Mitcheldean Surgery

Quality Report

Brook Street
Mitcheldean
Gloucestershire
GL17 0AU
Tel: 01594 542270
Website: www.mitcheldeansurgery.co.uk

Date of inspection visit: 14 January 2015
Date of publication: 11/06/2015

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

Ratings

Overall rating for this service	Good
Are services safe?	Requires improvement
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	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 Mitcheldean Surgery on Wednesday 14 January 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. They were also good for providing services for the all the population groups and had an outstanding element for how they treated patients with a learning disability. They required improvement for providing safe services particularly for the management of medicines.

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 the management of medicines and infection control.
- 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 named GP and there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.

Summary of findings

- 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 was proactive in understanding the needs of patients with a learning disability and delivered their care in a way that met their needs and promoted equality. For example, they had increased accessibility to the practice to meet patient's individual needs, such as patients having the first appointment of the day and the ability to wait outside the practice for their appointment, if they wanted. To increase patient's involvement and understanding in their treatment decisions the practice had produced easy read guidance for patients on cervical smears and smoking cessation. Feedback from learning disabilities homes was very positive about the practice 'can do' attitude in seeing patients at home promptly. Some residents had moved to this practice following recommendations from others using the service. Patients and others feel comfortable within the practice environment and used the practice facilities for some time to hold local Asperger's support group meetings.

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

Importantly the provider must;

- Ensure medicine management systems are reviewed to ensure all medicines are kept securely and monitored appropriately.

And the provider should;

- Ensure emergency equipment checks are recorded to ensure equipment is maintained and checked at the correct intervals.
- Ensure infection control audits were completed at appropriate timescales to ensure the practice followed adequate infection control procedures to keep patients safe from the risk of infection.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

The practice is rated as requires improvement for providing safe services as there were areas where it must make improvements.

Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. There were enough staff to keep patients safe.

Although risks to patients were assessed, the systems and processes to address these risks were not implemented well enough to ensure patients were kept safe. There were improvements required in ensuring medicines, including emergency medicines, were kept secure, safely administered and appropriate systems in place to monitor them to ensure they were safe to use. Staff told us emergency equipment was checked but there was no record of this. Also, there was no evidence that the practice infection control procedures had been audited in the last year.

Are services effective?

Good

The practice is rated as good for providing effective services.

National data from the Quality and Outcomes Framework (QOF) showed patient outcomes were generally at or above average for the locality. Staff referred to guidance from the National Institute for Health and Care Excellence and used it routinely. Patient's needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. There was evidence of appraisals and personal development plans for all staff. Staff worked well with multidisciplinary teams.

Are services caring?

Good

The practice is rated as good for providing caring services.

National GP patient survey data showed patients rated the practice higher than others for a high number of aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information to help patients understand the services available was easy to understand. We also saw staff treated patients with kindness and respect, and maintained confidentiality.

Summary of findings

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services.

The practice reviewed the needs of its local population and engaged with the NHS England local area team and Gloucestershire Clinical Commissioning Group to secure improvements to services where these were identified. Patients said they found it easy to make an appointment with a named GP and there was continuity of care, with urgent appointments available the same day. The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. There was learning from complaints with staff and other stakeholders.

The practice was proactive in understanding the needs of patients with a learning disability and delivered their care in a way that met their needs and promoted equality. For example, they enabled patients to have the first appointment of the day and wait outside the practice for their appointment. They also produced supporting easy read guidance for patients on cervical smears and smoking cessation to enable informed decisions about their treatment. Feedback from learning disabilities homes was very positive about the positive attitude in seeing patients at home promptly.

Are services well-led?

Good

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

The practice had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group was active.

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.

The practice had a high population of older patients. The Quality and Outcomes Framework showed outcomes for patients were good for conditions commonly found in older patients. The practice offered proactive, personalised care to meet the needs of the older patients in its population and was responsive to the needs of patients who were living with dementia or were receiving end of life care. They offered home visits and rapid access appointments for those with enhanced needs.

People with long term conditions

Good

The practice is rated as good for the care of patients 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 their health and medicine needs were being met. For those patients 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 most 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. The premises were suitable for children and babies.

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).

Summary of findings

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 reflected the needs of this age group.

People whose circumstances may make them vulnerable

Good

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

The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability. The practice was proactive in understanding the needs of patients with a learning disability and delivered their care in a way that met their needs and promoted equality. For example, they enabled patients to have the first appointment of the day and wait outside the practice for their appointment. They also produced supporting easy read guidance for patients on cervical smears and smoking cessation to enable informed decisions about their treatment. Feedback from learning disabilities homes was very positive about the positive attitude in seeing patients at home promptly. They had carried out annual health checks for patients with a learning disability and 97% of these patients had received a follow-up between April 2014 and January 2015. They also offered longer appointments for patients with a learning disability.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable patients. They 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 patients experiencing poor mental health (including patients with dementia). From April 2014 to January 2015, 58% of patients experiencing poor mental health had received an annual physical health check. The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those with dementia. They carried out advanced care planning for patients with dementia.

Summary of findings

The practice had a good relationship with adult psychiatry services and the community psychiatric nurse visited the practice twice a month to provide clinics for patients. The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations including MIND. They 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 patients with mental health needs and dementia.

Summary of findings

What people who use the service say

We found patient satisfaction from all sources was consistently positive about patients experience at the practice. We received 156 comment cards. We found 97% of patients who had commented were highly satisfied with the service received. Patients commented on the commitment of practice staff in managing their health problems professionally and sensitively. End of life care was positively commented on with how practice staff had listened to their wishes. There were five comments where patients showed dissatisfaction in the service. There were no evident themes found.

During our inspection we met with the practice patient forum which was formed in 2006. We met with two of the 21 members. They told us the practice was committed to improving patient care and included the forum in the decision making process when changes were planned. The two patient forum members spoke very highly of the service provided and the positive impact on the practice when it responded following suggestions made by the patient forum.

During our inspection we spoke with six patients who were very complimentary about the practice. Patients said they felt the service was excellent and commented highly on the GPs and other staffs ability to know their needs and how to manage them.

Prior to our inspection we reviewed other information sources of what patients experienced with the service provided. This included NHS Choices (a forum for patients to publicly provide their views about the practice and where the practice can respond to these views). We saw there had been three patient comments made about the practice in the last year. All of these were again highly positive about their experience at the practice. The practice had an opportunity to respond to these comments on the website. However they had not used this yet.

We reviewed the national GP patient survey taken from patients for the periods of January to March and July to September 2014. This is a national survey sent to patients by an independent company on behalf of NHS England. We saw 128 patients had completed the surveys from the 254 sent. We saw 98% of patients surveyed said their overall experience of the practice was good with 99% of patients saying they trusted and had the confidence in the last GP they spoke with. There were no areas of significant dissatisfaction from patients.

Areas for improvement

Action the service MUST take to improve

- Ensure medicine management systems are reviewed to ensure all medicines are kept securely and monitored appropriately.

Action the service SHOULD take to improve

- Ensure emergency equipment checks are recorded to ensure equipment is maintained and checked at the correct intervals.
- Ensure infection control audits were completed at appropriate timescales to ensure the practice followed adequate infection control procedures to keep patients safe from the risk of infection.

Outstanding practice

The practice was proactive in understanding the needs of patients with a learning disability and delivered their care in a way that met their needs and promoted equality. For example, they had increased accessibility to the practice to meet patient's individual needs, such as patients having the first appointment of the day and the ability to

wait outside the practice for their appointment, if they wanted. To increase patient's involvement and understanding in their decisions the practice had produced easy read guidance for patients on cervical smears and smoking cessation. Feedback from learning disabilities homes was very positive about the practice 'can do' attitude in seeing patients at home promptly.

Some residents had moved to this practice following recommendations from others using the service. Patients and others feel comfortable within the practice environment and used the practice facilities for some time to hold local Asperger's support group meetings. The group has now become too large and meets elsewhere in the local area.

Mitcheldean Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

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

Background to Mitcheldean Surgery

We inspected the location of Mitcheldean Surgery, Brook Street, Gloucestershire, GL17 0AU, where all registered regulated activities were carried out.

The practice serves approximately 6,125 patients and sees patients who live in the Forest of Dean and the surrounding areas. The national general practice profile shows the practice has a significantly higher population of patients aged between the ages of 65 and 69 years old approximately 8% higher than the England average. They are also just above the national and local average for 69 years and older. Levels of deprivation within the population served by the practice were lower than national average.

The practice can dispense medicines to patients who live over a mile from the practice. They dispense approximately 5000 medicines a month to patients.

Additional services are provided from the practice premises including NHS ultrasound service, pain clinic, primary mental health clinics, speech and language therapy and midwifery and health visitors' sessions. Patients can also access physiotherapy and chiropody privately within the practice. District nurses are permanently based in the practice.

At the time of our inspection there were three GP partners and one salaried GP; two male and two female. The salaried GP was leaving on the 19 January 2015 and a trainee GP was starting on the 5 February 2015. The practice has been a registered GP training practice for four years with one qualified GP trainer.

There were three female members of the nursing team which consisted of two practice nurses and one health care assistant.

The practice had a General Medical Service contract with NHS England. The practice referred its patients to Gloucester Access Centre and the NHS 111 service for out-of-hours services to deal with urgent needs when the practice was closed.

The practice had patients registered in four nursing homes, two residential homes for older people and eight learning disability residential homes.

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.

Detailed findings

How we carried out this inspection

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

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

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

- Older patients
- Patients with long-term conditions
- Families, children and young patients
- Working age patients (including those recently retired and students)
- Patients whose circumstances may make them vulnerable
- Patients experiencing poor mental health (including patients with a form of 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 spoke with the Gloucestershire Clinical Commissioning Group, NHS England local area team and local area Healthwatch. We carried out an announced visit on the 14 January 2015. During our visit we spoke with 13 staff including the four GP's, the practice manager, the dispensary manager and assistant, one practice nurse, one health care assistant, a reception manager, receptionist and two administration staff.

We spoke with eight patients including two members from the patient forum and reviewed 156 comment cards where patients shared their views and experiences of the service prior to our inspection.

Prior to the inspection we also spoke with four senior staff members from two nursing homes, a residential home and two learning disability homes where there were residents who were registered at Mitcheldean Surgery to gain their experience of the service provided.

Requires improvement

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents and 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 became threatening to a member staff whilst in the treatment room. A GP was used to help diffuse the situation and the patient left. The GP visited the patient to check they were ok as this was out of character for the patient. They also had a significant events meeting and agreed to change the protocol for accessibility of appointments for patients who required additional support. For example, patients to be prioritised for first appointments of the day, when a need for this had been identified.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. We saw six significant events had occurred during the last year. Significant events were discussed with relevant members of staff usually during the lunchtime after they had occurred and would be discussed more formally at monthly clinical meetings. There was evidence the practice had learned from these and the findings were shared with relevant staff. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

Staff could access incident forms via the practice intranet or hard copy forms were available and completed forms were sent to the practice manager. They showed us the system used to manage and monitor incidents. We saw incidents were logged and evidence of action taken as a result. For example, a patient had threatened a GP. The practice had taken action to ensure there was an alert on the system and the situation was dealt with sensitively to ensure all parties were kept safe and patient needs were met.

National patient safety alerts, such as from the Medicines and Healthcare Products Regulatory Agency (MHRA) were disseminated through the practice manager to relevant practice staff. Staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for. They also told us alerts were discussed together at monthly clinical meetings, where necessary, 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 read 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 vulnerable adults and children. They were aware of their responsibilities of sharing information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details were easily accessible via the practice safeguarding policy which was available for all staff on the intranet. One of the GPs told us of an example of when they had used safeguarding procedures for a vulnerable patient and how support was obtained through social services.

The practice had appointed a dedicated GP to lead in safeguarding vulnerable adults and children. All GPs had been trained in level three child protection training and could demonstrate they had the necessary training to enable them to fulfil this role. All staff we spoke with were aware who the lead was and who to speak with in the practice if they had a safeguarding concern. The lead GP attended national safeguarding meetings for leads and shared learning with the other GPs on his return of what was discussed.

GPs attended child case conferences and core group meetings when possible. An example was given of the level of input and support given along with relevant health care professionals. Also, one of the trainee GPs attended case conferences and the GP lead fed back to social services where it was felt a GP should have been invited to ensure continued learning to improve outcomes for patients involved.

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 a child who was on the child protection register.

We saw evidence of the practice advertising the use of a chaperone if a patient wanted one. There was a chaperone policy, which was visible on the waiting room noticeboard and in consulting rooms. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). Nursing staff, including health care assistants and receptionists had been shown how to be a chaperone by a GP and had criminal background checks completed through the Disclosure and Barring service.

Medicines management

The practice was a dispensing practice and had a wide range of medicines stored within the practice. There was a separate dispensing area which was attached to reception. We noted this area was not secured and there was no controlled access other than the reliance of staff presence within the area. For example, doors entering both the reception area and dispensary had no lock. However, the practice told us staff were present in this area during working hours at all times. Emergency medicines to treat anaphylaxis were stored in an unsecure cupboard in the corridor near the treatment and consulting rooms. Blank prescription forms were not held securely at all times although GPs were provided with a box of prescription pads at a time, which was held securely. However, some GPs kept unused prescription pads in their home visit bags, which were sometimes left in unsecure consulting rooms.

Vaccine refrigerators were kept at required temperatures through twice daily monitoring of the refrigerator including the current, minimum and maximum temperature recorded. We noted there was no manual thermometer if the installed refrigerator thermometer failed. Staff spoken with understood the action they needed to take in the event of a potential power failure or when the temperatures were outside of the guidelines. The nurses administered vaccines using up-to-date directions that had been produced in line with legal requirements and national guidance.

Processes were in place to check medicines were within their expiry date and suitable for use. Medicines in the dispensary that we checked were within their expiry dates and all medicines were checked every three months by dispensary staff. A member of the dispensary team checked home visit bags every six months and the GP were responsible for checking the bags during in the six month period. Staff told us they checked the emergency medicines were within their expiry date. However, there was no record of checks to ensure emergency medicines were safe to use. Expired and unwanted medicines were disposed of in line with waste regulations.

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. The practice was above national average on prescribing anti-psychotic medicines. They were also above average in the percentage of patients with dementia and nursing home allocation. The practice had undertaken an audit for patients who were taking these medicines and found there was regular and continued review of these medicines for these patients.

The practice held stocks of controlled drugs (medicines that required extra checks and special storage arrangements because of their potential for misuse) and had in place standard operating procedures that set out how they were managed. These were being followed by the practice staff. For example, controlled drugs were stored in a controlled drugs cupboard and access to them was restricted and the keys held securely. There were arrangements in place for the destruction of controlled drugs. Staff were aware of how to raise concerns around controlled drugs with the controlled drugs accountable officer in their area. However, we noted a vial of morphine was kept in a home visit bag, which was also sometimes left unattended in consulting rooms.

Dispensing staff ensured prescriptions were signed by the GP before they were dispensed to the patient. If patients requesting a repeat prescription that was past its due date then these were checked by the GP before it was dispensed. The practice had a system in place to assess the quality of the dispensing process and had signed up to the Dispensing Services Quality Scheme, which rewards practices for providing high quality services to patients using their dispensary. Dispensing staff told us they were in the process or had completed national vocational qualifications in dispensing.

Safe systems of dispensing were not in operation for compliance aids. Medicine compliance aids (dosette boxes)

were filled by one member of staff and were not routinely check by another staff member to ensure the patient received the correct medicines at the correct time and day. There had been four incidents in the last year where compliance aids had been filled incorrectly. Either the strength of the medicine was incorrect or in one case a medicine had been missing from the compliance aid. The practice manager told us that in one incident where a patient's relative had raised a concern about the dispensing of the compliance aid, they had met with the family and in this particular case the compliance aid was now double checked by another member of the dispensary staff. Since these incidents the practice manager double checked two of the complex compliance aids and staff alternate completing different patient aids every month to avoid complacently. However, not all compliance aids were double checked by another member of staff.

For the last 34 years the practice had established a service for patients to pick up their dispensed prescriptions at community locations in three outlying villages. They had systems in place to monitor how these medicines were collected. Controlled drugs were not provided through this service. They also had arrangements in place to ensure patients collecting medicines from these locations were given all the relevant information they required.

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.

The practice had a lead for infection control. All staff received training about infection control specific to their role. There had been a recent change in the lead for infection control and staff were unable to find the latest infection control audit. The practice manager assured us an audit had been completed and would be completing another replacement audit as soon as possible.

We saw personal protective equipment including disposable gloves, aprons, masks and couch coverings were available for staff to use. Hand washing sinks had hand soap and hand towel dispensers were available in treatment rooms.

The practice employed an external contractor to carry out regular checks in line with reducing the risk of legionella infection to staff and patients (Legionella is a bacterium that can grow in contaminated water and can be potentially fatal).

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. We were told and we saw equipment records which confirmed all equipment was tested and maintained regularly. We saw fire extinguishers, blood pressure monitors, electrocardiogram (ECG) and weighing scales had been recently tested and the weighing scales were due to be checked in the week we inspected. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date.

Staffing and recruitment

We reviewed two recently recruited staff recruitment files which contained evidence of appropriate recruitment checks that had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks through the Disclosure and Barring Service (DBS). The practice had a recruitment policy which had been last reviewed in January 2015. The policy set out the standards it followed when recruiting clinical and non-clinical staff. However, it did not specify what was required under legislation. For example, the necessity to have evidence of proof of identification, references from health and social care related employment and who is eligible for DBS checks.

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

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 actual staffing levels and skill mix were in line with planned staffing requirements.

Requires improvement

Are services safe?

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included annual and monthly checks of the building, the environment, staffing and equipment. Health and safety information was displayed for staff to see and there was an identified health and safety representative.

The practice used an external company to carry out a health and safety risk assessment, which was last completed in 2014. This covered fire safety, legionella checks, first aid, portable electrical equipment and check of the building. We saw recommendations from the risk assessment had been completed. The practice had invested in the building to improve its facilities for patients and in an event of a fire. For example, the practice planned to change the front entrance doors to automatic to increase accessibility for patients. Part of the practice upgrading plan the practice had installed intumescent strips to provide a block around the door frames to help to contain a fire.

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 in March 2014 and one member of staff had completed intermediate life support training. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). When we asked members of staff, they all knew the location of this equipment. We were told the emergency equipment was checked weekly. However there were no records of this. Emergency medicines were available, which included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. All the medicines we checked were in date and fit for use.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Risks identified included power failure, adverse weather, unplanned sickness and access to the building.

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 spoken with provided examples of when their procedures had changed following a guideline updated. For example, Public Health England had updated when children should receive a meningitis C vaccine and now the protocol reflected this change.

One of the GPs told us they lead in diabetes management following the additional training. They were now introducing new injectable treatments and insulin's for diabetes and reducing other medicines taken, in line with recommendations in current NICE guidelines. The other GPs referred patients with complex needs to this GP to ensure patients were treated by the most appropriate GP.

Staff we spoke with were open about asking for and providing colleagues with advice and support. GPs told us this supported all staff to continually review and discuss new best practice guidelines.

One of the GPs told us all hospital discharge letters were seen by the most appropriate GP within 24 hours of being received. Following a review of the discharge the GP would judge whether the patient required no action, a phone call or an appointment with the GP.

All GPs we spoke with used national and local standards for referral of patients with suspected cancers. Patients were usually referred the same day (and always within 24 hours in the event of presentation after office hours), to be seen in a consultant clinic within two weeks. We were told all suspected cancer referrals were reviewed to provide an overview of the referral process. The reviews included analysis of whether earlier diagnosis might have been possible. The practice secretary told us they had a system in place to prioritise urgent referrals and these were completed the same day as received. They checked the system each day to ensure referrals had been received by the hospital and called the hospital to check, if necessary. Maximum turnover for all referrals was three days.

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. For example, we heard of two cases where patients and the GP used the telephone interpretation line during a consultation to ensure they fully understood their treatment and had the ability to discuss their options before decisions were made.

Management, monitoring and improving outcomes for patients

The practice had a system in place for completing clinical audit cycles. The practice showed us six clinical audits that had been undertaken recently. Following each clinical audit, changes to treatment or care were made where needed and the audit was repeated to ensure outcomes for patients had improved. For example, following an alert from the Medicines and Healthcare Products Regulatory Agency (MHRA) regarding a medicine used for heart problems a clinical audit was carried out. The aim of the audit was to ensure that all patients prescribed this medicine were changed to a medicine with less risk of drug interactions. The first audit in January 2014 demonstrated that 26 patients had not had their medicine changed. The information was shared with GPs and patients were called for a medication review. A second clinical audit was completed in January 2015 which demonstrated that only one patient was not receiving the changed treatment.

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 effectively managing some of the most common long-term conditions and for the implementation of preventative measures). For example, we saw an audit carried out in February 2013 regarding the length of antibiotics treatment courses for cystitis. The practice had re-audited in February 2014, which had shown an increase in GPs prescribing a three day course (a short course recommended for uncomplicated presentations) of antibiotics from 5.3% in February 2013 to 57.8% in February 2014.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. We saw the practice had higher than England and Gloucestershire

Good

Are services effective?

(for example, treatment is effective)

Clinical Commissioning Group (CCG) average for completion of their QOF outcomes with an exception rate of 9.5%. For example, 99.5% of patients with diabetes had an annual medication review including a foot and eye check, which again was above national and CCG average. The practice was above national and local CCG average with 88.4% for patients who smoked who were offered support and advice to give up smoking. Also the percentage of patients with hypertension who were provided with lifestyle advice was above national and local CCG average with 89.8%.

The team was making use of clinical audit tools, clinical supervision and staff meetings to assess the effectiveness of interventions made by clinical staff. 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. The practice had monthly clinical meetings and alternated topics were presented from different members of the team. Topics were either based on their skills and experience or staff were asked to research a particular subject to enable team learning. We heard presentations had been used for flu vaccines, dementia following an audit completed and cervical screening programme.

The practice was part of the original project that informed the Gold Standards Framework for end of life care. They had a palliative care register at the time of the inspection. The practice had quarterly multidisciplinary meetings with district nurses and the palliative care team to discuss the care and support needs of patients and their families. They also had a good working relationship with the local pharmacies to ensure anticipatory care medicines were available for patients in advanced need. The practice dispensary also had these medicines available.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as basic life support and fire safety. We noted a good skill mix among the doctors with three having additional diplomas in obstetrics and gynaecology medicine, and one with a diploma in children's health. 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 proactive in providing training and funding for relevant courses, for example a nurse had requested further education in chest examinations and the practice had encouraged this and now the nurse had developed her role. Another member of staff had started in the practice as a phlebotomist and the practice had encouraged training for the health care assistant qualification and additional training in subjects, such as ear syringing and spirometry.

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. The practice 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. One of the GPs outlined their responsibilities of dealing with blood tests results and X-rays which were reviewed by the referring GP and usually within the same day. If this GP was unavailable then another GP would be allocated the results. The GP who saw these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well.

The practice was commissioned for the enhanced service for helping to avoid unplanned hospital admissions within the top 2% of patients at the highest risk of being admitted. (Enhanced services require an enhanced level of service provision above what is normally required under the core GP contract). The practice had completed 107 care plans, which was over 2% of their threshold. We were told further letters had been sent to patients to participate. Care plans reviewed areas such as any end of life decisions and patient choices on hospital admissions. All patients were provided with a copy of their care plan and GPs reviewed them every three months.

The practice provided care and treatment to a number of patients who resided in 13 local nursing homes, residential and learning disability homes. We spoke with five out of 13 who all provided us with positive feedback about the

Good

Are services effective?

(for example, treatment is effective)

service provided. All nursing homes had an allocated GP who visited each home once a week. The learning disability homes were visited by a GP as when they were needed. They all said they had a good relationship with the practice and the practice involved families regularly in decision making, where necessary. If patient's in the nursing home required urgent attention then this would be dealt with promptly alongside any repeat prescription requests.

Information sharing

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

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record in the patient record system to coordinate, document and manage patients' care. All staff were fully trained on the system, and commented positively about the system's safety and ease of use. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

Consent to care and treatment

We found staff were aware of the Mental Capacity Act 2005 and their duties in fulfilling them. All the GPs we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice. When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision. For example, a patient who was in need of hospital admission was declining this and a capacity assessment was made involving people the patient knew best and it was established their illness was not affecting their capacity and so the patient's wishes were respected.

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. All clinical staff demonstrated a clear understanding of Gillick competencies. (These are used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions). We heard an example of when this was used for emergency contraception for a child under the age of 16 years old.

The practice carried out minor surgery for patients with sebaceous cysts, non-suspicious moles, in-growing toe nails, skin biopsy and long active contraceptive implants. For all minor surgical procedures written consent was taken including risks of complications. An annual audit was completed by the GP completing the minor surgery, although, this did not include whether consent was obtained.

Health promotion and prevention

We noted a culture among the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing. The practice had also identified the smoking status of 91% of patients over the age of 15 and 90.4% of these patients had been actively offered nurse-led smoking cessation clinics, which was above Gloucestershire CCG and England average. Patients wishing to give up smoking were offered a 12 week programme with an advisor for smoking cessation.

The practice had numerous ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice kept a register of all patients with a learning disability. All 59 patients with a diagnosed learning disability were offered an annual physical health check. Since April 2014 to January 2015, 97% of the 59 patients had received an annual health check. The previous year April 2013 to March 2014, 100% of patients had received an annual health check.

It was practice policy to offer a health check with the health care assistant 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's performance for cervical smear uptake was 74.9%, which was lower than other practices in the Gloucestershire CCG area and England average. The practice offered a full range of immunisations for children,

Good

Are services effective?

(for example, treatment is effective)

travel vaccines and flu vaccinations in line with current national guidance. Child immunisations performance from April 2013 to March 2014 showed four out of 16 of different categories of immunisation were below average for the CCG. The other 12 results were either higher or on average with the Gloucestershire CCG area. We saw the uptake of flu vaccines for patients aged 65 years and over was 64.5% from September 2013 to February 2014, which was similar to expected in comparison to the England average.

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 GP patient survey from 2014 gaining views from 128 patients and a survey of 244 patients undertaken by the practice's patient forum in August 2013. The evidence from these sources showed patients were satisfied with how they were treated and that they had been treated with compassion, dignity and respect. Data from the national GP patient survey showed the practice was rated above Gloucestershire Clinical Commissioning Group (CCG) average as 98% of patients rated the practice as good or very good. The practice was above the CCG average for its satisfaction scores on consultations with doctors with 95% of practice respondents saying the GP was good at listening to them and 94% saying the GP gave them enough time. We saw 98% of patients had confidence in the nurses and 93% of patients said nurses were good at treating them with care and concern.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 156 completed cards which were highly positive about the service experienced with only five negative comments about the service. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. We also spoke with six patients visiting the practice on the day of our inspection and two members from the patient forum. 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 consultations and treatments were carried out in the privacy of a consulting room. Curtains were provided in consulting rooms and treatment rooms so patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted consultation and treatment room doors were closed during consultations and conversations taking place in these rooms could not be overheard.

We saw staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so confidential information was kept private. Patient calls were taken at the reception desk and there was a screen to assist with ensuring patient confidentiality. The reception desk had a lowered area for patient accessibility and also provided an additional area for staff to talk to patients more confidentiality or additionally patients could be taken to another room.

Staff told us that if they had any concerns or observed any instances of discriminatory behaviour or if patients' privacy and dignity was not being respected, they would raise these with the practice manager. The practice manager told us they would investigate these and any learning identified would be shared with staff.

There was a clearly visible notice in the patient reception area stating the practice's zero tolerance for abusive behaviour.

Care planning and involvement in decisions about care and treatment

The GP national patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example, 94% of practice respondents said the GP involved them in care decisions, 95% of patients said they were good at listening to them and 96% felt the GP was good at explaining treatment and results. The practice lowest satisfaction score was 22% of patients told us they had waited too long for an appointment to be seen in surgery. This had not been commented on through talking to patients or through the 156 comment cards completed by patients.

Patients we spoke with on the day of our inspection told us 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 translation services were available for patients who did not have English as a first language. We heard examples of when a GP had used a translation telephone service in a consultation.

Patient/carer support to cope emotionally with care and treatment

Patients spoken with on the day of the inspection provided us with examples of when they felt GPs had provided

Good

Are services caring?

compassionate care and supported patients in times of need emotionally and physically. For example, a patients relative told us they suffered with a mental health problem and when their relative rang staff were always aware of how to meet their needs and if they needed additional support.

Notices in the patient waiting room advised patients how to access a number of support groups and organisations. The practice's computer system alerted GPs if a patient was a carer so this could be taken into consideration when discussing treatment.

One of the GPs told us patients had an open door arrangement for support if they had suffered from a bereavement. GPs would signpost to local support groups and agencies, where necessary or could refer to a talking therapy service run by Gloucestershire NHS Foundation Trust. We heard from one patient who had lost their relative and the GP had phoned the next day and offered to visit them at home.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patient'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 NHS England local area team and Gloucestershire Clinical Commissioning Group (CCG) told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised. One of the practice nurses told us they had the opportunity to attend bi-monthly meetings with other practice nurses in the local area and there were opportunities for training depending on the needs within the local area. For example, there had been external speakers to discuss dermatology and atrial fibrillation, specialists nurses for Chronic Obstructive Pulmonary Disorder (COPD) and diabetes along with representatives from local support groups in the area.

The practice had implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient forum. The forum set up and developed a patient information area within the patient waiting area of the practice. This was set up to provide additional and relevant information for patients which was easy to find and identify. There were leaflets on; general service information, dispensary service, chaperone policy, confidentiality, access to medical records, antibiotics and keeping children and young people safe.

Tackling inequity and promoting equality

There was a proactive approach to understanding the needs of different groups of patients and to deliver care in a way that meets these needs and promotes equality. The practice had 59 patients who were diagnosed with a learning disability. The practice had worked hard to ensure patients with a learning disability felt welcomed in the practice and worked with them to improve how the practice run their services to better meet their needs. For example, to encourage and help support patients understanding of cervical smears and smoking cessation the practice had created an easy read booklet. Individual patients had informed the practice what could be improved when they visited the practice. The practice now had a policy to enable patients to book the first appointment of the day and if they chose to wait outside the practice and be called they could. We heard when we spoke to learning disability homes that they had chosen this practice from recommendations from others. They also told us phoning the practice to cancel appointments in the practice and requesting home visits was never a problem. The practice had the majority of patients registered from eight local care homes. All annual check-ups were completed in their own homes. The practice was active in supporting an Asperger's local support group and the group was able to hold their meetings at the practice.

The practice actively supported patients who have been on long-term sick leave to return to work by GPs supporting them through discussions about a phased return to work including duties they can complete and liaising with employers, where necessary.

The premises and services had been adapted to meet the needs of patient with disabilities. We saw that the waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities.

The practice had a population of almost 100% English speaking patients though it could cater for other different languages through translation services. The practice had access to telephone translation services and we heard of examples where translation lines had been used to assist patients who were unable to speak English. Where patients were unable to use the telephone individual agreements were made with the patients to ensure they could contact the practice. For example, patients had emailed the practice to make appointments or to raise any queries.

Access to the service

Appointments were available from 8:30am to 6:00pm from Monday to Thursday and on Fridays the practice closed at 5:30pm. Gloucester Access Centre was available for patient use when the practice was not open from 8:00am to 8:00pm seven days a week and outside of these hours patients were informed to use the NHS 111 service. The practice had a triage system for patients wishing to make an appointment; GPs split their time in the morning surgery to see patients, make phone calls to patients and see patients for same day appointments late morning and in the afternoon along with routine appointments.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Appointment system information was available to patients 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 not provided to patients through the practice website only extended hours information for Gloucester Access Centre.

Longer appointments were also available for patients who needed them. This also included appointments with a named GP or nurse. Home visits were made to allocated nursing homes on a specific day each week, by a named GP and to those patients who needed one.

Patients were generally satisfied with the appointments system. They confirmed they could see a GP on the same day if they needed to. They also said they could see another doctor if there was a wait to see the doctor of their choice. Comments received from patients showed that patients in urgent need of treatment had often been able to make appointments on the same day of contacting the practice

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. The complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. The policy also included details for the patient to contact advocacy services, if they wanted additional support. There was a designated responsible person who handled all complaints in the practice.

We saw information was available to help patients understand the complaints system in the practice complaints leaflet, which was available within the waiting area. Information on how to and who to complain to was detailed in full on the practice website. Patients we spoke with were generally aware of the process to follow if they wished to make a complaint.

We saw records of eight complaints which had been received from January 2014 to December 2014. We found complaints were around a number of areas, such as appointments and care received and there was no apparent theme. Where complaints constituted a significant event these were shared in significant event meetings. All learning from complaints was disseminated to appropriate staff after it had been investigated. We saw two complaints in detail which had been discussed and learning identified.

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 and business plan. The practice manager and senior partner had weekly business meetings and additional meetings were held involving all of the partnership to discuss the business direction and drive the business forward. The practice vision and values included; treat all patients and carers as individuals, ensure all patients receive the most appropriate care, administered by a suitably qualified member of staff and engage with our patients and note their feedback on services, implementing change wherever reasonably practicable/as necessary.

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 read nine of these policies and procedures and all had been reviewed annually and were up to date.

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 a GP partner was the lead for safeguarding. We spoke with 13 members of staff and they were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed their performance was consistently in line with national standards. The practice had an administrator and GP who lead on QOF to ensure it was kept up to date and accurate. Areas for improvement were highlighted to the lead GP to review and discussed at clinical meetings.

The practice had an on-going programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. For example, an audit was completed for patients taking a specific medicine for irregular heartbeats to ensure they were having an annual electrocardiogram (ECG) test annually. Audits had been completed in September 2013, March and December 2014. These showed an improvement at each audit cycle initially in September 2013 42% of patients had an ECG and by December 2014 73% of patients had received one.

The practice had arrangements for identifying, recording and managing risks. The practice manager told us the risk log was discussed either quarterly or every six months at practice meetings, which was confirmed by reviewing these meeting minutes.

Leadership, openness and transparency

Staff told us there was an open culture within the practice to raise concerns because staff felt supported and found the management team very approachable. All staff had the opportunity and were happy to raise issues at monthly team meetings. The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies including the recruitment policies, which were in place to support staff. Staff could access all policies and procedures through the staff intranet.

Seeking and acting on feedback from patients, public and staff

The practice had gathered feedback from patients through patient surveys and comment and complaints received. We read the results of the annual patient survey which had gained views from 244 patients in August 2013 and found 93% of patients rated the practice either good, very good or excellent. The results showed that out of 28 areas 27 of them were higher than the national average. The survey covered areas such as, satisfaction with opening hours, appointment times, ability for GPs to listen to patients and respect shown. Changes that had been made following patient feedback, involvement with the patient forum and practice staff were; upgraded telephone system to provide more lines including a dedicated cancellation line for patients wishing to cancel their appointments. In addition there was an upgrading of premises including reception, treatment room and recovering chairs in the waiting area.

The practice had an active patient forum which had 21 members and they had recently started a virtual group email. These groups included male and females from the ages of 35 years and above. The practice hoped the virtual group would encourage representatives from all population groups and ages. The practice manager

Are services well-led?

Good

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

showed us the analysis of the last patient survey, which was considered in conjunction with the patient forum. The results and actions agreed from these surveys were available on the practice website.

The practice had gathered feedback from staff through staff meetings, appraisals and discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

The practice had a whistleblowing policy which was available to all staff in the staff handbook and electronically on any computer within the practice.

Management lead through learning and improvement

Staff told us the practice supported them to maintain their clinical professional development through training and mentoring. All staff attended regular meetings within the practice and educational meetings were held regularly to develop and share learning on key topics, such as dementia.

The practice had completed reviews of significant events and other incidents and shared with staff at meetings 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 Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Patients were not protected against the proper and safe management of medicines because the systems to enable secure storage and monitoring of medicines needed to be improved. We found evidence of a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 (now Regulation 12(1) Safe care and treatment including Regulation 12(2)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014).