

Glovers Lane Surgery

Quality Report

Magdalen Square

Netherton

Bootle

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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

This is the report of findings from our inspection of Glovers Lane Surgery. The practice is registered with the Care Quality Commission to provide primary care services.

We undertook a planned, comprehensive inspection on 12 November 2014 at the practice location in Magdalen Square, Netherton. We spoke with patients, relatives, staff and the practice management team.

The practice was rated as Good. They provided effective, responsive and compassionate care that was well led and addressed the needs of the diverse population it served.

Our key findings were as follows:

- The practice had a good track record for maintaining patient safety. Effective systems were in place to ensure patients were safe from risks and harm. Incidents and significant events were identified,

investigated and reported. Lessons learnt were disseminated to staff. However improvements were required to ensure staff were safely recruited and required information was held in relation to staff.

- Patients spoke highly of the practice. They were very pleased with the individualised care given by all staff and told us staff were kind, compassionate and caring.
- The practice served a diverse population in a deprived area of Liverpool. The practice provided good care to its population taking into account their health and socio economic needs. Patients were listened to and feedback was acted upon. Complaints were managed appropriately.
- People's needs were assessed and care was planned and delivered in line with current legislation.
- The practice continued to monitor, evaluate and improve services. They worked in collaboration with the CCG and NHS England. Staff enjoyed working for the practice and felt well supported and valued.

Summary of findings

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

Importantly, the provider must:

- Take action to ensure its recruitment arrangements are in line with Schedule 3 of the Health and Social Care Act 2008 to ensure necessary employment checks are in place for all staff and these checks are relevant to their roles.

The provider should:

- Ensure audits follow a consistent format and are shared and disseminated across all staff and departments. The audit cycle should be fully completed in order to demonstrate actions taken have enhanced care and improvements have been made.
- Ensure the procedures for storage of paper patient records meet health and safety and fire regulations in accordance with the Department of Health's code of Practice for Records Management (NHS Code of Practice 2006) and other relevant guidance about information security and governance

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?

The practice is rated as requires improvement for providing safe services as there are areas where it should make improvements. Information from NHS England and the Clinical Commissioning Group (CCG) indicated that the practice had a good track record for maintaining patient safety. Effective systems were in place to provide oversight of the safety of patients. Incidents and significant events were identified, investigated and reported. Lessons learnt were disseminated to staff. Staff took action to safeguard patients and when appropriate, made safeguarding referrals. Required information relating to staff and their suitability for their role was not available, checked or held by the practice.

Requires improvement



Are services effective?

The practice is rated as good for providing effective services. National and local data showed patient outcomes were mostly average for the locality. The National Institute for Health and Care Excellence (NICE) guidance was accessible, referenced and used routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessment of capacity and health promotion. Staff had received training appropriate to their roles and further training needs had been identified and planned. The practice carried out appraisals and personal development plans were in place for all staff. Multidisciplinary and good team working was evident.

Good



Are services caring?

The practice is rated as good for providing caring services. Patients we spoke with and who completed the CQC comment cards were very complimentary about the service. They all found the staff to be patient-centred and felt they were treated with dignity and respect. We observed a patient-centred culture and found strong evidence that staff were motivated and provided kind and compassionate care. Staff we spoke with were aware of the importance of providing patients with privacy and of confidentiality.

Good



Are services responsive to people's needs?

The practice is rated as good for providing responsive services. The practice reviewed the needs of their local population. They engaged with the local Neighbourhood Team and the local Clinical Commissioning Group (CCG) to secure service improvements where

Good



Summary of findings

these were identified. The practice had acted to improve access to the appointments system. Urgent appointments were available the same day and home visits made where the need arose for vulnerable patients.

The practice responded appropriately to complaints about the service. There was an accessible complaints system.

Are services well-led?

The practice is rated as good for being well-led. Staff were clear about the practice values and vision and their responsibilities in relation to these. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity. Regular team meetings were held. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients. Staff had received induction, were well trained, received regular performance reviews and attended staff meetings.

Good



Summary of findings

The six population groups and what we found

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

Older people

The practice did not have a high population of elderly patients. The practice population age range was predominately in the 15 to 60 years old group. However, we saw that care was tailored to individual needs and circumstances, including a person's expectations, values and choices. Care and treatment was delivered in line with current published guidelines and good practice. For example the Quality and Outcomes Framework (QOF) information indicated the percentage of patients aged 65 and older who had received a seasonal flu vaccination was similar to the national average. It offered 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 extended appointments for those with enhanced needs.

The practice safeguarded older vulnerable patients from the risk of harm or abuse. There were policies in place, staff had been trained and were knowledgeable regarding vulnerable older people and how to safeguard them.

Good



People with long term conditions

The practice had a higher than average number of patients with long standing health conditions (65% of its population). There was a higher than average number of patients claiming disability allowance (9.9% of its population). Patients with long term conditions were supported by a healthcare team that cared for them using good practice guidelines and were attentive to their changing needs. There was proactive intervention for patients with long term conditions. Patients had health reviews at regular intervals depending on their health needs and condition. Registers of patients with long term conditions enabled the practice to monitor this population group's needs as a whole. Quality and Outcomes Framework (QOF) information indicated that patients with long term health conditions received care and treatment as expected for the national average including for example patients with diabetes having had regular screening and monitoring.

We spoke to patients with long term conditions at the inspection, they all said they received very good care and treatment; staff treated them with care, compassion and respect. The practice was fully accessible to disabled patients.

Good



Summary of findings

Families, children and young people

The practice served a higher than average younger population with the majority of patients in the 15 to 64 years of age group. We spoke with four patients who were younger than 64 years old and who had children and babies or were pregnant. We received positive feedback regarding their care and treatment at the practice. They told us they were confident with the care and treatment provided to them. We spoke with one patient who had children with differing complex health needs. They told us the practice cared for her and her family with respect and understanding of the children's complex needs.

Staff demonstrated a good understanding of safeguarding and protecting children from the risk of harm or abuse. The practice had a clear means of identifying in records those children (together with their parents and siblings) who were subject to a child protection plan. The practice had appropriate child protection policies in place to support staff and staff were trained to a level relevant to their role in safeguarding and child protection.

In some age groups there was a lower than average uptake of children receiving their childhood immunisations. The practice ran a weekly baby clinic with one of the GPs leading on this. They offered a full range of childhood vaccinations and chased up with text messages and phone calls those who had missed their vaccinations.

Good



Working age people (including those recently retired and students)

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

The practice had a higher than average working age population with the majority of patients falling within the 15 to 64 years of age group. The practice also served those in a high area of deprivation and with a higher than average number of unemployed people. The practice cared for this population group well with care and with compassion. The practice offered extended hours and telephone consultations that were appreciated by those working patients. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflected the needs for this age group.

We spoke with patients from this group. They told us they received good care from staff that were kind, caring and compassionate and that they had confidence in.

Good



People whose circumstances may make them vulnerable

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

Good



Summary of findings

The practice was aware of their vulnerable patients. The practice cared for children and older people living within high income deprivation and unemployment. They identified vulnerable patients and this was highlighted within patient records. The practice discussed any concerning patients as a team, safeguarding policies and protocols were in place and staff were trained in safeguarding vulnerable adults and children. The safeguarding lead was the lead GP who had received appropriate training.

The practice held a register of patients living in vulnerable circumstances including homeless people and those with a learning disability. They carried out annual health checks for people with a learning disability and cared for a group of patients with learning disabilities living in a local care home. It offered longer appointments for people with a learning disability when needed. The practice had a patient who had no fixed abode on their register. They ensured they would be able to receive medication and healthcare appropriately despite them not having a permanent place to live.

People experiencing poor mental health (including people with dementia)

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

The practice maintained a register of patients who experienced poor mental health. The register supported clinical staff to offer patients an annual appointment for a health check and a medication review. The practice monitored patients with poor mental health according to clinical quality indicators and in line with good practice guidelines. 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.

Good



Summary of findings

What people who use the service say

We spoke with ten patients on the day of our inspection and we received 31 completed CQC comment cards. Patients whom we spoke with varied in age and population group. They included older people, those with long term conditions, those of working age, those with a mental health condition and mothers and younger people.

All patients were very positive about the practice, the staff and the service they received.

They told us the staff were helpful, caring and compassionate, they were treated with dignity and respect and had confidence in the staff and the GPs who cared for and treated them. A patient with children who had mental and physical health concerns told us how the practice was particularly good at caring for her and her family. They understood specific needs of the children and mother and treated them with care and compassion.

The main concern from speaking to patients, comment cards received on the day and from the patient survey was appointments. Patients told us that it was sometimes difficult to get through on the telephone, appointments

were sometimes difficult to get and they sometimes had delays in waiting times to see the GP. This had since been addressed with extended opening hours introduced at the practice in October 2014.

The results of the national GP patient survey published in July 2014 told us that 83% of respondents said the last GP they saw or spoke to was good at treating them with care and concern, 75% of respondents said the last GP they saw or spoke to was good at involving them in decisions about their care and 60% of respondents said the last nurse they saw or spoke to was good at treating them with care and concern. Seventy five percent described their overall experience of this practice as good. Sixty seven percent were satisfied with the surgery's opening hours. These results were on average or slightly lower than the national results.

Patients told us they liked the doctors and felt they were very caring and helpful. They said staff listened to them and nothing was too much trouble. Doctors were very professional, effective and caring. Patients told us the environment was clean and hygienic and up to the standard expected.

Areas for improvement

Action the service **MUST** take to improve

- The practice must ensure its recruitment arrangements are in line with Schedule 3 of the Health and Social Care Act 2008 to ensure necessary employment checks are in place for all staff and these checks are relevant to their roles

Action the service **SHOULD** take to improve

- Audits should follow a consistent format and be shared and disseminated across all staff and departments. The audit cycle should be fully completed in order to demonstrate actions taken have enhanced care and improvements have been made.
- The procedures for storage of paper patient records should meet health and safety and fire regulations in accordance with the Department of Health's code of Practice for Records Management (NHS Code of Practice 2006) and other relevant guidance about information security and governance.

Glovers Lane Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

We undertook an inspection on 12 November 2014.

Our inspection team was led by a CQC Lead Inspector and included a second CQC inspector, a GP and a specialist advisor who was a Practice Manager:

Background to Glovers Lane Surgery

Glovers Lane Surgery is registered with the Care Quality Commission to provide primary care services. It provides GP services for approximately 7,500 patients living in the Netherton area of Liverpool. The practice has four GP partners, a salaried GP, a practice manager, practice nurses, healthcare assistant and administration and reception staff. The practice is a GP training practice, offering support and experience to trainee doctors.

The practice is open Monday to Friday from 8.30am to 6pm with extended opening hours on Wednesdays until 8.30pm for working people. They are closed on one Wednesday per month for half a day for training and development. Patients can book appointments in person, online or via the phone. The practice provides telephone consultations, pre bookable consultations, urgent consultations and home visits. The practice treats patients of all ages and provides a range of medical services.

The practice is part of South Sefton Clinical Commissioning Group (CCG). The practice is situated in an area of high deprivation. The practice population is made up of a higher than national average younger population and a lower

than national average of patients aged over 60 years. Sixty five percent of the patient population has a long standing health condition and a higher than national average number of unemployed.

All clinical services are delivered under a GMS contract. The practice does not deliver out-of-hours services. These are delivered by Go To Doc (GTD), a private provider of out of hour's services commissioned by South Sefton CCG. They provide a service locally in Netherton.

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.

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?

Detailed findings

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

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

Before our inspection we carried out an analysis of the data from our Intelligent Monitoring system. We also reviewed information we held and asked other organisations and key stakeholders to share what they knew about the service. We reviewed the practice's policies, procedures and other information the practice provided before the inspection. The information reviewed did not highlight any significant areas of risk across the five key question areas. We carried out an announced inspection on 12 November 2014 and spent eight hours at the practice.

We reviewed all areas of the practice including the administrative areas. We sought views from patients face-to-face, looked at survey results and reviewed comment cards left for us on the day of our inspection.

We spoke with the practice manager, registered manager, GP partners, a GP registrar, practice nurse, healthcare assistant, administrative staff and reception staff on duty. We spoke with patients who were using the service on the day of the inspection.

We observed how staff handled patient information, spoke to patients face to face and talked to those patients ringing the practice. We discussed how GPs made clinical decisions. We reviewed a variety of documents used by the practice to run the service. We also talked with carers and family members of patients visiting the practice at the time of our inspection.

Are services safe?

Our findings

Safe track record

Reports from NHS England indicated that the practice had a good track record for maintaining patient safety. Information from the General Practice Outcome Standards (GPOS) showed no concerns. Information from the Quality and Outcomes Framework (QOF), which is a national performance measurement tool, showed that the provider was appropriately identifying and reporting significant events. GPs told us they completed incident reports and carried out significant event analysis routinely and as part of their on-going professional development. We looked at some recent significant events from 2014 which had been analysed, reported and discussed with relevant staff.

The practice had systems in place to monitor patient safety. The practice manager and GPs discussed significant events and showed us documentation to confirm that incidents were appropriately reported. The partner GPs discussed them at their meetings and if relevant at all staff team meetings. Action was taken to learn lessons and put measures in place to reduce the risk of the event recurring in the future. Staff told us how they actively reported any incidents that might have the potential to adversely impact on patient care. Concerns regarding the safeguarding of patients were passed on to the relevant authorities as quickly as possible. We were told there was an open and 'no blame' culture at the practice that encouraged staff to report adverse events and incidents.

The minutes of practice meetings we reviewed showed that new guidelines, complaints, incidents and significant events, were discussed. The staff we spoke with were positive about the use of incident analysis and how this assisted them to develop the care provided. The clinicians were confident that treatment approaches adopted followed best practice.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events. A log was held of all events and detailed dates, category of event and how and where feedback and learning points were discussed.

We looked at the records of significant events that had occurred in the last 12 months. There was evidence that appropriate learning had taken place where necessary and that findings were disseminated to relevant staff at team

meetings. However, there was no regular review overall of significant events to analyse themes and trends in order to improve learning and practice. 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.

We saw evidence to confirm that, as individuals and a team, staff were actively reflecting on their practice and critically looked at what they did to see if any improvements could be made. Significant events, incidents and complaints were investigated and reflected on by the GPs and practice managers. GPs told us significant event audits were included in their appraisals in order to reflect on their practice and identify any training or policy changes required for them and the practice. The team recognised the benefits of identifying any patient safety incidents and near misses.

National patient safety alerts were disseminated by the practice manager to relevant staff. Staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for. They also told us relevant alerts were discussed at team 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 up to date child protection and protection of vulnerable adult policies and procedures in place. These provided staff with information about identifying, reporting and dealing with suspected abuse. The policies were easily available to staff on their computers and in hard copy. Staff had easy access to contact details for both child protection and adult safeguarding teams. We saw evidence of such information displayed in clinical, reception and administrative areas.

All staff had received training in the last 12 months on safeguarding. Clinical staff had a higher level of training than other staff. All staff we spoke with were knowledgeable about the types of abuse to look out for and how to raise concerns. Staff were able to discuss examples of at risk children and how they were cared for. Staff were made aware through an alert system on the computer and electronic records of vulnerable people and their immediate families.

Are services safe?

One of the GPs took the lead for safeguarding and had attended appropriate training to support them in carrying out their work, as recommended by their professional registration safeguarding guidance. They were supported by the practice nurse who was deputy safeguarding lead. They were knowledgeable about the contribution the practice could make to multi-disciplinary child protection meetings and serious case reviews. The safeguarding lead did not regularly attend local case conferences due to time constraints; however they did complete reports when necessary. All staff we spoke to were aware who the lead was and who to speak to in the practice if they had a safeguarding concern. All GPs were appropriately using the required codes on their electronic case management system to ensure risks to children and young people who were looked after or on child protection plans were clearly flagged and reviewed. The lead GP was aware of vulnerable children and adults at the practice.

The practice had a current chaperone policy. We saw evidence that non clinical staff who may be asked to act as a chaperone had received appropriate training for this role. There was a notice advising patients of the option to have a chaperone displayed in the reception area.

Medicines management

We checked medicines stored in the treatment rooms and fridges. We found that they were stored appropriately. There was a current policy and procedures in place for medicines management including cold storage of vaccinations and other drugs requiring this. We saw the checklist that was completed daily to ensure the fridge remained at a safe temperature and staff could tell us of the procedure in place for action to take in the event of a potential failure of the cold chain. All medicines that we checked were found to be in date.

Medicines for use in medical emergencies were kept securely in a cupboard in the reception office. We saw evidence that stock levels and expiry dates were checked and recorded on a regular basis. Staff knew where these were held and how to access them. The emergency medicines were also used in the case of doctors needing to take them on a home visit. We found there was sufficient stock of emergency medicines to ensure the practice was safe at these times; however there was no evidence that they were checked or signed for when the doctor removed

and replaced them. There was oxygen kept by the practice for use in case of an emergency. This was checked for function regularly. It was stored in one of the treatment rooms with an appropriate warning sign on the door.

The practice worked with pharmacy support from the Clinical Commissioning Group (CCG) to support the clinical staff in keeping up to date with medication and prescribing trends. The CCG pharmacy support visited the practice and regular meetings were held with them to discuss medicines optimisation plans.

Spare prescription pads were stored securely. Prescription pads held in the printer within the treatment rooms were kept out of sight but not locked and so there was a possible risk of them being stolen. Repeat prescriptions were held securely in the administration office. We saw these were not pre signed. Prescriptions waiting for collection were monitored to ensure they had all been collected and patients were not missing their medication.

GPs reviewed their prescribing practices as and when medication alerts were received. Patient medicine reviews were undertaken on a regular basis depending on the nature and stability of their condition.

Cleanliness and infection control

Patients commented that the practice was clean and appeared hygienic. The practice had an infection control audit undertaken by the community trust infection control team in June 2013. The practice had obtained 98% compliance with the audit. Cleaning was undertaken by specific cleaning staff, the practice manager monitored the cleaning schedule and standard of cleaning.

The practice nurse was lead for infection control. They had received training in infection control and this was updated annually.

We inspected the treatment and clinical rooms. We saw that all areas of the practice were clean and processes were in place to manage the risk of infection. We noted some of the consultation rooms, the reception area and corridor to rooms were covered with carpet. These carpets were old and stained. This was not suitable flooring in order to minimise risk of infection however we were told and saw evidence that bids had been submitted for funds to replace carpets with suitable laminate flooring.

There was an up-to-date infection control policy and associated procedures in place. A needle stick injury policy

Are services safe?

was in place, which outlined what to do and who to contact in the event of accidental injury. Needle stick injury flow charts were displayed in all treatment and consultation rooms. We saw current protocols for the safe storage and handling of specimens and for the safe storage of vaccines. These provided staff with clear guidance and were in line with current best practice.

Infection control training was undertaken by all staff. Appropriate frequency of updates was evident for different roles, for example, clinical staff had annual updates whilst non clinical staff had three yearly updates. Staff understood their role in respect of preventing and controlling infection. For example reception staff could describe the process for handling submitted specimens.

We observed all consultation and treatment rooms had adequate hand washing facilities. Instructions about hand hygiene were available throughout the practice with hand gels in clinical rooms. We found protective equipment such as gloves and aprons were available in the treatment/consulting rooms. Couches were washable. Privacy curtains in the treatment rooms were dated to identify when they were last replaced.

We were told the practice did not use any instruments which required decontamination between patients and that all instruments were for single use only. Procedures for the safe storage and disposal of needles and waste products were evident in order to protect the staff and patients from harm.

The practice did not undertake regular testing and investigation of legionella (bacteria found in the environment which can contaminate water systems in buildings). We saw a risk assessment which determined the risk of infection was low due to them not having any standing water. However on discussion with the practice manager it emerged that regular testing and management of legionella was being considered to further reduce the risk of infection to staff and patients.

Equipment

Staff we spoke with told us they had sufficient and suitable equipment to enable them to carry out diagnostic examinations, assessments and treatments.

All equipment was tested and maintained regularly and we saw equipment maintenance logs, contracts and other records that confirmed this. The practice had contracts in

place for annual checks of fire extinguishers and 'portable appliance testing'. The practice undertook annual calibration and servicing of medical equipment. We saw contracts and service records to demonstrate this

Emergency drugs were stored in a separate cupboard. There was an oxygen cylinder, nebulisers and an automated external defibrillator available at the practice. These were maintained and checked regularly.

Staffing and recruitment

An up to date recruitment policy was in place. We looked at a sample of recruitment files for doctors, reception and administrative staff, practice manager and nurses. The practice employed locum GPs. We were told they independently checked the suitability of locum doctors as well as reviewing the NHS performer's lists. We saw evidence of this.

We found gaps in the required information relating to workers in the staff files that we looked at. We looked at nine staff records. There were appropriate Criminal Records Bureau (CRB) or Disclosure and Barring Service (DBS) checks for the clinical staff (including practice nurses and GPs). CRB and DBS checks for non-clinical staff had not been carried out; however these staff sometimes undertook chaperoning duties. Staff undertaking chaperoning duties are required to have full employment checks including a CRB or DBS.

There were other gaps in the recruitment files such as not all staff had two references obtained prior to employment, nor did we see any evidence that checks had been undertaken to ensure staff were physically and mentally fit to undertake the roles and responsibilities required; however these staff had been employed for some time and prior to the requirements relating to workers information. We looked at the files of two staff who had been most recently employed; these demonstrated the required information was available. However there was no evidence of qualifications recorded for one of them. We were told that at interview the relevant documents had been seen but not copied and held on file as they should have been.

There was a system in place to record professional registration General Medical Council (GMC). However Nursing Midwifery Council (NMC) checks were not undertaken. We discussed this with the practice manager

Are services safe?

who told us they would implement a system of checks immediately. However we did see evidence that demonstrated professional registration for clinical staff was up to date and valid.

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. Procedures were in place to manage expected absences, such as annual leave, and unexpected absences through staff sickness. The staff worked extremely well as a team and as such supported each other in times of absence and unexpected increased need and demand. The practice manager and GP oversaw the rota for clinicians and we saw they ensured that sufficient staff were on duty to deal with expected demand including home visits and chaperoning.

The practice had developed clear lines of accountability for all aspects of care and treatment. The diversity and skill mix of the staff was good; each person knew exactly what their role was and undertook this to a high standard. Staff were skilled and knowledgeable in their field of expertise and were able to demonstrate how they could support each other when the need arose.

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. An up to date risk assessment log was seen. Each risk was assessed, rated and control measure recorded to reduce and manage the risk.

In May 2013 the practice underwent an independent Clinical Risk Assessment, carried out by the Medical Protection Society (MPS). The practice was judged at this assessment to be one of the best performing practices nationally.

The practice used electronic record systems that were protected by passwords on the computer system. We saw a

large number of historic paper records that were stored in open shelves around the reception and office area. We found that records storage conditions did not provide environmentally safe protection for archived and paper records. Records are a valuable resource because of the information they contain. A risk assessment had been undertaken of this storage system and deemed a low risk. The practice told us they were considering other more suitable storage systems for these paper records.

Arrangements to deal with emergencies and major incidents

There was a current emergency incident procedure in place. Staff could describe how they would alert others to emergency situations by use of the panic button on the computer system. During our visit we observed a medical emergency and this was dealt with appropriately by all staff.

A current business continuity plan was in place. The plan covered business continuity, staffing, records/electronic systems, clinical and environmental events. Key contact numbers were included and paper and electronic copies of the plan were kept in the practice and by the practice manager and GPs. Staff we spoke with were knowledgeable about the business continuity plans and could describe what to do in the event of a disaster or serious event occurring.

Staff had received training in dealing with medical emergencies including cardiopulmonary resuscitation (CPR). There was suitable emergency equipment and medicines available. Equipment included an automated external defibrillator, nebulisers and oxygen. These had been checked regularly and maintained.

There was a current fire procedures policy in place which identified key personnel, such as fire marshals and their duties in the event of a fire. Weekly fire alarm tests were carried out and equipment maintained by the contracted company. A fire evacuation drill had not taken place in 2014. The practice manager told us this was being planned for the near future

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The clinicians were familiar with, and using current best practice guidance. The GPs we spoke with could clearly outline the rationale for their treatment approaches. The staff we spoke with and evidence we reviewed confirmed that these actions were aimed at ensuring that each patient was given support to achieve the best health outcome for them. We found from our discussions that staff completed, in line with The National Institute for Health and Clinical Excellence (NICE) and local commissioners' guidelines, assessments of patients' needs and these were reviewed appropriately. NICE guidance was stored on the shared drive in the computer system so that staff had easy access to them. The practice had built bespoke protocols and alerts within the clinical system to ensure that patients with specific needs were highlighted to staff on opening the clinical record. For example, patients on the unplanned care register and palliative care register.

The practice nurse managed certain long term conditions such as diabetes, heart disease and asthma. This meant they were able to focus on specific conditions and provide patients with regular support based on up to date information. GPs also specialised and led in clinical areas such as safeguarding, minor surgical procedures and chronic diseases. Staff meetings and other clinical meeting minutes demonstrated that staff discussed patient treatments and care and this supported staff to continually review and discuss new best practice guidelines.

The practice provided a service for all age groups. They provided services for people in the local community including a younger than average population with a higher than average number of unemployed, patients living in deprived areas and those experiencing poor health with a lower than average life expectancy. We found GP's and other staff were familiar with the needs of each patient and the impact of the socio-economic environment. The practice had access to language translator services with which they had a contract. The practice nurses had completed accredited training around checking patient's physical health and specific disease/condition management.

The practice referred patients appropriately to secondary care and other services. We saw that the practice's referral rates for healthcare conditions reflected the national

standards for referral rates. All GPs we spoke with used national standards for referral, for example suspected cancers. They completed referral letters using templates on the computer system. There was an electronic audit trail for acting on test results and hospital consultation letter. Any information not received electronically was scanned into the system daily and alerted to the named GP. In the absence of this named GP the on call duty doctor would assess and action any such information.

We saw no evidence of discrimination when making care and treatment decisions. Interviews with GPs 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 that the GPs and clinicians ensured consent was obtained and recorded for all treatment including written consent for minor surgical procedures. One of the GPs carried out joint injections and minor surgical procedures. They did this in line with their registration and NICE guidance. The GP was appropriately trained to carry out this procedure and they ensured their skills and knowledge was kept up to date. They also had access to supervision and support from the local trust dermatology department when undertaking removal of skin lesions.

Management, monitoring and improving outcomes for people

The practice routinely collected information about patients' care and treatment. They used the Quality and Outcomes Framework (QOF) to assess their performance and undertook regular clinical audit. QOF data showed the practice performed averagely in comparison to local practices. The practice regularly monitored the Primary Care Quality Framework (PCQF) to identify all the practice performance areas. We discussed with the GPs and they showed us data from the local CCG of the practice's performance for medicines prescribing, which was comparable to similar practices. They regularly benchmarked their prescribing practices to other locality practices and considered their prescribing to be average with a predicted underspend of 2.5% this financial year.

Examples of clinical audits included; appointment system, A & E attendances and a variety of medicines management audits. The practice showed us four of the clinical audits that had been undertaken in the last 12 months. Two of these were completed audits where the practice was able to demonstrate the changes resulting since the initial audit.

Are services effective?

(for example, treatment is effective)

Two of these we looked at did not clearly identify the criteria or standards that were being audited, nor were they dated. They did contain a lot of information about the NICE guidelines being audited.

Clinical audits were often linked to medicines management information, local Clinical Commissioning Group (CCG) and locality performance indicators or as a result of QOF performance. Medicines management audits were undertaken in conjunction with the medicines management team from the local CCG. As an example, we saw an audit assessing Gliptin compliance with NICE guidance in general practice. This audit had a second cycle and demonstrated quality improvement for patients. Gliptins are a class of oral hypoglycaemic that can be used to treat diabetes mellitus type 2.

Discussion of audits, performance indicators and quality initiatives was evident in meeting minutes. Staff told us they received feedback through discussions and at meetings. However, we found that there was no overarching governance framework that pulled together all audits undertaken and shared this information and learning between all the staff. For example practice nurses had undertaken and completed their own audits but there was no evidence of these being discussed or shared between the clinical team and wider staff team.

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. Reception staff were involved in gathering lifestyle information from patients at the point of contact. This meant that for example, they had reached their target for collection of smoking data in QOF.

The practice had achieved and implemented the gold standards framework for end of life care. One of the GPs took the lead for this group of patients supported administratively by one of the reception/admin team. They had a palliative care register and held regular multidisciplinary meetings to discuss the care and support needs of patients and their families. We saw evidence of these meetings and saw evidence of patients and families identified as having these particular needs. Special notes were used to inform out of hours services of any particular needs of patients who were nearing the end of their lives. We discussed an example of successful implementation of the gold standards framework for a particular patient. It

was a complex case with risks to patient and carers however the patient was able to remain in their home, their preferred place of care. Additional support and care from the multidisciplinary teams ensured a positive outcome for the patient.

Effective staffing

The induction programme covered a wide range of topics including policies and procedures, confidentiality, staff training, organisational induction and job specific induction. We saw an example of a recent employee's induction checklist and they discussed with us the process of induction, however the checklist had not been completed or signed.

The practice had a mandatory training matrix which identified which subjects should be undertaken by which roles and the required frequency. The training matrix demonstrated that all staff were up to date with attending mandatory courses such as annual basic life support, infection control and safeguarding of vulnerable adults and children. Staff also had access to additional training related to their role. For example reception staff told us they had received conflict resolution and customer care training. Staff we spoke with told us they felt they were well trained and received good support to undertake training including that which was required by the practice and for training and development personal to their role. We confirmed that staff had the knowledge and skills required to carry out their roles.

The staff files we reviewed showed that staff of all disciplines had received an annual appraisal. Nursing staff did not have access to regular formal clinical supervision sessions. However they told us they regularly had team meetings and discussions with other clinical staff where they could discuss clinical issues and incidents. The administrative staff told us they were well-supported and regularly had conversations about their performance with their line manager. The practice had procedures in place to support staff in carrying out their work. For example, newly employed staff were supported in the first few weeks of working in the practice.

As the practice was a training practice, doctors who were training to be qualified as GPs had access to a senior GP throughout the day for support. Their clinical practice was reviewed regularly. We received positive feedback from the trainee we spoke with.

Are services effective?

(for example, treatment is effective)

All GPs were up to date with their yearly continuing professional development requirements and they had either been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by NHS England can the GP continue to practise and remain on the performers list with the General Medical Council).

The practice nurses performed defined duties and extended roles. They were able to demonstrate that they were appropriately trained to fulfil these duties. For example, on administration of vaccines and cervical cytology.

The practice manager and principal GP had ensured that all of the clinical equipment used in the practice was regularly calibrated and that relevant staff were competent to use it.

Working with colleagues and other services

The practice worked with other agencies and professionals to support continuity of care for patients. We were shown how the practice provided the 'out of hours' service with information, to support, for example, end of life care. Information received from other agencies, for example accident and emergency department or hospital outpatient departments were read and actioned by the GPs in a timely manner. Information was scanned onto electronic patient records in a timely manner.

The practice worked closely with other health care providers in the local area. The GPs and the practice manager attended various meetings for management and clinical staff involving practices across South Sefton CCG. South Sefton CCG organised themselves into localities and the practice met regularly with the CCG and other practices. These meetings shared information, good practice and national developments and guidelines for implementation and consideration. They were monitored through performance indicators and each practice was benchmarked. We saw evidence of performance monitoring with action plans developed for areas needing improvement.

The practice held multidisciplinary team meetings three monthly 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 also attended by district nurses, social workers, palliative care nurses and decisions about care planning were documented.

Information sharing

The practice used several electronic systems to communicate with other providers. Electronic systems were in place for making referrals using templates that the GPs completed and sent off.

The practice has signed up to the electronic Summary Care Record and planned to have this fully operational by 2015. (Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours).

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record 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.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. All the clinical staff we spoke to understood the key parts of the legislation and were able to describe how they implemented it in their practice. They gave examples in their practice of when best interest decisions were made and mental capacity was assessed prior to consent being obtained for a surgical procedure. All clinical staff demonstrated a clear understanding of Gillick competencies. (These help clinicians to identify children aged under 16 who have the capacity to consent to medical examination and treatment).

There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures, a patient's written consent was obtained and documented in the electronic patient notes with a record of the relevant risks, benefits and complications of the procedure.

Health promotion and prevention

The practice supported patients to manage their health and well-being. The practice offered national screening programmes, vaccination programmes, long term

Are services effective?

(for example, treatment is effective)

condition reviews and provided health promotion information to patients. They provided information to patients via their website and in leaflets and information in the waiting area about the services available.

The practice used a software package which enabled them to send and receive text messages from patients in order to send and receive information. For example this helped to improve call and recall of patients for areas such as flu vaccination, smoking and cervical smear uptake. The practice also provided patients with information about other health and social care services such as carers' support. Staff we spoke with were knowledgeable about other services and how to access them.

The practice used the coding of health conditions in patients' electronic records and disease registers to plan and manage services. For example, patients on disease registers were offered review appointments with the nurse.

The practice offered a health check to all new patients registering with the practice and also offered NHS Health Checks to all its patients aged 40-75. 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 average for the CCG.

The practice had 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 they were all offered an annual health check. There were local health and support groups that they accessed and referred patients with mental health and learning disabilities needs.

Are services caring?

Our findings

Respect, dignity, compassion and empathy

The practice had a patient dignity and respect policy in place. Staff we spoke with were aware of the importance of providing patients with privacy and of confidentiality. There was a room available if patients wished to discuss something with them away from the reception area. The computers at reception were shielded by a screen and the level of the desk to help maintain patient confidentiality.

Consultations took place in purposely designed rooms with an appropriate couch for examinations and screens to maintain privacy and dignity. We observed staff were discreet and respectful to patients.

The practice offered patients a chaperone prior to any examination or procedure. Information about having a chaperone was seen displayed in the reception area. Staff we spoke with were knowledgeable about the role of the chaperone and had received training to carry out this work.

Patients we spoke with told us they were always treated with dignity and respect in particular one patient who had children all with extra care needs told us about the very good care and support they received and felt that they were treated with dignity and respect in consideration of their children's disabilities. We found that staff knew the majority of their patients well and patients told us the practice had a family feel to it, the staff were all welcoming, caring and compassionate.

The most recent practice patient survey showed that 75% of patients who responded said overall satisfaction with the practice was good. The practice had a clear set of values and a mission statement, about patients being treated courteously and with confidentiality. This was reflected in the practice charter displayed in the practice.

Care planning and involvement in decisions about care and treatment

Patients told us they felt involved in decisions about their own treatment, they received full explanations about diagnosis and treatments and that staff listened to them and gave them time to think about decisions.

The patients told us they were happy to see any of the GPs or the nurses as they felt all were competent and knowledgeable. Most patients found that they had been able to see their preferred GP at every appointment and

two patients told us that this had been the case for well over five years. The rotas we reviewed showed that sufficient GPs and other clinicians were on duty to cover all the appointments including the extended hour's service.

Staff were knowledgeable about how to ensure patients were involved in making decisions and the requirements of the Mental Capacity Act 2005 and the Children's Act 1989 and 2005. GPs told us relatives, carers or an advocate were involved helping patients who required support with making decisions. For example when someone on the register for learning disabilities was called for their review the practice encouraged the patient's carer to attend also.

The practice had an 'access to records' policy that informed patients how their information was used, who may have access to that information, and their own rights to see and obtain copies of their records. Information was available for patients on the practice website and in leaflets.

Patient/carers support to cope emotionally with care and treatment

Patients were positive about the care they received from the practice. Patients we spoke with told us they had enough time to discuss things fully with the GP and most patients felt listened to and felt clinicians were empathetic and compassionate. They told us all the staff were compassionate and caring.

We observed that the reception staff treated people with respect and ensured conversations were conducted in a confidential manner. We observed that privacy and confidentiality were maintained for patients using the service on the day of the visit.

The practice had achieved and implemented the gold standards framework for end of life care. One of the GPs took the lead for this group of patients supported administratively by one of the reception/admin team. They had a palliative care register and held regular multidisciplinary meetings to discuss the care and support needs of patients and their families. We saw evidence of these meetings and saw evidence of patients and families identified as having these particular needs. Special notes were used to inform out of hours services of any particular needs of patients who were coming towards the end of their lives. We discussed an example of successful implementation of the gold standards framework for a particular patient. It was a complex case with risks to

Are services caring?

patient and carers however the patient was able to remain in their home, the preferred place of care, with additional support and care from multidisciplinary teams with a positive outcome for the patient.

GPs had various ad hoc methods of supporting bereaved patients. Some would contact them personally. The practice did not have a consistent protocol for communication and care of bereaved patients.

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 people'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 held information about the prevalence of specific diseases. This information was reflected in the services provided, for example screening programmes, vaccination programmes and reviews for patients with long term conditions and mental health conditions.

The practice cared for a number of adult patients who had a learning disability and lived in a local care home. Patients with dementia and enduring mental health conditions were reviewed annually. They were encouraged to bring carers with them to these reviews. The practice had implemented the 'named GP' for patients over 75 to support continuity of care. The practice was proactive in contacting patients who failed to attend vaccination and screening programmes. For example for women who had not attended for their cervical smear tests the practice used a software package to text alerts to those who had registered their mobile numbers with the practice.

The practice did not have an active Patient Participation Group (PPG). Attempts had been made to start up a PPG again with no success as patients did not respond. The practice looked at other methods to engage patients and have them contribute to and feedback regarding the service provided. Due to the majority of the population being younger than 65 years old, they decided on information technology to reach out to the patients. This included a Twitter and Facebook account (200 plus followers) and an electronic newsletter (300 subscribed to it). They also used the comments section of the website for feedback, comments cards and recently a smartphone application for the practice to keep patients up to date with service developments and initiatives. The software package they used could send and receive text information to and from patients and this fed directly into the computer system.

Tackling inequity and promoting equality

The practice was aware of the challenges they faced with their diverse population. They are situated in the Seaforth and Litherland locality which is in a deprived area of the

city. This presented various challenges due to socio economic disparity. The practice ethos strived to provide quality care to all patients taking into account their diverse needs. The practice analysed its activity and monitored patient population groups. This enabled them to direct appropriate support and information to the different groups of patients. The practice had a majority population of English speaking patients though it could cater for other languages as it had access to translation services.

The practice provided equality and diversity training for all staff. Records we saw demonstrated that all staff had completed the required training and were up to date.

The premises and services had been adapted to meet the needs of people with disabilities. All treatment and consultation rooms were located on the ground floor with doorways wide enough for wheelchair access. There were disabled parking and toilet facilities available also including baby changing facilities. We were told of a recent bid to NHS England for monies to enhance access by means of electronic door openings in the main entrance and reception area. There was an audio loop system in place in reception.

The practice demonstrated how they supported patients who had no fixed abode. They ensured all their post and medication was delivered to the surgery to ensure they did not go without information regarding their healthcare or without medication.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its complaints policy was in line with recognised guidance and contractual obligations for GPs in England and there was a designated responsible person who handled all complaints in the practice. This was the practice manager although they did liaise with all relevant staff in dealing with the complaints on an individual basis.

We looked at the complaints log for the last 12 months and found that complaints had been dealt with and responded to appropriately. The practice took action in response to complaints to help improve the service. Complaints were investigated thoroughly. A summary and overview log was recorded which broke down the complaints into subjects and themes, however there was no regular review overall of complaints, such as annually, to analyse themes and trends in order to improve learning and practice.

Are services responsive to people's needs?

(for example, to feedback?)

Patients we spoke with were all aware of the complaints procedure. An appropriate information leaflet detailing the process for making complaints or comments about the practice was available to take away at the reception desk. Staff we spoke with were trained in customer care and were able to tell us how they would handle initial complaints made at reception or by telephone.

Access to the service

The practice offered pre bookable and urgent (on the day) appointments, telephone consultations and home visits. The practice was open Monday to Friday 8.30am until 6pm with an extended clinic one evening per week. They were closed one Wednesday afternoon per month for training and development. Information was available to patients about appointments on the practice website and in the practice information leaflet. This included who to contact for advise/appointments out of normal working hours when the practice was closed such as contact details for the out of hours medical provider, walk in centre and NHS 111.

Appointments would be tailored to meet the needs of patients, for example those with long term conditions and those requiring assistance from translators would be offered longer appointments. Home visits were made to care homes, older patients and those vulnerable housebound patients.

Patients whom we spoke with, comment cards and patient survey results told us they there was some difficulty getting through to the practice on the telephone for appointments and general information. The practice used feedback from patients to improve access to the surgery. They increased the number of phone lines from one to two and increased the number of receptionists working at peak times in order to handle call more quickly. We found that in the case of urgent need for example if there was an unwell child the practice would always fit them in on the same day.

Patients with poor mental health received annual health checks and had care plans in place. A counsellor attended weekly to see patients at the practice.

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

Staff were able to articulate the values of the practice. The mission statement was displayed in the reception and staff areas. The practice had a clear vision to deliver high quality care and promote good outcomes for patients.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the computer shared drive and in hard copy in the offices. Policies and procedures were dated and reviewed appropriately. Staff confirmed they had read them and were aware of how to access them.

There was a clear organisational and leadership structure with named members of staff in lead roles. For example, there was a lead nurse for infection control and a GP partner was the lead for safeguarding. We spoke with staff of varying roles and they were all clear about their own roles and responsibilities. They all told us there was a friendly, open culture within the practice and they felt very much part of a team. They all felt valued, well supported and knew who to go to in the practice with any concerns. They felt any concerns raised would be dealt with appropriately.

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.

Clinical audits were undertaken regularly by nursing and medical staff. We looked at a selection of these. Generally they were completed well; however we did see two audits that weren't fully completed with evaluation of actions taken not having been done. Audits undertaken by the practice nurse were not shared with other staff for learning and improvements. Audits undertaken by medical staff were mostly medicines management audits decided on either by local CCG or national priorities. Audits undertaken by medical staff were stored for sharing on the shared drive of the computer; however we did not see that findings and actions or improvements from the audits were discussed at team meetings.

The practice had arrangements in place for identifying and managing risks. We saw a basic risk log which addressed potential issues, such as slips, trips and falls, fire damage to paper records and legionella. Risk assessments had been carried out where risks were identified and control measures were in place.

Leadership, openness and transparency

There was a well-established clearly identified management structure with clear lines of responsibility. We spoke to staff with differing roles within the service and they were clear about the lines of accountability and leadership. They all spoke of good clear leadership which articulated vision and motivated staff to provide a good service.

Staff felt well supported in their role. They felt confident in the senior team's ability to deal with any issues, including serious incidents and concerns regarding clinical practice. Staff reported an open and no-blame culture where they felt safe to report incidents and mistakes. All the staff we spoke with told us they felt they were valued and their views about how to develop the service acted upon.

Examples of various practice meeting minutes demonstrated information exchange, improvements to service, practice developments and learning from significant events. Regular monthly team meetings were held at which staff had the opportunity and were happy to raise any suggestions or concerns they had.

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

The practice regularly reviewed the results of the patient survey and we saw actions taken in response. For example, the telephone system was reviewed and additional phone line added to try to improve the service and access to appointments.

We looked at complaints and found they were well managed. The practice investigated and responded to them in a timely manner, and complainants were satisfied with the outcomes. They were discussed at staff meetings and were used to ensure staff learned from the event.

There was a whistleblowing policy in place. Staff told us they had no concerns about reporting any issues internally. They gave examples of reporting incidents openly and believed there was a no-blame culture at the practice, which encouraged reporting and evaluation of incidents and events. The practice gathered feedback from staff

Are services well-led?

Good 

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

through staff meetings, appraisals and discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management.

Management lead through learning and improvement

Staff told us they had annual appraisals which included looking at their performance and development needs. We saw these were up to date. The practice had an induction programme and a training and development policy and procedures to ensure staff were equipped with the knowledge and skills needed for their specific individual roles. Mandatory training was up to date for all staff.

Staff told us they had good access to training and were well supported to undertake further development in relation to their role. The practice management monitored staff training. We saw that a training matrix for staff employed in the organisation was in place. The matrix and the training policy identified the frequency of refresher update training and which roles needed to undertake which topics.

The practice was a GP training practice. There was one GP registrar who was supported by a GP trainer and the other GPs at the practice. We spoke with the GP registrar who told us they were well supported by the GPs and rest of the staff.

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	Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers People who use services and others were not protected against the risks associated with unsuitable staff because the provider did not have an effective procedure in place to assess the suitability of staff for their role. Not all the required information relating to workers was obtained and held by the practice.
Family planning services	
Maternity and midwifery services	
Surgical procedures	
Treatment of disease, disorder or injury	