South Wight Medical Practice

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at South Wight Medical practice on 24 March 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing, well-led, effective, caring and responsive services. However, it requires improvement for providing safe services. It was also good for providing services for the following population groups; 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).

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 well managed, with the exception of those relating to recruitment checks.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- Patients said they found it easy to make an appointment with a GP and that there was continuity of care, with urgent appointments available the same day.

Summary of findings

- The practice had good facilities and was well equipped to treat patients and meet their needs.
- 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 one area of outstanding practice:

The practice had developed a mobile application which could be used on a Smartphone or Tablets, by patients, their carers or family members. The application was available 24 hours a day and provided information on the services available at the practice and could be used to book appointments and order repeat prescriptions without the need to contact the practice directly. There was also a feature on the application that allowed patients to give feedback on their experience of the service received and send messages to a particular member of staff, such as a nurse or GP.

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

Importantly the provider must

- Carry out a legionella risk assessment.
- Handle blank prescription forms in accordance with national guidance.

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 good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. However, a legionella risk assessment had not been carried out and blank prescriptions were not always handled securely. There were enough staff to keep patients 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 the National Institute for Health and Care Excellence and used it routinely. Patients' 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 for patients about the services available was easy to understand and accessible. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) 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 had good facilities and was well equipped to treat patients and meet their

Summary of findings

needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.

Are services well-led?

Good

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

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in dementia and end of life care. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs. A healthcare assistant is employed to identify unmet health needs in the over 75 year age group and all these patients have a named GP. The dispensary provided medicines in monitored dosage packs (blister packs) or in containers which could be easily opened. Arrangements were in place to deliver medicines to patients' homes if needed.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. All these patients had a named GP and a structured annual review to check that their health and medication needs were being met. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Good

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

Summary of findings

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group. A full range of contraception and women's' health services were offered by the practice. Students who returned home to the island during breaks from studying were able to register as temporary patients, and could be seen immediately if needed for treatment.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including travellers and those with a learning disability. It had carried out annual health checks for people with a learning disability. It offered longer appointments for people with a learning disability.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. It had told vulnerable patients about how to access various support groups and voluntary organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). 96.3% of people experiencing poor mental health had an agreed care plan in their records and 95.12% of patients living with dementia had received an annual physical health check. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. It carried out advance care planning for patients with dementia.

The practice had told patients experiencing poor mental health about how to access various support groups and voluntary

Summary of findings

organisations. It had a system in place to follow up patients who had attended accident and emergency (A&E) where they may have been experiencing poor mental health. Staff had received training on how to care for people with mental health needs and dementia.

Summary of findings

What people who use the service say

We received 15 comment cards that patients had completed in the two weeks prior to our inspection visit. All comments were positive about the service provided by the practice. One comment card said that they had to wait for up to 60 minutes after their scheduled appointment time to be seen. However, another comment card said that the practice were proactive in trying to manage appointments. All respondents considered that they were treated with respect and GPs were able to build a rapport with their patients and provide continuity of care. Other comments about staff included that they were professional, excellent and considerate. Some comment cards singled out particular members of staff for praise and mentioned they had been patients for many years.

Respondents who used the dispensary found this service to be valuable and considered that dispensary staff were helpful and excellent. Patients we spoke with during our inspection were also positive about the practice and dispensary service.

Results from the national GP patient survey showed that 89.3% of patients would recommend the practice to others and 94.71% described their overall experience of the GP practice as fairly good or good.

Areas for improvement

Action the service MUST take to improve

- Carry out a legionella risk assessment.
- Handle blank prescription forms in accordance with national guidance.

Outstanding practice

The practice had developed a mobile application which could be used on a Smartphone or Tablets, by patients, their carers or family members. The application was available 24 hours a day and provided information on the services available at the practice and could be used to book appointments and order repeat prescriptions without the need to contact the practice directly. There was also a feature on the application that allowed patients to give feedback on their experience of the service received and send messages to a particular member of staff, such as a nurse or GP.

South Wight Medical Practice

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC inspector. The team included a GP, a practice manager, a CQC pharmacy manager and a CQC pharmacy inspector.

Background to South Wight Medical Practice

South Wight Medical Practice is situated in a largely rural area of the Isle of Wight. The practice has approximately 7500 patients on its register, this number increases during the summer months when the tourist season is at its height.

The practice has significantly higher numbers of patients who are aged 55 to 85 years and older when compared the England average. There are lower numbers of patients aged 0 to 44 years when compared with the England average.

South Wight Medical Practice has four full time GP partners, three of whom are male and one who is female; one registrar, a doctor who is training to be a GP; five practice nurses one of whom is training to be an advance nurse practitioner and one health care assistant. The clinical team are supported by a practice manager; two senior medical receptionists/secretaries; five receptionists; one audit information clerk; one accounts clerk; and one administrator. The practice is also a training practice for doctors who want to become GPs.

The practice is a dispensing practice; the dispensary is staffed by a dispensary supervisor and six dispensing staff.

Appointments were available at the practice on Monday to Fridays between 9am - 1pm and onMonday, Wednesday and Fridays between 2.30 - 6pm. When the practice was closed patients could be seen at the branch locations. When the practice is closed out of hours, patients are directed to the out of hours service provided by the Beacon Health centre via the 111 telephone number.

South Wight Medical Practice is situated at The Surgery, New Road, Brighstone, Isle of Wight PO30 4BB.

Branch surgeries are situated at:

The Surgery, Yarborough Close, Godshill, Isle of Wight. PO38 3HS and The Surgery, Blackgang Road, Niton, Isle of Wight PO38 2BN. Staff work across all three sites.

Why we carried out this inspection

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.

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 that we hold about the practice and asked other organisations to share what they knew. Including local NHS England,

Detailed findings

Healthwatch and the clinical commissioning group. We carried out an announced visit on 24 March 2015 at South Wight Medical Practice. During our visit we spoke with a range of staff which included GPs, nurses and reception staff. We spoke with patients who used the service. We reviewed 15 comment cards where patients and members of the public shared their views and experiences of the service.

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 and procedures and some audits. We also reviewed the practice website and looked at information posted on NHS Choices website.

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 prioritised safety and used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. For example, a patient was receiving injections as part of their treatment for cancer and when these were stopped the patient was not followed up in a timely manner. This resulted in the patient not being seen for a number of years. This incident was recorded and shared with the Clinical Governance Committee of the NHS Trust which oversaw clinical governance of GP practices on the island, in order that learning could be shared on an island wide basis.

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. We reviewed records of significant events that had occurred during the last 12 months and saw this system was followed appropriately. Significant events were a standing item on the practice meeting agenda and a dedicated meeting was held to review actions from past significant events and complaints. There was evidence that the practice had learned from these and that the findings were shared with relevant staff. For example, in February 2015 the practice reviewed dispensing incidents and ensured that these had been recorded and actions taken completed to minimise risk. 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 and sent completed forms to the practice manager. We tracked incidents from the past 12 months and saw records were completed in a comprehensive and timely manner. We saw evidence of action taken as a result of the incident and that the learning had been shared. For example when there was a dispensing error and a patient was given the incorrect medicine, procedures were put into place to ensure that specific medicines such as insulin were double checked by dispensing staff with a GP. This incident was discussed at the weekly practice meeting which the dispensing manager also attended. The dispensing manager said that they had regular meetings with dispensers about significant events or incidents, but would also email them to avoid a delay in communicating any changes required. Records were saw confirmed this.

National patient safety alerts were disseminated by a named GP, and the dispensing manager when appropriate, to practice staff. Staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for. For example, a recent alert related to the potential interactions between methotrexate and trimethoprim. The practice carried out a check of patients on these medicines to ensure they were necessary.

They also told us alerts were discussed at practice meetings to ensure all staff were aware of any that were relevant to the practice and where they needed to take action.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed that all staff had received relevant role specific training on safeguarding. We asked members of medical, nursing and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children.

The practice had appointed dedicated GPs as leads in safeguarding vulnerable adults and children. They had been trained in adult safeguarding and to level three in child safeguarding and could demonstrate they had the necessary competencies to enable them to fulfil these roles. All staff we spoke with were aware who these leads were and who to speak with in the practice if they had a safeguarding concern. Examples given included a patient who was at risk of neglect. A district nurse had alerted the practice of their concerns. The practice carried out a home visit and made a safeguarding referral. Extra care and support was provided by community teams and the practice visited the patients to ensure their condition was improving once this support had been provided.

Requires improvement

Are services safe?

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments; for example children subject to child protection plans. There was active engagement in local safeguarding procedures and effective working with other relevant organisations including health visitors and the local authority.

There was a chaperone policy, which was visible on the waiting room noticeboard and in consulting rooms and on the practice web site. (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 nursing staff, including health care assistants, had been trained to be a chaperone. All staff undertaking chaperone duties had received Disclosure and Barring Service (DBS) checks. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).Chaperones were usually nurses or health care assistants. When a receptionist was required to carry out chaperoning duties they had received appropriate training and checks to carry this out.

Medicines management

We checked medicines stored in the dispensary, treatment room and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. Practice staff monitored the refrigerators temperatures and appropriate actions had been taken when the temperatures were outside the recommended ranges. If a medicine alert was received which required a recall of stock already dispensed, then the dispensary manager would ensure this action was taken.

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

Nurses administered vaccines using Patient Group Directions (PGD) that had been produced in line with legal requirements and national guidance. We saw up-to-date copies of both sets of PGDs and evidence that the nurses had received appropriate training to administer vaccines. There were also appropriate arrangements in place for the nurses to administer medicines that had been prescribed and dispensed for patients.

There was a system in place for the management of high risk medicines, which included regular monitoring in line with national guidance. Appropriate action was taken based on the results. Staff told us that high risk medicines were not "on repeat" and when requested, a GP would generate the prescription, if appropriate. Whilst most prescriptions were for 28 days, prescriptions of shorter durations may be issued where clinically appropriate.

The practice held stocks of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse) and had in place standard procedures that set out how they were managed. These were being followed by the practice staff. For example, controlled drugs were stored in a metal cupboard, access to them was restricted, and the keys held securely. There were arrangements in place for the destruction of controlled drugs.

All prescriptions were reviewed and signed by a GP before they were given to the patient or dispensed. We saw that this process was working in practice. Blank prescription forms were not handled consistently in accordance with national guidance, whilst they were locked away the access to the key was not restricted at all times and they were not always tracked through the practice. The practice started to address these concerns during the inspection.

The practice participates in the Dispensing Services Quality Scheme (DSQS). Dispensing errors identified at the final checking stage or after collection were recorded, investigated, discussed and systems changed to reduce the risk of further errors.

The practice had established delivery service for dispensing patients including medicines requiring refrigeration or Controlled Drugs and additional processes were in place for these medicines.

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. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control. Domestic staff that cleaned the practice were directly employed by the practice, this allowed close supervision of the standard of

cleanliness of the practice. The practice manager said that as the cleaners were directly employed they were part of the team and had personal pride in the work they carried out.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, 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.

The practice had a lead for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. The lead for infection control had responsibility for all three locations and said they were currently undertaking hand hygiene audits across all three sites. They added that they were in the process of unifying working processes at each site to ensure there was a consistent approach and staff were working within best practice requirements. For example, training had been given on specimen handling and assembling sharps boxes correctly. All staff received induction training about infection control specific to their role and received annual updates. We saw evidence that the lead had carried out audits for each of the last three years and that any improvements identified for action were completed on time. Minutes of practice meetings showed that the findings of the audits were discussed.

Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with liquid hand soap, hand cleansing gel and hand towel dispensers were available in treatment rooms. We saw that hand cleansing gel was also available at the reception and by the dispensing counter.

The practice had not undertaken a risk assessment for legionella. (Legionella is a term for particular bacteria which can contaminate water systems in buildings.) However, we found that water was stored at the required temperature.

Suitable arrangements were in place for handling and disposing of clinical waste in line with current guidance. A clinical waste contract was in place and certificates of collection confirmed the waste was taken to be disposed of on a regular basis.

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 which was June 2014 and had been booked to be tested again in May 2015. We saw evidence of calibration of relevant equipment; for example weighing scales, spirometers, blood pressure measuring devices and the fridge thermometer. Calibration is where a piece of equipment is checked to ensure it measures accurately.

Staffing and recruitment

The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, evidence of satisfactory conduct in previous employment, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service. (These checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).

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

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. The practice manager showed us records to demonstrate that actual staffing levels and skill mix met planned staffing requirements.

Requires improvement

Are services safe?

Monitoring safety and responding to risk

The practice had systems and processes in place to manage and monitor risks to patients, staff and visitors to the practice. These included checks of the building, the environment, medicines management and dealing with emergencies and equipment. For example, we saw records which confirmed that the burglar and fire alarms were serviced and tested on a regular basis. The fire alarm was tested weekly by the practice and this was recorded. Health and safety information was displayed for staff to see and there was an identified health and safety representative.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support. 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. We checked that the pads for the automated external defibrillator were within their expiry date.

Emergency medicines were available in the practice and; all staff knew of the locations. These included those for the treatment of cardiac arrest and anaphylaxis. Processes were also in place to check emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use. When GPs gave flu injections to patients in their own homes they carried an emergency medicines pack, which included adrenaline which is used in the treatment of anaphylaxis, a severe allergic reaction which can be life threatening.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Mitigating actions were recorded to reduce and manage the risk. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to. For example, contact details of a heating company to contact if the heating system failed.

The practice had carried out a fire risk assessment in January 2015 that included actions required to maintain fire safety, which had been completed. Records showed that staff were up to date with fire training and that they practised regular fire drills.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. Staff we spoke with all demonstrated a good level of understanding and knowledge of NICE guidance and local guidelines.

Staff described how they carried out comprehensive assessments which covered all health needs and was in line with these national and local guidelines. They explained how care was planned to meet identified needs and how patients were reviewed at required intervals to ensure their treatment remained effective. For example, patients with hypertension (high blood pressure), were given home blood pressure monitors to record their blood pressure over a period of time. When needed they were referred to other services if required. Feedback from patients confirmed they were referred to other services or hospital when required.

A health care assistant was responsible for carrying out health checks for the over 75s and said that these patients had a patient passport which contained details of their gender, age, current medication and any allergies. The health care assistant added that they used a specific template to assess a patient's physical health and when needed referred them to a GP for further assessment and treatment, for example if the patient's blood pressure was high.

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

The GP who undertook minor surgical procedures said that they had systems in place to send samples off for testing and would refer a patient for further tests at the hospital when needed. Patients were advised to contact the practice if they had not received test results, so that these could be followed up. Electronic records were maintained when this occurred.

The practice identified patients who were at high risk of admission to hospital. These patients were reviewed regularly to ensure multidisciplinary care plans were documented in their records and that their needs were being met to assist in reducing the need for them to go into hospital. We saw that after patients were discharged from hospital they were followed up to ensure that all their needs were continuing to be met.

Discrimination was avoided when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were cared for and treated based on need and the practice took account of patient's age, gender, race and culture as appropriate.

Management, monitoring and improving outcomes for people

Information about people's care and treatment, and their outcomes, was routinely collected and monitored and this information used to improve care. 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.

The practice showed us a sample of clinical audits that had been undertaken in the last three years. One of these was a completed audit where the practice was able to demonstrate the changes resulting since the initial audit. For example, the prescribing of Diclofenac, a pain reliving medicine which is not recommended for use, due to more effective and suitable alternatives being available. The audit undertaken identified the patients on this medicine and action was taken in discussion with the patient on whether they would change to an alternative. A re audit undertaken in 2014 showed that there had been limited improvement in changing patients to alternative medicines, an action which had been put into place was to ensure that a discussion was held with patients on Diclofenac and recorded. If the patient chose to remain on this medicine, then they would be requested to sign a form to indicate they were aware that alternatives were available, but they preferred to remain on Diclofenac.

Good

Are services effective?

(for example, treatment is effective)

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

The practice was aware of all the areas where performance was not in line with national or clinical commissioning group figures. For example, the practice had higher prescribing rates for specific antibiotics. A GP said that since a recent change in partners at the practice, the GP with overall responsibility for this area was working with all GPs to ensure that prescriptions of these medicines were effective and necessary. The practice was aware that there figures for prescribing sedating medicines was higher. We were told that they now were cautious when prescribing these types of medicines and would only do so for short periods.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. This practice was not an outlier for any QOF (or other national) clinical targets, It achieved 99.6% of the total QOF target in 2014, which was above the national average of 94.2%. Specific examples to demonstrate this included:

- Performance for diabetes related indicators was better than the national average.
- The percentage of patients with hypertension having regular blood pressure tests was better than the national average.
- Performance for mental health related indicators was better than the national average.

The team was making use of clinical audit tools, clinical supervision and staff meetings to assess the performance of clinical staff. The staff we spoke with discussed how, as a group, they reflected on the outcomes being achieved and areas where this could be improved. Staff spoke positively about the culture in the practice around audit and quality improvement, noting that there was an expectation that all clinical staff should undertake at least one audit a year.

There was a protocol for repeat prescribing which followed national guidance. This required staff to regularly check patients receiving repeat prescriptions had been reviewed by the GP. They also checked all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines. We saw evidence that after receiving an alert, the GPs had reviewed the use of the medicine in question and, where they continued to prescribe it, outlined the reason why they decided this was necessary.

The practice 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. As a consequence of a patient who was terminally ill not receiving the best possible care, the practice had introduced a 'just in case box' which contained medicine for pain relief, protective personal equipment, such as gloves and aprons and mouth care equipment.

The practice also kept a register of patients identified as being at high risk of admission to hospital and of those in various vulnerable groups for example, those with learning disabilities. Structured annual reviews were also offered undertaken for patients with long term conditions, such as heart failure or diabetes.

The practice participated in local benchmarking run by the CCG. This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area. This benchmarking data showed the practice had outcomes that were comparable to other services in the area.

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 courses such as annual basic life support. All GPs were up to date with their yearly continuing professional development requirements and all either have 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 the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

All staff undertook annual appraisals that identified learning needs from which action plans were documented. Our interviews with staff confirmed that the practice was

Good

Are services effective?

(for example, treatment is effective)

proactive in providing training and funding for relevant courses, for example in practice nursing, respiratory and diabetic care. Staff said that their first appraisal occurred after their six month probation period, and then annually after that. As the practice was a training practice, doctors who were training to be qualified as GPs were offered extended appointments and had access to a senior GP throughout the day for support. We received positive feedback from the trainees we spoke with.

Practice nurses and health care assistants had job descriptions outlining their roles and responsibilities and provided evidence that they were trained appropriately to fulfil these duties. For example, on administration of vaccines and cervical cytology. Those with roles including seeing patients with long-term conditions such as asthma, COPD, diabetes and coronary heart disease were also able to demonstrate that they had appropriate training to fulfil these roles.

Two GPs offered dermoscopy, at all three locations, and had received appropriate training to carry out this procedure. (Dermoscopy is where photographs are taken of skin conditions and these are sent electronically to a hospital consultant for review and suggested treatment. This enables a diagnosis to be made in a timely manner and treatment commenced when needed).

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

Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and manage those of patients with complex needs. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post.

The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from these communications. Out-of hours reports, 111 reports and pathology results were all seen and actioned by a GP on the day they were received. Discharge summaries and letters from outpatients were usually seen and actioned on the day of receipt. The GP who saw these documents and results was responsible for the action required.

A GP said that dispensers would monitor changes to prescribed medicines and request a GP review when needed. Blood test results were received twice a day and actioned by the responsible GP or their buddy. When urgent abnormal results were received, this information was telephoned through to the relevant GP to deal with. We were shown computer records which documented when the results had been received and when action had been taken.

We found that in all cases results had been dealt with promptly and letters that had been received had been reviewed. There were no instances identified within the last year of any results or discharge summaries that were not followed up.

Emergency hospital admission rates for the practice were at 13.6% which was comparable to the national average of 13.3%.

The practice held multidisciplinary team meetings to discuss patients with complex needs. For example, those with multiple long term conditions, mental health problems, people from vulnerable groups, those with end of life care needs or children on the at risk register. These meetings were attended by district nurses, social workers, palliative care nurses and decisions about care planning were documented in a shared care record. Staff felt this system worked well. Care plans were in place for patients with complex needs and shared with other health and social care workers as appropriate.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. We saw evidence there was a system for sharing appropriate information for patients with complex needs with the ambulance and out-of-hours services.

The practice had also 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'

Good

Are services effective?

(for example, treatment is effective)

care. All staff were fully trained on the system. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005 and their duties in fulfilling it. All the staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it. Training had been provided on the Mental Capacity Act and Deprivation of Liberty Safeguards. One GP said this made them more confident in making best interest decisions when needed.

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. 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. All clinical staff demonstrated a clear understanding of the Gillick competency test. (These are used to help assess whether a child under the age of 16 has the maturity to make their own decisions and to understand the implications of those decisions).

There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures, a patient's verbal consent was documented in the electronic patient notes with a record of the discussion about the relevant risks, benefits and possible complications of the procedure. In addition, the practice obtained written consent for significant minor procedures and all staff were clear about when to obtain written consent.

Health promotion and prevention

It was practice policy to offer a health check to all new patients registering with the practice. The GP was informed of all health concerns detected and these were followed up in a timely way. The practice also offered NHS Health Checks to all its patients in line with national guidance. For example, patients who had learning disabilities were offered support to make healthy eating choices at their reviews.

The practice's performance for the cervical screening programme was 88.55%, which was above the national average of 83.13%. The practice also encouraged its patients to attend national screening programmes for bowel cancer and breast cancer.

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 was above average for the majority of immunisations where comparative data was available. For example:

- Flu vaccination rates for the over 65s were 74.43%, and at risk groups 62.79%. These were similar to and above national averages respectively.

The practice said they had a system in place to monitor take up of immunisations and if a child did not attend then the parent or guardian would be contacted and an alternative appointment would be given. If a child repeatedly did not attend then this would be discussed with the health visitors' team or midwives and GP.

We saw health promotion leaflets in the waiting room, which provided information on areas such as stopping smoking; being active and falls prevention. The practice website also had information on staying well, along with relevant links.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey 2014, the Family and Friends test, and comment cards received during our inspection.

The evidence from all these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the national patient survey showed the practice was rated favourably for patients who rated the practice as good or very good. The practice was also above average or in line with comparators for its satisfaction scores on consultations with doctors and nurses. For example:

- 90% said the GP was good at listening to them compared to the CCG average of 90% and national average of 88%.
- 91% said the GP gave them enough time compared to the CCG average of 87% and national average of 86%.
- 94% said they had confidence and trust in the last GP they saw compared to the CCG average of 95% and national average of 93%.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 15 completed cards and the majority were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. One comment was less positive but there were no common themes to these. We also spoke with five patients on the day of our inspection. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

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.

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. The practice switchboard was located away from the reception desk which helped keep patient information private. Additionally, 96% said they found the receptionists at the practice helpful compared to the CCG average of 92% and national average of 87%.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example:

- 88% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 85% and national average of 82%.
- 78% said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 77% and national average of 74%.

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.

Staff told us that translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patents this service was available.

Patient/carer support to cope emotionally with care and treatment

The patient survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. For example:

- 91% said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 86% and national average of 82%.
- 80% said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 82% and national average of 78%.

Good

Are services caring?

The patients we spoke with on the day of our inspection and the comment cards we received were also consistent with this survey information. For example, these highlighted that staff responded compassionately when they needed help and provided support when required.

Notices in the patient waiting room, on the TV screen and patient website also told patients how to access a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer. Patients were asked if they were carers or were cared for, when registering with the practice and at their health checks.

Staff told us that if families had suffered bereavement, their usual GP contacted them. This call was sometimes followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service. A GP said that if the patient was on the end of life register, then bereavement counselling would be offered automatically.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

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

The practice said they engaged regularly with other practices in their locality, with GP practices on the island as a whole and the Clinical Commissioning Group to discuss local needs and service improvements that needed to be prioritised. We saw minutes of meetings where this had been discussed and actions agreed to implement service improvements to better meet the needs of its population. For example, use of the community matron to avoid unplanned admissions to hospital.

The practice had a virtual patient participation group and had recently completed an in house survey, the results of which were being analysed.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example, longer appointment times were available for patients with learning disabilities.

The majority of the practice population were English speaking patients but access to online and telephone translation services were available if they were needed.

The premises and services had been designed to meet the needs of people with disabilities. The practice was accessible to patients with mobility difficulties as facilities were all on one level. The consulting rooms were also accessible for patients with limited mobility and there were access enabled toilets and baby changing facilities. There was a small waiting area with some space for wheelchairs and prams. The practice had a hearing loop for patients who were hearing impaired.

Staff told us that they did not have any patients who were of "no fixed abode" but would see someone if they came to the practice asking to be seen and would register the patient so they could access services. There was a system for flagging vulnerability in individual patient records. Some patients misused drugs and alcohol; these patients were provided with consistent care and treatment by all staff at the practice. The practice had a lead nurse on mental health conditions to enable patients with this condition to receive continuity of care.

There were male and female GPs in the practice; therefore patients could choose to see a male or female doctor.

We spoke with a manger of a local care home, who told us that all of their patients were registered with the practice and added that they were able to arrange home visits and all patients had a medication review with a named GP. The manager said that if needed advice could be sought via telephone. Able patients were assisted to keep their appointments in the GP practice and there was a wheelchair at the practice for patients to use.

For those patients living with dementia in the care home reviews of treatment and care were carried out by the home with the assistant of GPs in the practice. The manager said that for those patients who were receiving end of life care there were good working arrangements in place between the pharmacy, GP practice and other health professionals to ensure patients' needs were met in a timely manner.

Access to the service

Appointments were available at the practice on Monday to Fridays between 9am - 1pm and on Monday, Wednesday and Fridays between 2.30 - 6pm. When the practice was closed patients could be seen at the branch locations. Routine appointments were able to be booked from 48 hours up to one month in advance and same day appointments were available. Those patients who had minor surgical procedures automatically were assigned a half an hour appointment. The practice had an appointment protocol which gave information on the types of appointments available to enable patients to book the correct appointment for their needs.

Patients who had more than one condition, for example an enduring mental health diagnosis and diabetes were offered longer appointments so all their health needs could be addressed. Staff said they treated patients holistically.

The practice had developed a mobile application which could be used on a Smartphone or Tablets, by patients, their carers or family members. The application was available 24 hours a day and provided information on the services available at the practice and could be used to book appointment and order repeat prescriptions without

Good

Are services responsive to people's needs?

(for example, to feedback?)

the need to contact the practice directly. There was also a feature on the application that allowed patients to give feedback on their experience of the service received and send messages to a particular member of staff, such as a nurse or GP.

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 also available for older patients, those experiencing poor mental health, patients with learning disabilities and those with long-term conditions. This also included appointments with a named GP or nurse.

The patient survey information we reviewed showed patients responded positively to questions about access to appointments and generally rated the practice well in these areas. For example:

- 82.34% were satisfied with the practice's opening hours compared to the national average of 79.82%.
- 91% described their experience of making an appointment as good compared to the CCG average of 84% and national average of 73%.
- 90% said they could get through easily to the surgery by phone compared to the CCG average of 85% and national average of 61%.

Patients we spoke with were satisfied with the appointments system and said it was easy to use. They confirmed that they could see a doctor on the same day if they felt their need was urgent although this might not be their GP of choice. One patient said they had had a blood test the previous week and the nurse had been able to book this appointment for the results at the same time as they booked the blood test. Comments received from patients also showed that patients in urgent need of treatment had often been able to make appointments on the same day of contacting the practice. For example, a patient said they had telephoned that morning and thought it was excellent that they were able to be seen the same day.

Listening and learning from concerns and complaints

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

We saw that information was available to help patients understand the complaints system in the form of leaflets and on the practice website. Patients we spoke with were aware of the process to follow if they wished to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice.

We looked at four complaints received in the last 12 months and found these were dealt with in a timely manner and when needed a full and unreserved apology provided. Correspondence showed that concerns were investigated thoroughly and resolved as far as practicably possible to the complainant's satisfaction. When needed learning was shared in the practice and with other health professionals, for example, minutes of a practice meeting showed that there were knowledge gaps in the team of professionals who were caring for a patient who was terminally ill and "just in case medicines" had not been used effectively. Discussions were held with the hospice consultant, MacMillan nurses and district nurses and it was agreed that further information would be provided on using medicines in a timely manner.

The practice reviewed complaints annually to detect themes or trends. We looked at the report for the last review and no themes had been identified. However, lessons learned from individual complaints had been acted on and improvements made to the quality of care as a result.

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 deliver high quality care and promote good outcomes for patients. We found details of the vision and practice values were part of the practice's strategy. We saw evidence the strategy and business plan were regularly reviewed by the practice. Staff were aware of the vision and values of the practice and were proud that the practice operated in an open and transparent manner to provide a holistic service to 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 desktop on any computer within the practice. We looked at a sample of these policies and procedures and staff had completed a cover sheet to confirm that they had read the policy and when. All policies and procedures we looked at had been or were being reviewed to ensure they were up to date. Paper copies of policies and procedures were available in a folder in the reception.

The practice had a named Caldicott guardian who was responsible for information governance within the practice. Staff had or were reading the policy on information governance to ensure they were up to date with current requirements. The practice had a confidentiality procedure which all staff were expected to adhere to.

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. We spoke with members of staff and they were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

The GP and practice manager took an active leadership role for overseeing that the systems in place to monitor the quality of the service were consistently being used and were effective. The included using the Quality and Outcomes Framework to measure its performance (QOF is a voluntary incentive scheme which financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). The QOF data for this practice showed it was performing in line with national standards. We saw that QOF data was regularly discussed at monthly team meetings and action plans were produced to maintain or improve outcomes.

The practice also had an on-going programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. Evidence from other data from sources, including incidents and complaints was used to identify areas where improvements could be made. Additionally, there were processes in place to review patient satisfaction and that action had been taken, when appropriate, in response to feedback from patients or staff. The practice regularly submitted governance and performance data to the CCG.

The practice held staff meetings where governance issues were discussed. We looked at minutes from these meetings and found that performance, quality and risks had been discussed.

The practice manager was responsible for human resource policies and procedures. The electronic staff handbook was available to all staff and included sections on equality and harassment and bullying at work. Staff we spoke with knew where to find these policies if required. The practice had a whistleblowing policy which was also available to all staff in the staff handbook and electronically on any computer within the practice.

Leadership, openness and transparency

The partners in the practice were visible in the practice and staff told us that they were approachable and always take the time to listen to all members of staff. All staff were involved in discussions about how to run the practice and how to develop the practice: the partners encouraged all members of staff to identify opportunities to improve the service delivered by the practice.

We saw from minutes that team meetings were held every month. Staff told us that there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and were confident in doing so and felt supported if they did. We also noted that team away days were held regularly every six months. Staff said they felt respected, valued and supported, particularly by the partners in the practice. Social events were also held in the summer and winter months to promote cohesive working relationships.

Are services well-led?

Good

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

Seeking and acting on feedback from patients, public and staff

The practice encouraged and valued feedback from patients. It had gathered feedback from patients through surveys and complaints received. The patient participation group was a virtual group and therefore there were limited face to face meetings with the practice. However, the practice was reviewing this virtual group to ensure it had representatives of all population groups and would develop to take a more active role in the running of the practice. The practice participated in the Friends and Families test and initial results showed that in December 2014 95% of respondents would recommend the practice to friends or family.

We also saw evidence that the practice had reviewed its' results from the national GP survey to see if there were any areas that needed addressing. The practice was actively encouraging patients to be involved in

shaping the service delivered at the practice.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at staff files and saw that regular appraisals took place which included a personal development plan. Staff told us that the practice was very supportive of training and that they had staff away days where guest speakers and trainers attended.

The practice nurses met with other practice nurses on the island each quarter and whole island away days were organised for all GP practices to meet and discuss learning and best practice. The practice lead GP for diabetes was also the clinical commissioning group lead for this area was able to inform all relevant staff of best practice.

The practice was a GP training practice and trained final year medical students, nurse practitioners and GP trainees. The lead GP for training said that being involved with training a variety of students enabled them to review skill mix within the practice when there were vacancies to help ensure patients' needs were met.

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

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 Patients who used the service were not protected against the risk of unsafe care and treatment. This was in breach of regulation of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The registered person did not have suitable systems in place to ensure the secure storage and appropriate record of medicine related stationery. Regulation 12(1) (2) (g)

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 Patients who used the service were not protected against the risk of unsafe care and treatment. This was in breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The registered person did not have suitable systems to assess the risk of preventing and controlling the spread of infections. Regulation 12 (1) (2) (h)