Joshi Na

Quality Report

Dr NA Joshi, Village Surgery
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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?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Dr Joshi, Village Surgery on 15 September 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing caring, effective, responsive and well-led services. We found the practice required improvement for providing safe services.

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

- Staff understood and fulfilled their responsibilities to raise concerns, and report incidents and near misses;
- Risks to patients and staff were assessed and well managed;
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and responsibilities;
- The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand;
- Patients said they were treated with compassion, dignity and respect and were involved in decisions about their care and treatment.
- The majority of patients who provided us with feedback did not raise any concerns over access to appointments. Results from the National GP Patient Survey showed that patient satisfaction with access to appointments, practice opening hours and appointment waiting times was broadly in line with local CCG and national averages;
- There was a clear leadership structure and staff felt well-supported by the management team. Good governance arrangements were in place;
- Staff had a clear vision for the development of the practice and were committed to providing their patients with good quality care. This was demonstrated by the steps staff were taking to develop additional services to meet the needs of their patients.

Summary of findings

However, there was also an area where the practice must make improvements.

Importantly, the provider must:

- Ensure that the arrangements for storing and recording controlled drugs is reviewed and strengthened to comply with schedule 2 of the Misuse of Drugs (Safe Custody) Regulations 1973

In addition the provider should:

- Ensure that all staff receive comprehensive infection control training.
- Ensure that the practice has a regular schedule of meetings and that practice and multi- agency meetings are minuted more effectively
- Review the system currently in place for planning, carrying out, recording and reviewing clinical audits
- Make better use of the patient participation group and ensure that consideration is given to disseminating learning and information from speakers attending PPG meetings to the practice population on a whole

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?

Good

The practice is rated as good for providing safe services.

Staff understood and fulfilled their responsibilities with regard to raising concerns, recording safety incidents and reporting them both internally and externally. The partners and practice management team took action to ensure lessons were learned from incidents, concerns and complaints and shared these with staff as and when required to support improvement. There were enough appropriately trained staff on duty at all times to keep patients safe. The practice was clean and hygienic and there was evidence to confirm that cleaning and regular infection control audits were completed. Not all staff had received training on infection control. The practice had a chaperone policy in place and all staff who acted as a chaperone had received the appropriate training. All staff had received a Disclosure and Barring Service (DBS) check. The system currently in place for the storage of controlled drugs needed strengthening to ensure that access was limited and to ensure that the system in place was safe and effective. Processes were in place for the safe management of prescriptions, including repeat prescription requests and the safe storage of blank prescriptions.

Are services effective?

Good

The practice is rated as good for providing effective services.

Nationally reported data showed patient outcomes for effectiveness were in line with other practices in the local clinical commissioning group (CCG) and England. Patients' needs were assessed and care was planned and delivered in line with current legislation and best practice guidance produced by the National Institute for Health and Care Excellence (NICE). This included assessing capacity and promoting good health. Although the practice could evidence clinical audits they should review their process for planning, reviewing and learning from the audits to improve patient care and to support multi-disciplinary working with other health and social care professionals in the local area. Staff had access to the information and equipment they needed to deliver effective care and treatment. Arrangements were in place to support clinical staff with their continual professional development. With the exception of infection control training staff had received training appropriate to their roles and responsibilities. Staff received yearly appraisals which gave them the opportunity to formally discuss personal and performance issues and identify training and development needs.

Summary of findings

Members of the administrative team had been supported to train as health care assistants to improve patient access to services. This included quicker access to electrocardiograms and, in conjunction with the practice manager, the delivery of a smoking cessation programme.

Are services caring?

Good

The practice is rated as good for providing caring services.

Nationally reported data showed patient outcomes for caring were generally better than the national average. Patients said they were treated well and were involved in making decisions about their care and treatment. Patients had access to information and advice on health promotion, and they received support to manage their own health and wellbeing. We saw staff treated patients with kindness and respect and were aware of their responsibilities with regard to maintaining patient confidentiality. The practice had developed an effective working relationship with other providers of care and support locally. For example, a number of local care and nursing homes, supported living services and the local carers association. A comprehensive carers information pack was available for those patients identified as having caring responsibilities.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services.

Nationally reported data showed patient outcomes for this area were generally in line with or better than the national average. Services had been planned so they met the needs of the key population groups registered with the practice. Demand for appointments was continuously monitored and extra sessions held when necessary. Patient feedback about the practice was good and most patients stated they found it was easy to make an appointment with a GP within an acceptable timescale. Systems were in place to ensure patients discharged from hospital were supported. The practice worked cohesively with multi-agency practitioners. Easy to understand information about how to complain was available and evidence showed the practice responded quickly and appropriately to issues raised.

Are services well-led?

Good

The practice is rated as good for being well-led.

The leadership and management of the practice assured the delivery of person-centred care which met patients' needs. The practice had a clear vision for improving the service and promoting good patient outcomes and had a written business plan in operation. Staff were clear about their roles and responsibilities and

Summary of findings

felt well supported and valued. The practice had a range of policies and procedures covering its day-to-day activities which were easily accessible by staff. The practice proactively sought feedback from patients, which they acted upon. The practice had a patient participation group (PPG) which met regularly; however information shared with the patient participation group by guest speakers attending their meetings was not always disseminated to the practice population on a whole limiting its effectiveness. The practice worked collaboratively with the PPG to identify problem areas and improve services. Comprehensive induction guidance was available for staff. Regular staff meetings were held and staff received yearly appraisals.

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 patients.

Nationally reported data showed the practice had achieved good outcomes in relation to the conditions commonly associated with older people. Patients over the age of 75 (7.87% of the practice population) had a named GP and were routinely invited to attend an over 75 health check which was carried out as a home visit for housebound patients. Elderly patients who had been discharged from hospital were seen within two weeks of discharge to try to avoid re-admission. The practice employed a prescribing nurse practitioner who specialised in the care of the elderly. The practice had also established effective working relationships with the four nursing homes and two residential homes in the practice area.

The percentage of patients aged 65 and older who had received a seasonal flu vaccination was in line with the national average and the practice offered annual flu clinics with a take up rate of over 70%.

The practice actively identified and flagged palliative care patients to ensure they were supported appropriately and multi-agency palliative care meetings were held on a quarterly basis.

People with long term conditions

Good

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

The practice had systems in place to ensure patients with long term conditions were recalled for review when required. Home visit reviews were available for housebound patients. The nurse practitioner was a nurse prescriber which meant they were able to review and prescribe most medication following a long term condition review without GP intervention. This not only reduced the time patients waited for a prescription but also reduced pressure on the GPs.

Longer appointments were available for patients with long term conditions and those with life limiting long term conditions were discussed at weekly practice meetings. In conjunction with the palliative care team, comprehensive end of life care plans were offered to palliative care patients. Palliative care patients were prescribed anticipatory medication following consultation with the palliative care team.

Summary of findings

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 looked after children or children subject of a child protection plan. The practice had identified one of the GPs as safeguarding lead who was responsible for providing information to and attending multi-agency safeguarding meetings. The practice also held regular meetings with health visitors to discuss safeguarding cases and concerns.

The practice had a recall system in place for childhood immunisations and rates were in line with or above local averages for all standard childhood immunisations. The parents/carers of children who did not attend for immunisations were contacted to establish a reason for the non-attendance and ascertain whether there were any safeguarding concerns. Appointments were available outside of school hours, starting at 7:00am one day per week and up to 6:00pm each weekday. Cervical screening rates for women aged 25-64 were above local and national averages.

The practice was in the process of developing a separate clinic for young and adolescent patients where the focus would be on maintaining sexual health and contraception. Young and adolescent patients were offered the choice of either a GP or nurse appointment.

Working age people (including those recently retired and students)

Good

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

Nationally reported data showed that 55.8% of the practice population either worked or was in full time education (national average 60.2%). The practice was proactive in meeting the needs of these patients by offering online services such as being able to order repeat prescriptions, book appointments and view parts of their medical records. The practice was open from 8.00am to 6.00pm on a Monday, Tuesday and Friday and from 7.00am to 6.00pm on a Wednesday and Thursday and the practice offered telephone appointments with their triage service on request. The practice was part of Sunderland's West Locality Extended Access Team which meant that patients could access emergency appointments at a local primary care centre between 6.00pm and 8.00pm weekdays and from 8.30am to 10.30am on a Saturday. Repeat prescriptions

Summary of findings

could be ordered at any time either online, in person or by telephone. The practice also used the choose and book scheme which enabled patients referred to a hospital or clinic to choose the provider of their choice and at date and time which was convenient.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the population group of patients whose circumstances may make them vulnerable.

The practice had a register of patients aged 18 or over with a learning disability, people receiving palliative care and carers. A recall system was in place to ensure patients with a learning disability were offered an annual health check.

Staff knew how to recognise signs of abuse in vulnerable adults and children and how to raise safeguarding concerns with the relevant agencies. The practice had identified a clinical lead for dealing with vulnerable adult and vulnerable children cases and all practice staff had undertaken safeguarding training at a level appropriate to their role. Clinicians had received training on their responsibilities in relation to the Mental Health Act.

The practice was proactive in identifying and responding to the needs of carers and a comprehensive carer's pack was available. Carers were routinely signposted to Sunderland Carers' Centre, the Essence Service (for people with dementia and their carers) and to the local adult care service for a carer's needs assessment.

The practice offered an interpretation service for their non-English speaking patients.

People experiencing poor mental health (including people with dementia)

Good

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

The practice had exceeded the national average in ensuring comprehensive and agreed care plans were in place for patients with schizophrenia, bipolar affected disorder and other psychoses (100% compared to an England average of 86%) and for ensuring patients diagnosed with dementia had received a face-to-face review within the preceding 12 months (94.4% compared to an England average of 83.8%).

Practice staff had undertaken dementia awareness training to ensure they had a greater understanding of the needs of patients with dementia. Patients with dementia received annual reviews and patients on the practice mental health register were offered health

Summary of findings

and other appropriate checks. Care plans were in place for patients with dementia and mental health conditions and this group of patients and their carer's were signposted to appropriate support services.

Practice clinicians were aware of their responsibilities under the Mental Capacity Act (2005) in respect of gaining consent to care and treatment.

Summary of findings

What people who use the service say

During the inspection we spoke with five patients, three of whom were members of the patient participation group (PPG) and reviewed 17 Care Quality Commission (CQC) comment cards completed by patients. The feedback we received indicated that the majority of patients were very happy with the care and treatment they received, felt they were treated with dignity and respect and received a service which met their needs. The three cards that contained some slightly negative comments highlighted concerns regarding delays in being called in for an appointments and a lack of extended opening hours.

Findings from the 2015 National GP Patient Survey published in July 2015 for the practice indicated most patients had an average or higher level of satisfaction with the care and treatment they received. For example:

- 80.8% of respondents said the last GP they saw or spoke to was good at involving them in decisions about their care. This compared to a local CCG average of 84.9% and a national average 81.5%
- 91% of respondents said the last GP they saw or spoke to was good at treating them with care and concern. Local CCG average 87.5% and national average 85.1%
- 95.5% of respondents said the last nurse they saw was good at treating them with care and concern. Local CCG average 93.3% and national average 90.4%

These results were based on 117 surveys that were returned from a total of 377 that were sent out (a response rate of 31% which represented 2.91% of the entire practice population).

Areas for improvement

Action the service MUST take to improve

Ensure that the arrangements for storing and recording controlled drugs is reviewed and strengthened to comply with schedule 2 of the Misuse of Drugs (Safe Custody) Regulations 1973

Action the service SHOULD take to improve

- Ensure that all staff receive comprehensive infection control training.
- Ensure that the practice has a regular schedule of meetings and that practice and multi- agency meetings are minuted more effectively
- Review the system currently in place for planning, carrying out, recording and reviewing clinical audits
- Make better use of the patient participation group and ensure that consideration is given to disseminating learning and information from speakers attending PPG meetings to the practice population on a whole

Joshi Na

Detailed findings

Our inspection team

Our inspection team was led by:

a Care Quality Commission (CQC) Inspector. A GP specialist advisor was also in attendance.

Background to Joshi Na

The practice is located within Silksworth Health Centre in a residential area of Sunderland, South of the River Wear. The practice provides care and treatment to 4,014 patients from the Middle Herington, Tunstall, Hillview, Thornhill, Ryhope, East Herrington,Grangetown, Thorney Close, Farringdon, Silksworth, Leechmere and High Barnes areas of Sunderland. It is part of the NHS Sunderland Clinical Commissioning Group (CCG) and operates on a Personal Medical Services (PMS) contract.

The practice provides services from the following address, which we visited during this inspection:

Village Surgery, Silksworth Health Centre, Silksworth, Sunderland, SR3 2AN.

The practice is located in a purpose built building which it shares with another GP practice, a chiropodist and community based healthcare staff including health visitors, district nurses and the community midwife. All communal areas, waiting areas and consultation rooms are fully accessible for patients with mobility issues. Car parking facilities, including disabled car parking spaces and lockable bike storage are available on site.

The practice is open between 8.00am to 6.00pm on a Monday, Tuesday and Friday and from 7.00am to 6.00pm on a Wednesday and Thursday. The practice is also part of Sunderland's West Locality Extended Hours Access Scheme meaning that their patients are able to access emergency out of hour's appointments at Grindon Lane primary care centre between 6.00pm and 8.00pm weekdays and between 8.30am and 10.30 am on a Saturday. It is also a member of the Sunderland GP Alliance. This is a federation of 40 GP practices representing approximately 85% of Sunderland's patient population working collaboratively to achieve better health outcomes for the people of Sunderland.

The service for patients requiring urgent medical attention out-of-hours is provided by the NHS 111 service and Northern Doctors Urgent Care Limited.

Village Surgery offer a range of services and clinic appointments including chronic disease management clinics, antenatal clinics, baby clinics, well woman/well man clinics, travel vaccinations and childhood immunisations. The practice consists of:

- Two GP partners (both male)
- Two practice nurse (female)
- One nurse practitioner (female)
- Two health care assistants (who also provide administration and secretarial duties)
- A practice manager (who is also a partner in the practice)
- Four administrative/secretarial staff

The practice also employed a female locum GP for one session per week. This gave patients the ability to choose to see a doctor of a particular sex if preferred.

The practice is a teaching and training practice and provides training to third and fourth year medical students as well as GP trainees.

The area in which the practice is located is in the fifth most deprived decile. In general people living in more deprived areas tend to have greater need for health services.

Detailed findings

The practice's age distribution profile showed a lower percentage of patients aged 45 and over than the national average.

Why we carried out this inspection

We inspected this service as part of our 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 registered 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 Care Quality Commission (CQC) at that time.

How we carried out this inspection

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

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

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

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

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 15 September 2015. During our visit we spoke with a mix of clinical and non-clinical staff including GPs, practice nurses, the practice manager, and administration staff. We also spoke to five patients, three of whom were also members of the practice's patient participation group (PPG). We observed how staff communicated with patients who visited or telephoned the practice on the day of our inspection and reviewed 17 Care Quality Commission (CQC) comment cards that had been completed by patients. We also looked at the records the practice maintained in relation to the provision of services.

Good

Are services safe?

Our findings

Safe track record and learning

As part of planning our inspection we looked at a range of information available about the practice including information from the latest National GP Survey results published in July 2015 and the Quality and Outcomes Framework (QOF) results for 2013/14. None of this information identified any concerning indicators about the practice. The local clinical commissioning group (CCG) did not raise any concerns with us about how the practice operated. Patients we spoke with told us they felt safe when they attended appointments and comments from patients who completed Care Quality Commission (CQC) comment cards reflected this.

The practice used a range of information to identify potential risks and to improve quality in relation to patient safety. This included reported incidents, national patient safety alerts, comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report accidents and near misses.

We reviewed a sample of significant event audit records and serious incident reports. This included an incident where a hospital referral was not actioned and subsequently delayed due to the clinician failing to record a consultation in a patient's medical records. We saw evidence to confirm that the matter had been reported appropriately and that an apology had been given to the patient. In addition the practice had embedded with clinicians the importance of updating patient's notes immediately after consultation and had arranged training on voice activation software. We were told by the practice manager that the practice regularly analysed significant events to identify trends and themes and that the findings were discussed at whole team meetings. We were satisfied that the practice had managed significant events and serious incidents consistently over time.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. We found the practice had recorded 17 significant events/ incidents during the period 1 April 2014 to 31 March 2015 and a further five for the period 1 April 2015 to the date of our inspection. The practice was able to demonstrate the action taken to ensure these issues did not happen again. Clinical and non-clinical staff knew how and when to raise an issue immediately or for future consideration at staff meetings.

A member of the administrative staff was responsible for cascading national patient safety alerts to the clinical staff and had a system in place to ensure these were read. Clinical staff would then ensure appropriate action was taken which included medication reviews, contacting affected patients and amending their care plans.

Reliable safety systems and processes including safeguarding

The practice had an effective policy and system in place to manage and review risks to vulnerable children, young people and adults. One of the GPs had been identified as the lead for safeguarding vulnerable children and another for safeguarding vulnerable adults. Effective working relationships had been established with multi-agency practitioners. For example, monthly multi-disciplinary meetings were held involving the GPs and health visitors. Staff we interviewed stated they would feel confident in making a safeguarding referral. We saw records that confirmed staff had received the appropriate level of safeguarding training relevant to their individual roles. A system was in place to highlight vulnerable patients on the practice's electronic records so staff were aware of any relevant issues when they rang to make or attend appointments.

A chaperone policy was in place and information about this was displayed in the practice waiting room. The administrative staff acted as a chaperone when required and had received training on their roles and responsibilities as a chaperone (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 practice staff had received a Disclosure and Barring Service (DBS) check.

Patients' records were kept on an electronic system which stored all relevant medical information. As well as flagging vulnerable children and adults, the system also flagged patients with dementia, mental health conditions, a learning disability, carer's and those receiving palliative care. This helped ensure risks to patients were clearly identified and reviewed.

Good

Are services safe?

Staff were able to easily access the practice's policies and procedures. This helped to ensure staff could access the guidance they needed to meet patients' needs and keep them safe from harm.

Medicines management

Effective arrangements were in place to ensure medicines requiring cold storage, such as vaccines, were stored appropriately. A policy was in place to ensure refrigerator temperatures were checked and recorded regularly throughout the day to confirm that medication stored in the refrigerators was safe to use.

The practice held a supply of emergency medicines and controlled drugs on the premises. These medicines were stored in a combination locked central visiting bag which was stored in a locked cupboard one of the consultation rooms. During our inspection we found that although a process was in place to check these medicines on a regular basis to ensure they were in date, destroyed appropriately and re-ordered when required there was no central log detailing when medicines were disposed of or re-ordered. In addition the storage arrangements for the controlled drugs which was not in line with schedule 2 of the Misuse of Drugs (Safe Custody) Regulations 1973. This gives guidance on the storage of controlled drugs and states that they must be stored in fixed cupboard with a robust multiple point lock and restricted access. In addition a separate log should be maintained of controlled drugs held on the premises which should not be kept in the same bag or cupboard as the drugs. We raised this issue with the GPs and the practice manager on the day of the inspection and were assured that immediate action would be taken to improve security.

Patients were able to re-order repeat prescriptions either on-line, in person or by phone. All staff were aware of the processes they needed to follow in relation to the authorisation and review of repeat prescriptions and were clear about what action to take when a patient had reached the authorised number of repeat prescriptions or when prescriptions were not collected. Blank prescription forms were stored securely and in line with best practice guidance issued by NHS Protect.

We saw the practice recorded medicines incidents and prescribing errors as significant events to ensure that similar errors did not recur.

The practice nurses used patient group directions (PGDs) to administer vaccines and other medicines that had been produced in line with legal requirements and national guidance.

One of the practice GPs met with a local pharmacist on a monthly basis to discuss medicine optimisation (this helps patients to make the most of medicines and ensures medicine use is as safe as possible). The practice had developed a medicine optimisation action plan for 2015/16 where the objectives included reducing antibiotic prescribing, optimising strong opiate prescribing and reviewing patients prescribed multiple laxatives and constipation medication.

Cleanliness and infection control

The premises were clean and hygienic throughout. The patient we spoke with and those that had completed CQC comment cards did not have any concerns regarding the level of cleanliness at the practice. Cleaning was carried out by the building landlord, NHS Prop Co. and a cleaning schedule was in place. Audits of cleaning standards were carried out by the health care assistant on a regular basis.

An infection control policy was in place which provided guidance to staff about the standards of hygiene they were expected to follow. This included guidance on the use of personal protective equipment (PPE) such as aprons and latex gloves as well as how to deal with patient specimens, needle stick injuries and the disposal and management of clinical waste. One of the practice nurses had been designated as the infection control lead and provided advice and guidance to colleagues when needed. Not all staff had received comprehensive infection control training although staff told us they had received training on good hand washing techniques and dealing with specimens. The practice was able to demonstrate they had carried out regular infection control audits. The last audit, carried out in July 2015 had identified that four sinks within the practice had overflows. As this is not recommended for infection control purposes the practice had made immediate arrangements to have these replaced.

The clinical rooms we inspected contained PPE and there were paper covers and privacy curtains for the consultation couches. A process was in place to ensure the curtains were checked for cleanliness and replaced on a monthly basis.

Spillage kits were available to enable staff to deal safely with any spills of bodily fluids. Sharps bins were available in

treatment rooms but some of the bins we looked at had not been appropriately dated. The treatment rooms also contained hand washing sinks, hand soap and hand towel dispensers to enable clinicians to follow good hand hygiene and infection control practice. The practice had a protocol for the management of clinical waste and a contract was in place for its disposal. All waste bins were visibly clean and in good working order.

Responsibility for the management, testing and investigation of legionella (a bacterium that can grow in water) for the entire building lay with NHS Prop Co. but the practice held a copy of the testing certificates to confirm that appropriate tests had been completed.

Equipment

Staff had access to the equipment they needed to carry out diagnostic examinations, assessments and treatments. We saw evidence to confirm the equipment was regularly inspected and serviced by either the practice or on their behalf by NHS Prop Co. or Sunderland Royal Hospital. This included the practice defibrillator, spirometer, oxygen equipment and portable electrical equipment. The practice used single use equipment. The equipment we check was in date and a process was in place for checking expiration dates on a regular basis.

Staffing and recruitment

The practice had a recruitment policy that set out the standards they intended to follow when recruiting staff. This included a requirement to obtain photographic identification, references and verification of qualifications/ professional registrations (where relevant). We checked the General Medical (GMC) and Nursing and Midwifery Council's (NMC) records to confirm that all of the clinical staff were licensed to practise and received confirmation that all staff had received DBS checks.

The practice manager told us about the arrangements that were in place to ensure there were enough staff on duty at all times. A rota system was in place and only a certain number of staff were allowed off at any one time. Staff were flexible and would work additional hours if necessary. An example of this was that one of the practice nurses had increased the hours worked to make up a shortfall in nurse appointments as a result of one of the nursing staff being on long term sick leave. If the practice did have to use locum GPs they tended to use a GP from a neighbouring practice who had been a registrar at the practice so was familiar with practice policies and procedures. The practice had a comprehensive locum induction handbook.

Staff and patients we spoke to on the day of our inspection told us they felt there were enough staff to maintain the smooth running of the practice and to keep patients safe.

Monitoring safety and responding to risk

The practice had systems in place to manage and monitor risks to patients, staff and visitors to the practice. For example, they had created a latex free room and appropriate risk assessment when it was discovered that one of their patients suffered from a severe latex allergy. The practice also carried out regular checks of medicines management, equipment and staffing. The practice had a health and safety policy and staff had received health and safety training. Health and safety information was displayed for staff to see. We checked the premises and found it to be safe and hazard free.

Staff told us of the process they would follow if there was a medical emergency on site. All clinical rooms had panic buttons installed to alert other clinicians that their attendance was required. If the emergency occurred in the reception or waiting area staff would shout for help and a process was in place to ensure another member of staff collected the defibrillator and resuscitation kit, which were readily available for use.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. We saw records confirming that staff had received training in basic life support and/or cardio-pulmonary resuscitation (CPR).

Emergency equipment was available including a defibrillator and oxygen. Emergency medicines held on site were in line with national guidelines. This included medicines for the treatment of cardiac arrest and life threatening allergic reactions. Arrangements were in place to regularly check these were within their expiry date and suitable for use.

The practice had a comprehensive business continuity plan for dealing with a range of potential emergencies that could impact on the day-to-day operation of the practice and had a reciprocal arrangement in place with a

Good

Are services safe?

neighbouring practice. Mitigating actions had been recorded to reduce and manage the risks. Risks identified included the loss of the building, utilities, equipment (including IT and telephones), personnel and supplies.

The premises landlord (NHS Prop Co.) was responsible for carrying out fire risk assessments, fire alarms and fire drills.

Fire alarms were tested weekly but the premises had not had a recent fire drill. The practice manager was aware of this and had taken the appropriate action of raising the matter with NHS Prop Co. Staff had received on line training in fire safety and fire marshal's had been identified. Fire extinguishers were subject to an annual check.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The clinical staff we spoke with were able to clearly explain why they adopted particular treatment approaches. They were familiar with current best practice guidance and were able to access National Institute for Health Excellence (NICE) guidelines. From our discussions with clinical staff we were able to confirm they completed thorough assessments of patients' needs and these were reviewed when appropriate.

Practice staff were given regular protected time to carry out online training activities and attend training events. Clinical case discussion meetings involving all clinical staff were held on a weekly basis. These meetings included discussions about patients who regularly rang the 111 service, requested urgent appointments or attended A&E to see if a cause could be established.

The practice had a system in place to recall patients with long term conditions and chronic diseases for a review on an annual basis. This included a single review for patients with multiple long term conditions. Comprehensive personalised care plans were in place for the 2% of the practice population most at risk of unplanned admission to hospital. The practice nurse practitioner contacted any patient over the age of 70 who had been discharged from hospital to review the reason for the admission and whether a medication review or referral to the district nurse or community matron was required. It was hoped that this would result in a reduction in the number of unplanned admissions to hospital. Emergency admissions to hospital for those at risk of unplanned admission to hospital for the practice was 16.34% for the period 1 January 2014 to 31 December 2014. The national average was 14.4%

Interviews with the clinical staff demonstrated the culture in the practice was that patients were referred to relevant services on the basis of need. Patients age, sex and ethnicity was not taken into account in the decision making process unless there was a clinical reason for doing so.

Management, monitoring and improving outcomes for people

The clinical staff monitored how well the practice performed against key clinical performance indicators such as those contained within the Quality and Outcomes Framework (QOF).

The practice was able to demonstrate that it undertook clinical audit cycles to help improve patient outcomes. The practice was able to demonstrate that it had completed clinical audits although not all were two cycle audits. A two cycle audit of the prescribing of allopurinol to prevent gout had taken place in June 2013 and June 2014. The audit revealed that the practice did not have an effective protocol for the long term management of the condition and it was not following NICE or Rheumatology Society of UK guidance for prescribing the medication. The practice intended to repeat the audit in June 2015 but there was no evidence that this was done. The practice approach to carrying out clinical audits appeared to be inconsistent with no real evidence of why a topic was selected for audit or of follow up (2nd cycle) audits to check for improvement.

The practice used the information collected from QOF and performance against national screening programmes to monitor outcomes for patients. For example:

- 100% of patients with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive care plan documented in their record in the preceding 12 months which had been agreed with the patient and their family/carers (national average 86%).
- 95.6% of patients with diabetes had received a foot examination and risk classification within the preceding 12 months (national average 88.4%).
- 92.4% of patients with hypertension in whom the last blood pressure reading measured within the preceding 9 months was 150/90mmHg of less (national average 83.1%).

The practice had scored in line with or above the England average in the majority of QOF indicators. We confirmed the practice had obtained the maximum number of points available to them for delivering a good standard of care to patients with a range of conditions including asthma, atrial fibrillation, chronic kidney disease, dementia, epilepsy, hypothyroidism, and diabetes and to patients with a learning disability or mental health issue and those in need of palliative care.

Good

Are services effective?

(for example, treatment is effective)

The practice had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss the care and support needs of palliative care patients and their families.

Effective staffing

The staff team included medical, nursing, managerial and administrative staff. The partnership consisted of two GP partners and the practice manager. We reviewed staff training records and found that staff had received a range of mandatory and additional training. This included basic life support, fire safety, information governance, safeguarding and appropriate clinical based training for clinical staff. Staff had not received formal infection control training.

The GPs were up to date with their yearly continuing professional development requirements and had been revalidated (every GP is appraised annually and every five years undertakes a fuller assessment called revalidation. Only when revalidation has been confirmed by NHS England can the GP continue to practice and remain on the performers list). The practice nurses reported they were supported in seeking and attending continual professional development and training courses. The practice was also a teaching and training practice with both GP partners being approved trainers for third and fifth year medical students and GP registrars. The practice had also participated in an induction programme for German doctors, a GP career start programme and had also applied to host fully trained doctors carrying out humanitarian work. In addition the practice welcomed work experience applications from A level students interested in a career in a healthcare profession. The practice were committed to their involvement in teaching and training as they felt it could encourage GPs to remain in the area once qualified and therefore go towards addressing recruitment and retention problems. One of the GP partners was an approved GP appraiser and felt this was an opportunity for him to identify and implement good practice from other GPs.

All staff undertook annual appraisals from which personal development plans listing training requirements were developed. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses.

We looked at staff cover arrangements and identified that there were sufficient GPs on duty when the practice was open. Holiday, study leave and sickness were covered in house whenever possible.

Working with colleagues and other services

The practice worked with other service providers to meet patients' needs and manage complex cases. The practice received written communication from local hospitals, the out-of-hours provider and the 111 service, both electronically and by post. Staff we spoke to were clear about their responsibilities for reading and actioning any issues from communications with other care providers. They understood their roles and how the practice's systems worked.

The practice demonstrated they worked with other services to deliver effective care and treatment across the different patient population groups. The practice held monthly multidisciplinary team meetings with health visitors and the community matron to discuss palliative care patients and vulnerable children. The practice informed the health visitor for the area if any child under the age of five had registered with the practice to ensure that any safeguarding concerns were identified as soon as possible.

The practice had a system in place to ensure that hospital discharge letters were reviewed and patients contacted, if appropriate to review their medication and ensure the patients' needs were being met.

We found appropriate end-of-life care arrangements were in place. The practice maintained a palliative care register. We saw there were procedures in place to inform external organisations about any patients on a palliative care pathway. This included identifying such patients to the local out-of-hours provider.

Information sharing

The practice used electronic systems to communicate with other providers. Electronic systems were in place for making referrals, and the GPs were responsible for making referrals using the choose and book service which gives patients the ability to choose their own appointment dates and times. However, the practice had introduced a coloured card system to remind GPs to action referrals.

The practice had systems in place to provide staff with the information they needed. An electronic patient record was used by all staff to co-ordinate, document and manage

Good

Are services effective?

(for example, treatment is effective)

patients' 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

Patients were supported to express their views and were involved in making decisions about their care and treatment. Of the 117 patients who participated in the National GP Patient Survey published in July 2015, 80.8% reported the last GP they visited had been good at involving them in decisions about their care. This compares to a national average of 81.5% and local clinical commissioning group average of 84.9%. The same survey revealed that 94% of patients felt the last nurse they had seen had been good at involving them in decision about their care compared with a national average of 84.9% and local CCG average of 89.4%.

Staff told us they ensured they obtained patients' written, verbal or implied consent before undertaking any care or treatment and acted in accordance with their wishes.

The clinicians we spoke with showed they were knowledgeable of Gillick competency assessments of children and young people. Gillick competence is a term used in medical law to decide whether a child (16 years or younger) is able to consent to his or her own medical treatment, without the need for parental permission or knowledge.

Health promotion and prevention

There was a range of information on display within the practice reception area which included a number of health promotion and prevention leaflets, for example on child health, contraception and travel vaccinations. The travel vaccination leaflet and request form had been developed by one of the practice nurses to ensure that the length of the required appointment was identified at the time of booking. There were also separate notices for carers and in relation to dementia. The practice website also included links to a range of patient information including family health, long-term conditions and minor illnesses.

We found patients with long-term conditions were recalled to check on their health and review their medications for effectiveness. Processes were in place to ensure the regular screening of patients was completed, for example, cervical screening. Performance in this area for 2013/14 was 89.9% which was above the national average of 81.9%. One of the practice nurses told us that they had carried out 149 cervical smears during the period 1 April 2013 to 31 March 2014 and that only two of these had proved to be inadequate samples requiring the patient to be re called for a re test.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. On the basis of the nationally reported data available to the Care Quality Commission (CQC), we saw that, where comparisons allowed, the delivery of the majority of childhood immunisations was in line with or higher than the local CCG average. The parents/carers of children who did not attend for immunisations were contacted to ensure a reason was recorded and that there were no safeguarding concerns. The percentage of patients in the 'influenza clinical risk group', who had received a seasonal flu vaccination, was 51.6% (national average 52.3%) and the percentage of patients aged 65 or older who have received a seasonal flu vaccination was 73% compared to a national average of 73.2%. The practice offered a drop in clinic system for flu vaccinations and also used an external company to send invitation card to at risk patients.

The practice also offered NHS health checks for patients between the age of 40 and 74 and annual reviews for it's over 75s. New patients were not offered a health check but were asked about their smoking and drinking status, whether they had a long term condition or were a carer when registering with the practice. They were also asked to use a machine in the waiting room which took a reading of the patients' blood pressure, height and weight. This information would then be reviewed by a member of the clinical staff team.

One of the practice nurses and a health care assistant had been trained to be smoking cessation advisors.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

The patient we spoke with said they were treated with respect and dignity by the practice staff. Comments made by patients on Care Quality Commission (CQC) comment cards reflected this. Of the 17 CQC comment cards completed 13 were positive. Words used to describe the practice and staff included caring, helpful, professional, understanding, attentive and hygienic. Negative comments received were in respect of delays in getting an appointment, delay in being seen at appointment time and lack of continuity of care.

Data from the National Patient Survey, published in July 2015, showed the practice was in line with the national average for patients who rated the practice as good or very good. The practice was also rated as average or slightly below average for its satisfaction scores on consultations with doctors. For example:

- 87.8% said the GP was good at listening to them compared to the clinical commissioning group (CCG) average of 90.6% and national average of 88.6%.
- 94.6% said the GP gave them enough time compared to the CCG average of 94.3% and national average 91.9%.
- 91.7% said they had confidence and trust in the last GP they saw compared to the CCG average of 95.7% and national average of 95.3%

We observed staff who worked in the reception area and other staff as they received and interacted with patients. Their approach was considerate and caring whilst remaining respectful and professional. We saw that any questions asked or issues raised by patients were handled appropriately and the staff involved remained polite and courteous at all times. National GP Patient Survey results showed that 91.1% of respondents found the receptionists at the practice helpful compared with the CCG average of 89.9% and national average of 86.9%.

Reception staff made efforts to ensure patients' privacy and confidentiality was maintained. Voices were lowered and personal information was only discussed when absolutely necessary. A separate room was available if a patient wished to speak to a receptionist in private.

Staff were familiar with the steps they needed to take to protect patients' dignity. Consultations took place in rooms with an appropriate couch for examinations and curtains to maintain privacy and dignity. We noted that consultation and treatment room doors were closed during consultations and that conversations taking place in those rooms could not be overheard.

Staff were aware of the need to keep records secure and maintain confidentiality and had received training on information governance. We saw that patient records were computerised and systems were in place to keep them safe in line with data protection legislation.

Care planning and involvement in decisions about care and treatment

The National GP Patient Survey information we reviewed showed patients responses were generally in line with or above local and national averages in relation to questions about their involvement in planning and making decisions about their care and treatment. For example, the survey showed 80.8% of the 117 patients who responded to the survey said the last GP they saw or spoke to involved them in decisions about their care (CCG average 84.9% and national average 81.5%). 94% said the last nurse they saw or spoke to involved them in decisions about their care (CCG average 89.4% and national average 84.9%).

We saw that a translation and interpretation service was available for patients who did not have English as their first language and a hearing loop was available for patients with a hearing impairment. Providing this type of service helps to promote patients' involvement in decisions about their care and treatment.

Patient/carer support to cope emotionally with care and treatment

The patient we spoke with on the day of our visit told us staff responded compassionately when they needed help and provided support when required. The CQC comment cards we received were also consistent with this feedback. For example, patients commented that staff were caring, helpful and understanding.

We saw there was a variety of patient information on display throughout the practice. This included information on health conditions, health promotion and support groups.

The practice was proactive in identifying and responding to the needs of carers. A comprehensive carer's pack was

Good

Are services caring?

available which gave advice on the support available from the local carers centre and the Essence Service (for people living with dementia and their carers) and in respect of local authority carer's needs assessments.

The practice held quarterly multi-agency palliative care meetings. The practice regularly contacted patients experiencing bereavement to offer support.

The National GP 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 local CCG average of 87.5% and national average of 85.1%.
- 95.5% said the last nurse they spoke to was good at treating them with care and concern compared to the local CCG average of 93.3% and national average of 90.4%.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice had considered the needs of its patient population in planning its services. This included:

- Constant monitoring of demand for appointments which often led to increasing the number of GP appointments available. The practice manager told us that the GPs usually saw 14 patients during a morning session and 13 during an afternoon session but that this was often increased to 16 appointments per session per GP when demand dictated this.
- The roles of two of the administrative staff had been developed so that they also acted as health care assistants. These roles were created to specifically address delays and problems encountered in carrying out electrocardiograms which were now carried out on a daily basis. One of the health care assistants and the practice manager had also received training to enable them to become smoking cessation advisors.

The practice worked collaboratively with other agencies and regularly shared information to ensure timely communication of changes in care and treatment. For example, the practice had a palliative care register and held quarterly multidisciplinary meetings to discuss patients and their families' care and support needs. Practice staff were also able to demonstrate that they worked closely with other health care professionals such as school nurses, health visitors, drug and alcohol workers and counsellors. The practice had also developed effective working relationships with local nursing and residential homes, an extra care housing service for patients with dementia and a home for people with learning disabilities who required personal care.

The practice held a register of those patients with a learning disability or mental health condition. An alert was placed on the practice computer system for all vulnerable patients which enabled staff to identify them and ensure their needs were met when requesting appointments or during consultations. The practice had taken steps to ensure patients living with dementia were identified and received appropriate treatment and services.

The practice had ensured that all of its patients over the age of 75 had a named GP and were offered a health check. The practice was proactive in identifying and responding to the needs of carers.

The practice could demonstrate that it had considered suggestions for improvement and changes to the way services were delivered as a consequence of feedback from patients. The results of a patient survey carried out by the practice patient participation group (PPG) in February 2015 had led to the practice developing an action plan to:

- Increase the uptake of online services
- Update the practice website
- Develop a triage system for emergency appointments.

The PPG consisted of approximately 18 members who met on a bi monthly basis. We spoke to three members of the PPG on the day of our inspection who told us that the practice regularly arranged for speakers to attend their meetings, for example a podiatrist and representatives from the local carers association and the citizens advice bureau. However, as this information was not always disseminated it was not always of benefit to the practice population on a whole. The PPG had not identified future aims or objectives for the coming year and did not appear to be effectively engaged by the practice to inform improvement. Nor was information shared with the PPG by speakers attending their meetings made available to the practice population on a whole.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups of people in the planning of its services. The practice had access to a telephone translation service if required for those patients for whom English was not their first language. The practice also maintained registers for patients with caring responsibilities, patients with learning disabilities and patients receiving palliative care. All of these measures helped to ensure that all patients had equal opportunities to access the care, treatment and support they needed.

The reception are, waiting room and consultation rooms were all situated on the ground floor of the building which met the needs of people with disabilities. They were all accessible by those with mobility difficulties and there was step free and wheelchair access to the building. The practice had a car park with dedicated disabled parking. Lockable bicycle storage units were also available.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Although the GP partners were both male the practice employed a female locum GP from a neighbouring practice for one session per week. This gave patients the ability to choose to see a doctor of a particular sex if preferred. The locum GP had completed their GP training at the practice so was well known to patients and staff and aware of practice policies and procedures.

Access to the service

The practice was open from 8.00am to 6.00pm on a Monday, Tuesday and Friday and from 7.00am to 6.00pm on a Wednesday and Thursday. As the practice was part of Sunderland's West Locality Extended Hours Access Scheme their patients could also access emergency appointments at Grindon Lane primary care centre from 6.00pm to 8.00pm on a Monday to Friday and from 8.30am to 10.30am on a Saturday.

The practice had recognised the needs of different groups in the planning of its services. For example, the practice offered early opening from 7.00am two days per week to ensure appointments were accessible for patients who worked or students

The patients we spoke with and those who completed Care Quality Commission (CQC) comment cards said they were satisfied with the appointment system operated by the practice. Of the patients who participated in the 2015 National GP Patient Survey published in July 2015, 93.6% said they could easily get through to someone at the practice on the telephone (local CCG average 79.3%; national average 74.4%) and 80.3% stated they were satisfied with the practice opening hours (local CCG average 81.2%; national average 75.7%).

Appointments could be booked in the surgery, by telephone or online. We looked at the practice's appointment system during our inspection and found that a routine appointment was available with a GP five working days later. Urgent appointments were available the same day and telephone consultations were available by appointment. On Monday mornings the practice ran a Nurse Practitioner led triage system for urgent/emergency appointment requests. Every other day the urgent/emergency appointments requests were triaged by the on call GP. The on call GP also triaged requests for home visits which were carried out by the practice nurse if the patient was aged over 75. Telephone consultations were not routinely available but were available on request.

There were arrangements in place to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed there was an answerphone message advising the called to ring the NHS 111 service for further advice and guidance.

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. The practice manager was designated to handle all complaints and would investigate complaints in conjunction with the practice secretary. A leaflet detailing how to make a complaint was available and information was displayed in the reception areas and on the practice website.

The practice had recorded ten complaints for the period 1 April 2014 to 31 March 2015. From the complaints we looked at we found that they had been dealt with appropriately and apologies given where a complaint was felt to be justified. We saw evidence of complaints being discussed at team meetings with the aim of trying to identify trends and themes.

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. This was clearly outlined in their statement of purpose and their mission statement which stated that the practice aimed 'to deliver safe, effective quality of care, making it a truly patient centred service; treating people with dignity, being open, honest and truthful; to enhance care for our patients by providing high standards'.

The staff we spoke to told us they understood and were committed to their roles and responsibilities in relation to this.

The practice had a written business plan which they had entitled 'A Lifetime of Care'. The aims and objectives that the practice had identified included:

- To join the local GP alliance to aid collaborative working and integrated care (achieved in January 2015)
- To improve communication with patients. Achievements in relation to this to date were the development of a practice newsletter and the installation of a patient suggestion box.
- To improve the premises and, in particular the reception area
- To develop a young person's drop in clinic and consider the possibility of a community clinic at a local supermarket
- To improve the amount and availability of appointments

Governance Arrangements

There was a clear leadership structure with named members of staff in lead roles. For example GP leads had been identified for safeguarding and medicines management and one of the practice nurses was the lead for QOF with another being a specialist in the care of the elderly. Members of staff we spoke with told us they were clear about their own roles and responsibilities as well of the roles of others. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

The practice had a number of policies and procedures in place to govern activity and these were available to staff via the shared drive on any computer within the practice. We looked at a sample of these policies and procedures which were up to date.

The practice held regular staff meetings; however, consideration should be given to ensuring there is a more regular schedule of meetings and that practice and multi-agency meetings are minuted more effectively.

Leadership, openness and transparency

The GP partners had the experience, capacity and capability to run the practice and ensure high quality care. They had created a culture which encouraged and sustained learning at all levels in the practice, and had, through their partnership working with other agencies, promoted quality and continuing improvement. Staff told us the practice was well led, that they felt respected, valued and supported and would feel comfortable raising issues as they knew they would be addressed in a positive manner.

The practice was committed to their involvement in teaching, training and research and also in empowering their staff to develop their skills.

Seeking and acting on feedback from patients, public and staff

The practice had gathered feedback from patients through patient surveys, comments and complaints received.

The practice had an active patient participation group (PPG) who met on a bi monthly basis and were involved in carrying out patient surveys. The priorities identified from the survey carried out in February 2015 were to:

1. Improve the uptake of online services
2. Review and update the practice website
3. Develop a triage system for emergency appointment requests

There were four patient reviews of the practice on the NHS Choices website resulting in a rating of five (out of five) stars. Of the four reviews which were posted between November 2014 and July 2015, three were very positive. The negative review posted in November 2014 was in relation to dissatisfaction with reception staff but the reviewer still gave the practice a rating of four out of five stars overall. The practice had responded appropriately to all of the reviews.

Are services well-led?

Good

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

The practice gathered feedback from staff through staff meetings and on a more informal day to day basis. Staff we spoke with told us they regularly attended staff meetings and felt these provided them with the opportunity to discuss the service being delivered, feedback from patients and raise any concerns they had. They said they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged in the practice which they said helped to improve outcomes for both staff and patients.

A whistle blowing policy was in place which was available to all staff electronically on any computer within the practice. Staff we spoke with were aware of the policy, how to access it and said they would not hesitate to raise any concerns they had.

Management lead through learning and improvement

The practice provided staff with opportunities to continuously learn and develop, such as training to develop administrative staff to take on the role of health care assistant. A practice nurse told us they had opportunities for continuous learning to enable them to retain their professional registration and develop the skills and competencies required for chronic disease management. Regular staff appraisals were taking place for all staff which included agreeing personal development plans. In addition the practice nurses also attended monthly clinical supervision sessions with nurses from other practices in the locality. This gave them an additional opportunity to share good practice and learning.

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 Care and treatment was not provided in a safe way for service users through the proper and safe management of medicines. Specifically, the arrangements for storing and recording controlled drugs must be reviewed and strengthened to comply with schedule 2 of the Misuse of Drugs (Safe Custody) regulations 1973 (Regulation 12(1)(2)(g)