a documented care plan in their notes and a record of

their alcohol consumption, within the previous 12 months. GPs also had a system in place to follow up patients who had attended accident and emergency when they had been experiencing poor mental health. Staff had received training on how to care for people with mental health needs and dementia.

Psychological services held weekly outreach clinics at the practice; this provided talking therapy for those patients who wished to receive it. There was information available for patients experiencing poor mental health about how to access various support groups and voluntary organisations including MIND and SANE and GPs undertook staff and patient talks at local care homes.

Summary of findings

What people who use the service say

We received 12 completed patient comment cards and spoke with 16 patients at the time of our inspection visit. These included older patients, mothers with babies, vulnerable patients and patients of working age.

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

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

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

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

• 92% of respondents said their experience of making an appointment was good

• 90% of respondents said the last GP they saw or spoke to was good at giving them enough time

• 95% of respondents said they had confidence and trust in the GP treating them

Areas for improvement

Action the service MUST take to improve

- Produce an action plan after each infection control audit.

Outstanding practice

- The practice had a proactive patient participation group (PPG). We met with two members of the PPG who were extremely positive about the practice and told us they felt welcomed and involved in the development of the practice.
- GPs supported an alcohol rehabilitation unit, a mental health recovery unit, temporary housing for vulnerable families and other vulnerable groups. Homeless patients who were registered at the practice, were able to use the practice address for correspondence.
- Patients had access to fact sheets from the practice and from the practice website. These had been written to explain the role of the NHS to newly-arrived individuals seeking asylum. The fact sheets were available in a choice of 20 different languages which included; Polish Albanian, Urdu, Somali and Croatian.

Sandown Health Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector.

The team included a GP specialist advisor and a practice manager specialist advisor.

Background to Sandown Health Centre

Sandown Health Centre is a training practice situated in Sandown on the east side of the Isle of Wight.

The practice shares a building with district nursing, health visitors and the community rehabilitation team. The practice has an NHS general medical services (GMS) contract to provide healthcare and does this by providing health services to approximately 11,800 patients.

Sandown Health Centre is a GP training practice for 5th year medical students. We were told the practice had trained students since 1988 and recently applied to become a placement for trainee nurses.

Appointments are available between 8.30am and 6pm from Monday to Friday. Evening appointments are also available on Wednesdays and Thursdays between 6.30pm and 8pm. The practice has opted out of providing out-of-hours services to their own patients and refers them to Beacon Health Centre via the NHS111 service.

The mix of patient's gender (male/female) is almost half and half. Approximately 27% of patients are aged over 65 years old which is higher than the average for England. The practice is located in an area of average deprivation. Sandown Health Centre treats a number of patients who have high intake of drug and alcohol and/or experience poor mental health. The practice also treats a high number of temporary residents especially during summer months when people come to the Isle of Wight for holidays.

The practice has eight GP partners who together work an equivalent of six and a quarter full time staff. In total there are six male and two female GPs. The practice also has a nurse prescriber, lead nurse, eight practice nurses and four health care assistants. The GPs and the nursing staff are supported by a team of ten reception staff and ten administrators and the practice manager.

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

Broadway

Sandown

Isle of Wight

PO36 9GA

Why we carried out this inspection

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

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

and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Detailed findings

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

How we carried out this inspection

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

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

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

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

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

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

The population groups are:

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

Requires improvement

Are services safe?

Our findings

Safe track record

The practice 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. A GP was the lead for safety and medical alerts and planned how they carried out a search of patient records to identify who could be affected by the alert and acted accordingly. We were told a member of the administration staff was responsible for these when the GP was absent. Staff were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. For example, a patient's blood test results were received by the practice which was abnormal. The results were not marked urgent by the hospital and fast tracked which meant they were not actioned immediately by the practice. This was raised as a significant incident and the hospital was contacted to ensure this error did not occur again. We reviewed safety records, incident reports and minutes of meetings where these were discussed for the last 12 months. This showed the practice had managed these consistently over time and so could show evidence of 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 during the last 12 months and we were able to review these. Significant events were a standing item on the weekly practice meeting agenda and meetings were attended by GPs and representatives from the administration and nursing teams. There was evidence that the practice had learned from these and that the findings were shared with relevant staff. 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 to raise issues and we saw these were completed appropriately. We tracked three incidents and saw records were completed in a comprehensive and timely manner. We saw evidence of action taken as a result. For example, a patient presented at the practice with a grade two pressure sore (an ulcer that looks like an open wound or a blister) that was undiagnosed during their stay at a local hospital. The practice treated the pressure sore and investigated the issue with the hospital. 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.

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 training records which were supplied to us before our visit. These showed that six of the ten GPs and 13 of the 16 nursing staff had received relevant role specific training on safeguarding. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details were easily accessible.

A GP was the lead clinician for child safeguarding. There was also a dedicated safeguarding administrator and a lead safeguarding nurse. The leads had been trained and could demonstrate they had the necessary training to enable them to fulfil this role. All staff knew this and were aware of the potential issues with vulnerable adults and children. Records demonstrated good liaison with partner agencies such as the police and social services.

We saw a chaperone policy, which was visible in consulting and treatment rooms, in the practice leaflet and on its website. A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure. All the practice health care assistants had been trained to be chaperones and understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination. All had received a criminal records check through the Disclosure and Barring Service.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators. 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 demonstrated their understanding of this policy.

The practice had five fridges for medicines including vaccines plus a sample fridge. It used Task Line Data log as well as paper records to record fridge temperatures. Task

Requires improvement

Are services safe?

Line Data log is an electronic device which is kept in the fridge and records the temperature every 10 minutes, the results of which can then be downloaded on to a computer. Records were kept from an inbuilt fridge temperature gauge as well as external thermometer to ensure accuracy. Both were checked in the morning and recorded in a paper log. Nursing staff routinely checked temperatures during the day and all fridges had audible alarms if the temperature went below two or above eight degrees Celsius.

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

Prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times. For example, boxes of blank prescriptions were signed in by the practice and the serial numbers were checked. Each consulting room was issued a complete box of prescriptions at a time. The box was kept securely and a note made of the relevant serial numbers of prescriptions contained within which allowed for tracking in the event of theft.

Nurses administered vaccines using directions that had been produced in line with legal requirements and national guidance. We saw up-to-date copies of both sets of directions and evidence that nursing staff had received appropriate training to administer vaccines. For example, all nursing staff received refresher training at start of flu season.

Cleanliness and infection control

We observed the premises to be clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. All the patients we asked, on the day of our visit, said they always found the practice clean and had no concerns about cleanliness or infection control.

The practice had a named GP lead for infection control. A nurse also undertook this role 'day to day' and had undertaken training to enable them to provide advice on the practice infection control policy and carry out staff training.

An infection control policy was available for staff to refer to which had been reviewed in November 2014. Areas covered by the policy included hand hygiene, clinical waste protocols, uniform cleaning and specimen handling. Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with liquid hand soap, sanitizing hand gel and paper hand towel dispensers were available in treatment rooms. Personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these to comply with the practice's infection control policy. There was also a policy for needle stick injury and staff knew the procedure to follow in the event of an injury. Clinical waste was disposed of appropriately and was kept in locked waste bins to await collection.

We asked for records of infection control audits and were given one audit that had been completed the day before our visit. We were told this was the first audit carried out since the practice registered with the Care Quality Commission in 2013. Areas which required improvement had been identified but an action plan had not been compiled by the time of our visit. We asked the practice for their annual infection control statement and was told this had also not been completed. By completing an annual statement the practice would identify shortfalls in its infection control measures and the areas which required remedial action. In this case the lack of an infection control audit would be identified when the statement was written.

The practice had a policy for the management, testing and investigation of Legionella (a bacterium that can grow in contaminated water and can be potentially fatal). A Legionella risk assessment had been carried out in 2014.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date was March 2014.

A schedule of testing was in place for fire detection and fighting equipment. The most recent test of fire extinguishers was September 2014. We saw evidence of annual calibration of medical equipment. Calibration is the

process adjusting the precision and accuracy of measurement equipment. A specialist company carried out the most recent calibration in September 2014. Equipment included weighing scales, ultrasound machine, ECG equipment, spirometers, blood pressure measuring devices and the refrigerator thermometers.

Staffing and recruitment

All the GPs and nursing staff who worked at the practice had current registrations with their professional bodies, these being the General Medical Council for GPs and Nursing and Midwifery Council for nursing staff. The practice had a recruitment policy which detailed the checks to be undertaken before a person started work. For example, proof of identity, a full employment history, evidence of relevant qualifications and employment checks including satisfactory conduct in previous employment.

Staff recruitment records were stored securely and kept in an ordered way. Staff had evidence of having received a criminal records checks through the Disclosure and Baring Service (DBS) where required. We saw a risk assessment for a receptionist role which resulted in the decision that a DBS check was not required. The practice employed locum GPs (a locum GP is a GP who temporarily employed). We were shown recruitment records for two locums and found that the necessary recruitment checks required were in place for both.

Staff told us there was always enough staff on duty to keep patients safe. The practice manager showed us records to demonstrate that actual staffing levels and skill mix were in line with planned staffing requirements. We were shown the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system in place for all the different staffing groups to ensure that enough staff was 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.

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. Health and safety information was displayed for staff to see and there was an identified health and safety representative.

Health and safety risk assessments were carried out annually in every room in the practice and recorded appropriately. Risks assessed included waste storage, lighting, cables, flooring and cleanliness. We saw records to confirm that an assessment was carried out in November 2014 and June 2013.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all clinical staff had received training in basic life support in the last 12 months. Emergency equipment was available including access to oxygen and an automated external defibrillator (a portable electronic device that analyses life threatening irregularities of the heart including ventricular fibrillation and is able to deliver an electrical shock to attempt to restore a normal heart rhythm.) When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly.

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 and severe allergic reactions. Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

A business continuity plan, dated May 2013, was in place which addressed a range of emergencies that may impact on the daily operation of the practice. A major incident plan was incorporated in the continuity plan which included telephone numbers of all staff and companies who provided services to the practice. We were told that both the practice manager and a GP held a paper copy of the plan at their home addresses. There were reciprocal arrangements in place to buddy with another local GP practice which would enable services to continue in the event of an incident which may render Sandown Health Centre unusable. We were told about a recent incident when a pipe burst and leaked into reception resulting in no heating. Staff were contacted and told to wear warm clothing and take in heaters. Cascading of information in line with the plan proved effective.

Requires improvement

Are services safe?

The practice had carried out a fire risk assessment in June 2014 that included actions required to maintain fire safety. Records showed that 41 out of 47 staff were up to date with fire training and that the practice had carried out a planned fire drill in September 2014.

Risks associated with staffing changes were monitored by the reception supervisor who managed duty staff rotas for both clinical and non-clinical staff. Staff told us the practice expected them to be flexible and cover colleagues who may either be on leave or sick. Overtime was available to staff who worked extra hours.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Patients' needs were assessed and treatment was delivered in a way which followed national standards and guidance. 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. Patients confirmed that they received an in depth assessment of their symptoms before GPs and nurses recommended treatment.

The GPs told us they led in specialist clinical areas such as diabetes, heart disease and asthma and the nurses supported this work, which allowed staff to focus on specific conditions. Clinical leads had specific training to support them in these roles.

Patients aged over 75 had a named GP to help provide continuity in care planning and delivery. Patients with long term conditions, such as diabetes, were offered 30 minute health reviews to assist management of their conditions. This enabled staff to provide comprehensive checks and offer advice to patients. Nurses also led in managing specific conditions. We spoke with nurses who led in diabetes and asthma care and found they received specific training and support to fulfil these roles. There was a process the practice used to review patients recently discharged from hospital and this ensured GPs reviewed the needs of these patients, according to need.

We saw no evidence of discrimination when making care and treatment decisions. Interviews with GPs and practice staff showed that the culture in the practice was that patients were referred on need and that age, sex and race was not taken into account in this decision-making.

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. For example, patients who required medicines, such as Warfarin, to thin their blood were given doses of medicine in accordance with national prescribing guidance.

Management, monitoring and improving outcomes for people

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, and managing child protection alerts and medicines management. This information was collated to support the practice to carry out clinical audits.

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. The practice showed us 11 clinical audits that had been undertaken in the last two years. Two of these were completed audits where the practice was able to demonstrate the changes resulting since the initial audit. For example, following an audit of patients taking simvastatin (a cholesterol lowering medicine) alongside amlodipine or diltiazem (medicines used to treat raised blood pressure and angina) alerts were placed on patients notes to advise GPs of the lower recommendend maximum level of simvastatin and advice to change the medicine to atorvastatin (a similar cholesterol lowering medicine).

Other examples included an annual audit to confirm that a GP who undertook contraceptive device fittings was doing so in line with their registration and National Institute for Health and Care Excellence guidance.

Practice meetings were held where updated guidelines were shared with staff. Records confirmed this. Staff told us they openly raised and shared concerns about clinical performance and anything they felt was important to them. GPs told us they completed regular NHS health checks to identify potential health conditions which gave them the opportunity to work with the patients about how to manage these conditions proactively. The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. For example, 82% of patients with dementia had their care reviewed face to face and 96% of patients with diabetes, on the register, had a record of a foot examination within the preceding 12 months. The practice was not an outlier for any QOF (or other national) clinical targets.

Good

Are services effective?

(for example, treatment is effective)

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.

The practice had achieved and implemented the Gold Standards Framework for end of life care. It had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss the care and support needs of patients and their families.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as annual basic life support.

There was a structured induction programme in place for new members of staff and records confirmed this was used. Areas covered included arrangements for computer access, sickness reporting, health and safety and confidentiality.

GPs undertook regular training including that provided by the clinical commissioning group. This kept GPs up to date with how to promote best practice. GPs and nursing staff met regularly to talk about individual patient's care needs. Treatment options were discussed to ensure best practice was promoted and followed. There were arrangements in place to support learning and professional development. These included NHS appraisals and practice staff annual appraisals. Staff confirmed there were annual appraisal meetings which included a review of their performance, forward planning and the identification of training needs. We were told these were positive. Practice nurses were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these. For example, three nurses were trained to carry out family planning services and all had family planning diplomas. A nurse practitioner had prescribing and history taking training and four nurses who carried out cervical smear tests had received appropriate training and monitoring of their practice to ensure they were competent.

The practice manager told us that poor performance was monitored by line managers for non-clinical staff and fed back to them for appraisal. Clinical performance which required improvement would be picked up by significant events and complaints and dealt with accordingly.

Working with colleagues and other services

There were arrangements in place for engagement with colleagues and other health and social care providers and we saw evidence that services worked well together to ensure that he needs of patients were met.

Practice meetings were held every Monday and attended by GPs, practice manager, lead nurse, and nurse practitioner. Palliative care meetings were held bi-monthly and safeguarding meetings were held every three months and attended by GPs, health visitors, the nurse practitioner and lead nurse

Patient treatment information gathered by the out-of-hours service was shared with the practice the following morning via an electronic document system called DocMan. Information was reviewed by the relevant GP first thing each morning and followed up by additional actions and any urgent matters were seen to the same day as required. GPs operated a buddy system to ensure this information was reviewed in a timely way when one was away from the practice. All staff we spoke with understood their roles and felt the system in place worked well. There were no instances identified within the last year of any results or discharge summaries that were not followed up appropriately.

Information sharing

Patient information was stored on the practice's electronic record system which was held on practice computers that were all password protected. This information was only accessible to appropriate staff.

The practice had an area which contained historical paper patient records. This was located away from the public areas of the practice and accessed only by authorised staff via key coded doors.

Reception and administration staff had systems in place to add to patient records information that was received from other healthcare providers. We saw that information was transferred to patient records promptly following out of hours or hospital care.

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record system called INPS Vision to coordinate, document and manage patients' care. All staff were fully trained on the system, and commented positively about the system's

Good

Are services effective?

(for example, treatment is effective)

safety and ease of use. This software enabled computerised path links, radiology reports, discharge summaries, NHS 111 contacts, some clinical letters and out of hours contact information.

Consent to care and treatment

GPs and staff explained the discussions that took place with patients, to help ensure they had an understanding of their treatment options. We reviewed data from the national patient survey published in January 2015. This showed the practice was rated above the national patient satisfaction average by patients who were asked how good they felt the GP was at involving them in decisions about their care and treatment. Of the patients asked, 77% said they felt the GP was good or very good.

We found that staff were aware of the Mental Capacity Act 2005 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. When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision. A GP told us how they initiated or contributed to best interest meetings should a patient lack capacity to make a decision about their care. They added that they would always involve the mental health team and the practice adult safeguarding lead in this.

Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it) and had a section stating the patient's preferences for treatment and decisions. For example, 82% of patients with dementia had their care plans reviewed face to face in preceding 12 months.

All clinical staff 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 minor surgical procedures, initially a patient's verbal consent was documented in the electronic patient notes with a record of the relevant risks, benefits and complications of the procedure. For example, a GP who carried out punch biopsies (a system used for diagnosing skin conditions using a special instrument to punch a small hole in the skin to obtain a skin sample). They explained how they obtained written consent for the first injection and biopsy. They told us that the risk was explained again and consent obtained for subsequent injections/biopsies. We were shown an example of both the written and verbal consent and the explanation of risk recorded in patient's notes to confirm the system followed.

Health promotion and prevention

We saw a large range of health promotion information available at the practice and on its website. This information included preventative health care services available. For example, cervical smears and vaccinations for influenza (flu) and shingles. The practice manager told us whilst they did not meet with commissioners to discuss the implications of the joint strategic needs assessment they viewed information about this on the public health website and commented as appropriate.

The new patient registration form included information about a patient's medical history, alcohol intake, smoking status, diet, and carer responsibilities. It was practice policy that all newly registered patients were asked to complete a health questionnaire and then offered a consultation with a GP if medically appropriate or they wished to have a health check. If a new patient was taking warfarin, or medicines for an organ transplant, or had been told by their last GP that they were due a blood test soon after joining the practice they were requested to inform the practice, so that they could ensure that this happened at the correct time. New patient packs were available in reception and electronically on the practice's website.

The practice also offered NHS Health Checks to all its patients aged 40 to 74 years. Patients were invited on their 40th birthday. They were sent a letter and one reminder. Ad hoc health checks were also carried out if requested by the patient. Practice data showed that 293 of patients in this age group took up the offer of the health check.

The practice had numerous ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice kept a register of all patients with a learning disability and 42 were offered an annual physical health check. Practice records showed 62% had received a check up in the last 12 months. The practice actively offered nurse-led smoking cessation clinics to patients who wished to stop smoking. There was

Good

Are services effective?

(for example, treatment is effective)

evidence that 36 patients reported to have stopped smoking in the last 12 months. Similar mechanisms of identifying 'at risk' groups were used for patients who were obese and those receiving end of life care. These groups were offered further support in line with their needs. For example, the practice recognised that 1211 of its patients, over 16 years old, were obese. These and any other patients who requested support were offered 12 weeks free weight management with weight loss organisations and could also attend a local health centre where they received an introductory reduced rate membership. The practice was unable to tell us how many patients were reported to have successfully lost weight.

The practice's performance for cervical smear uptake was 80%, which was comparable to national figures. There was a policy to offer telephone reminders for patients who did not attend for cervical smears and the practice audited patients who do not attend.

The practice offered a full range of immunisations for children, travel vaccines and vaccinations in line with current national guidance. Flu vaccinations were offered to all the patients who were eligible (those over 65, in risk groups or pregnant). We were told that 76% patients came forward for this so far in the current 12 month period ending 31 March 2015. Shingles vaccinations were also offered and 78% of those patients invited took this up over the same period as the flu vaccinations. We were unable to compare these figures to local and national figures as the current year had not ended. However, when comparing the previous year we saw that the practice performed above the national average for patients who received the flu vaccination who were either over the age of 65 years of age or in an at risk group.

Last year's performance for all immunisations was above average for the clinical commissioning group, and again there was a clear policy for following up non-attenders by the named practice nurse or health care assistant.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We looked at the results of the most recent GP patient survey, published in January 2015. Results showed the practice was rated above the national patient satisfaction average by patients who were asked about how they were treated by GPs and nurses. Of the patients asked, 81% said they felt GPs treated them with care and concern and 86% also said they felt nurses treated them with care and concern. Patients completed CQC comment cards to tell us what they thought about the practice. We received 16 completed cards and almost all were positive about the service they experienced. Patients said they felt the practice offered an excellent service and staff were polite, helpful, welcoming and offered a first class service. They said staff treated them with dignity and respect. We also asked 12 patients on the day of our inspection and 10 said their dignity and privacy was respected all the time and two said this happened a lot of the time.

The waiting room and reception desk were in the same area of the practice. Staff were aware of the need for privacy and spoke quietly to patients. We asked 12 patients how they felt about this and seven said they didn't mind being overheard, two said they couldn't be overheard and three didn't know. The practice switchboard was located away from the reception desk which helped keep patient information private. There was a room available for patients to talk to staff about confidential matters. Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Disposable 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.

The evidence from all these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect.

Care planning and involvement in decisions about care and treatment

Patients were made aware of the options, services and other support available to them. We spoke with staff who confirmed that discussions took place about these options which enabled patients to make informed choices. Information was given verbally, via leaflets, printed by the GP and from the practice website. Staff told us that translation services were available for patients who did not have English as a first language.

The same national 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 rated the practice well in these areas. For example, data showed 77% of practice respondents said the GP involved them in care decisions and 85% felt the GP was good at explaining treatment and results. Both of these results were comparable to local clinical commissioning group practices in the area and better than national rating.

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

Patient/carer support to cope emotionally with care and treatment

The patients we spoke with on the day of our inspection and the comment cards we received showed us that patients found staff supportive and compassionate. We were told by patients that staff understood patient's personal circumstances and were able to respond to their emotional needs. GPs had their own patient lists which meant they had a closer relationship with patients which appeared to work well at times of crisis.

Staff told us GPs made contact with the bereaved relative/ spouse when they were made aware of a person had died. This was also confirmed by the GPs we spoke with who told us that whilst they didn't have a set policy they knew their own patients and families and would always invite their relative to an appointment to review or re-contact if required. If needed the GP would signpost family members and friends to bereavement support organisation such as Cruse Bereavement Care or support them themselves.

Good

Are services caring?

Information in the patient waiting room and the practice website signposted patients to a number of support groups and organisations including Cruse. The practice's computer system alerted GPs if a patient was also a carer.

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice was responsive to people's needs and had sustainable systems in place to maintain the level of service provided. Staff and GPs told us they took into account patients views and preferences as a natural part of consultations and would note this on their system. The practice was proactive in working with patients and their families. They worked closely with other providers in providing palliative care and ensuring patient's end of life wishes were recorded and shared with out of hour's providers.

We were shown the process staff followed when they received patient test results. This included making follow up appointments or arranging further tests. Staff confirmed this process when asked.

The practice was part of an Isle of Wight, drop-in service called, 'You're Welcome' which was an accredited young person's sexual health clinic for under 25 year olds. This service included outreach visits to a local high school, youth club and girl guides group by a Sandown Health Centre practice nurse. This resulted in a positive take up of contraceptive and sexual health services. Four GPs carried out contraceptive device fitting and provided emergency coil fitting for their own as well as patients registered at other practices. Patients were encouraged to attend the practice with minor injuries rather than going to A&E.

The practice also supported patients whose circumstances made them vulnerable. The practice also supported patients whose circumstances made them vulnerable. Services for these patients included clinics for adult and young people's alcohol, drug and mental health recovery.

The practice had a proactive patient participation group (PPG). We met with two members of the PPG who were extremely positive about the practice and told us they felt welcomed and involved in the development of the practice. Following feedback received by way of patient surveys carried out between 2011 and 2014 the practice increased in house blood test sessions, reupholstered waiting room seats and had purchased an electronic notice board for the waiting area.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. The practice had an equality and diversity policy. We observed staff acting in an appropriate way to every patient they engaged with. Staff said they had received equality and diversity training. However, training records supplied to us before our visit showed that only 14 of the 47 staff had received formal training.

The practice was accessible to disabled patients who required level access. We saw two disabled person's parking spaces positioned close to the entrance door. The practice had a wheelchair available for patients who found it difficult to manoeuvre around the practice.

We saw that the waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice and included baby changing facilities.

The practice was spacious and uncluttered throughout. The practice was situated on the ground and first floor of the building with most services for patients on the ground floor. Treatment rooms were large and easily accessible. There was lift access to the first floor. The practice had provided turning circles in the wide corridors for patients with mobility scooters. This made movement around the practice easier and helped to maintain patients' independence.

Patients who experienced poor mental health were offered support both at the practice and from external organisations which included a consultant psychiatrist, counsellor and iTalk. Longer appointments were also offered for these patients.

Practice staff had access to interpreting services, via language line and there were facilities for patients to translate the practice website into 90 different languages. Patients had access to fact sheets from the practice and from the practice website. These had been written to explain the role of the NHS to newly-arrived individuals seeking asylum. They covered issues such as the role of GPs, their function as gatekeepers to the health services, how to register and how to access emergency services. Sheets were available in a choice of 20 different languages which included; Polish Albanian, Urdu, Somali and Croatian.

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

The practice also had a regular intake of temporary patients. These were generally people on holiday on the Isle of Wight. Homeless people were also registered as temporary patients and treatment offered appropriately.

Access to the service

Appointments were available from 8.30am to 6.00pm on weekdays. The practice also held evening surgeries on Wednesdays and Thursdays between 6.30pm and 8.00pm for pre-booked appointments only. The practice's extended opening hours on these days was particularly useful to patients with work commitments and older patients who were taken to the practice by working relatives.

The practice offered different types of appointments which included routine appointments that could be booked up to five weeks ahead usually with a GP of choice. One day appointments were released at 8.00am every morning. If a patient wished to speak to a GP without an appointment they could request a GP called them back later the same day. There was also an open ended 'sit and wait' surgery everyday where patients who wished to be seen the same day could log in with reception and wait to be seen.

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 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. Dedicated GPs also made weekly visits to patients residing in local care homes.

Patients were satisfied with the appointments system and ease of getting through to the practice by phone. We looked at the results of the most recent GP patient survey, published in January 2015. Of the patients asked, 93% said their last appointment was convenient and 77% said they found it easy to get through to the practice by phone both of these were higher than national patient satisfaction averages. We did however receive one comment card which informed us that a patient had difficulty in getting through to the practice by phone at 8am.

Comments received from patients showed that patients in urgent need of treatment had often been able to make appointments on the same day of contacting the practice. One patient commented about two separate occasions when they rushed their young children to the practice. They said that staff cared for the children swiftly on both occasions.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its complaints policy had been reviewed in November 2014 and was in line with recognised guidance and contractual obligations for GPs in England. There was a designated responsible person who handled complaints in the practice. How to complain information was available on the practice website and in the practice leaflet and on request in reception. Patients we spoke with told us they knew how to make a complaint if they felt the need to do so.

We were shown a spread sheet which contained brief details of complaints and was told that full details of complaints and resulting investigations were kept separately. We reviewed the complaints folder that contained details of all complaints raised. All complaints had been dealt with appropriately; investigated and the complaint responded to in a timely manner. Staff reported that complaints which were relevant to them were relayed either at the practice meetings or via individual feedback if this was appropriate.

For example, a complaint was made by a patient who was given a smear test during a 'well woman' check-up when it wasn't needed because it was not due. As a result of this the patient complained. We saw evidence of a full investigation plus an apology letter which was sent to patient. We also saw a letter of acceptance and thanks received from patient. As a result of this nurses checked Open Exeter (a national NHS screening programme which traces and checks screening histories) to confirm that smear is actually due before proceeding.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to offer the highest standard of patient-centred healthcare.

We found details of the vision on the practice website. All the staff we spoke with knew and understood the vision and values and knew what their responsibilities were in relation to these

We were shown the practice's five year business plan which was dated October 2013. Areas identified included, current service provision, changes to staff over the next five years, strategic direction and planned developments. Staff told us they were not formally involved in the business planning, but it was cascaded down as appropriate through practice meetings.

Governance arrangements

There were governance arrangements in place and staff were aware of their own roles and responsibilities. Staff were clear about these and understood what they were accountable for. For example, we saw that some staff members had designated lead roles for different aspects of the practice. This included roles such as safeguarding infection control medical emergency medicines lead. Staff told us they followed strict confidentiality guidelines. Training records seen confirmed that all but one member of staff had received information governance training. All staff who worked at the practice were made aware of the Caldicott provision (this sets out a number of general principles which health and social care organisations should use to protect patient/client personal information).

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 six of these policies and procedures which were up to date. These included; cold chain policy, information governance, confidentiality agreement and chaperone policy. The practice manager explained that the practice used a mix of policies from different sources but was in the process of standardising and using one source which would allow staff online access, version control and tracking of when staff had read each policy.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed it in 2013/14 they had met 99.8% of the outcomes. This was higher than the national average for GP practices. We saw that QOF data was regularly discussed at monthly team meetings and action plans were produced to maintain or improve outcomes.

The practice had arrangements for identifying, recording and managing most risks. We saw that the risks were regularly discussed at team meetings and updated in a timely way. For example, a fire risk assessment was seen and records kept of fire alarm tests, fire extinguishers, emergency lighting tests, fire doors and fire evacuation drills. However, risks relating to medicines management and infection control.

Leadership, openness and transparency

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 the senior partner was the lead for safeguarding. Staff 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. GPs told us they had an equal say in the running of the practice and staff confirmed this too.

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 which included the practice training policy, disciplinary procedure, grievance procedure and sickness and absence policy. We were shown the electronic staff handbook that was available to all staff, which included sections on equality and harassment and bullying at work. Staff we spoke with knew where to find these policies if required.

Seeking and acting on feedback from patients, public and staff

The practice had gathered feedback from patients through the national patient survey, patient participation group surveys and compliments and complaints. We saw that there was a robust complaints procedure in place, with details available for patients in the practice leaflet and on

Are services well-led?

Good

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

its website. We reviewed complaints made to the practice over the past twelve months and found they were fully investigated with actions and outcomes documented and learning shared with staff through team meetings.

We reviewed the results of the GP national survey, published in January 2015, and noted 86% of patients described their overall experience of the practice as good. Also, of those asked, 90% said they would recommend the practice to someone new to the area. This was higher than the national patient satisfaction average.

The practice had an active patient participation group (PPG) which had been in place since 2011. The PPG included representatives from various population groups. These included patients across all age ranges, and patients who were English, Polish and Indian. The PPG met every three months and meetings were supported by the practice manager and GPs always attended. The practice manager showed us the analysis of the last patient survey, which was considered in conjunction with the PPG. The results and actions agreed from these surveys are available on the practice website.

The practice engaged with staff through meetings which were held at least monthly. Appraisals were carried out annually and training needs identified and met. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients. The practice had a whistleblowing policy which was available to all staff in the staff handbook and electronically on any computer within the practice.

Management lead through learning and improvement

Sandown Health Centre was a GP training practice for 5th year medical students. We were told the practice had trained students since 1988 and recently applied to become a placement for trainee nurses.

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We were told appraisals took place which records confirmed. We looked at four staff files and saw that regular appraisals took place which included a personal development plan. Nursing staff did not operate a peer review system but did meet up and communicate with other practice nurses regularly. A lead nurse at the practice was chair of the local practice nurse forum. From the summary of significant events and complaints we were provided with and speaking with staff we saw learning had taken place and improvements were made.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment We found that the registered person did not ensure that effective systems were in place to assess the risk of, and prevent, detect and control the spread of infections. An action plan required following an infection control audit and an annual infection control statement had not been written. This was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12 (2)(h) of the Health and Social Care Act 2008 (Regulated Activities)Regulations 2014. The registered person must - Ensure the effective operation of systems designed to assess the risk of and to prevent, detect and control the spread of a health care associated infection.