Cookham Medical Centre

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Cookham Medical Centre on 11 March 2015. This was the first inspection of the practice.

Overall the practice is rated as good.

Specifically, we found the practice to be good for providing effective, caring, responsive and well led services. However, the practice requires improvement in the provision of safe services and should review the availability of appointments for patients who work. Specifically, control of infection processes need to be improved as do some aspects of monitoring quality and maintaining records.

The practice had undergone a period of significant change during 2014. Two GP partners had left the practice and there had been an interim period before new partners came into post. The practice manager had been in post for eight months. Prior to their coming into post a locum manager had supported the practice.

Our key findings for the practice were:

- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses.
- Staff had a clear understanding of safeguarding both vulnerable adults and children and there were examples of appropriate safeguarding alerts being raised.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment. Information was provided to help patients understand the care available to them.
- The practice implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from patients and from the Patient Participation Group (PPG).
- 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

Summary of findings

- The practice had a firm commitment to training and staff were committed to maintaining and improving their skills and abilities to carry out their roles.

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

Importantly, the provider must:

- Implement a cleaning specification for the practice and monitor cleaning standards. Reduce the risk of cross infection from cleaning equipment by ensuring appropriate segregation of such equipment and undertake a Legionella risk assessment.
- Ensure systems are in place to identify, assess and manage risks to the health, safety and welfare of patients and others and maintain appropriate records that support such systems.

In addition the provider should:

- Ensure that records of all pre-employment checks required by legislation are retained.
- Expand the number of completed clinical audit cycles to monitor clinical quality and systems to identify where action could be taken.
- Consider improved access to appointments for patients of working age and expand the availability of online access to services.
- Review and undertake a risk assessment to determine which emergency medicines should be held in the practice.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

The practice is rated as requires improvement for providing safe services as there are areas where it should make improvements. Staff understood their responsibilities to raise concerns, and to report incidents and near misses. Risk assessments of the building and health and safety matters were undertaken. Although risks to patients who used services were assessed, the systems and processes to address these risks were not implemented well enough to ensure patients were kept safe. The practice must make improvements in providing consistent standards of general cleanliness to reduce the risk of cross infection from general cleaning procedures. Checks of the safety of the environment must also be undertaken and recorded. It should also complete and record all pre-employment checks for staff to ensure they are of good character and fit for the post to which they are employed.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. Staff referred to best practice guidelines from a variety of sources and used these 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. Training was actively promoted and a comprehensive training plan was in place for all grades and disciplines of staff. There was evidence of appraisals and staff worked with health and social care professionals on a regular basis. However, we noted the range of completed clinical audit cycles was limited and the practice should introduce an audit programme to identify, plan and monitor improvements to clinical care.

Are services caring?

Good

The practice is rated as good for providing caring services. Data form 2014 showed that patients felt the practice team were caring but could improve further. Our discussions with patients during the inspection and recent feedback to the practice showed that improvements had been made and patients were more positive about the care they received. Patients were very positive about being treated with compassion, dignity and respect and they were

Summary of findings

involved in decisions about their care and treatment. Information to help patients understand the services available was easy to understand. We observed that staff treated patients with kindness and respect, and maintained confidentiality.

Are services responsive to people's needs?

Good

The practice is rated good overall for providing responsive services. However improvements should be made for patients who work. It understood the majority of the needs of its local population and focussed on local priorities included on the Clinical Commissioning Group (CCG) agenda. The practice had a larger than average number of patients who were elderly and these patients reported good access to services as did families with younger children. However, patients of working age found accessing services more difficult due to the opening hours of the practice and the limited availability of online services. All groups of patients said they found it easy to access urgent appointments on the same day. The practice had good facilities and was well equipped to treat patients. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. Learning from complaints was shared with staff.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a strong patient centred ethos and staff were aware of their responsibilities in relation to it. There was visible leadership from both the GPs and the practice manager and staff felt well supported to carry out their roles. Evidence showed a commitment to training and continual improvement. However, some records of essential maintenance of the premises could not be located and not all risk assessments aimed at identifying, assessing and managing risk to the health, safety and welfare of patients and others had been undertaken.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and provided care for patients living in a number of local care homes. It was responsive to the needs of older people, and 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 people with long-term conditions.Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. All these patients had a structured annual review to check that their health and medication needs were being met. Patients with long term conditions told us they received good explanations of their diagnosis and were given advice on self-managing their conditions. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children who may be at risk and there was evidence of close working with the local team of health visitors. Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals. They also told us they felt safe bringing their child to see the GPs. Appointments were available outside of school hours and the premises were suitable for children and babies. The practice performance for childhood immunisations met national targets.

Working age people (including those recently retired and students)

Requires improvement

The practice is rated as requires improvement for providing safe and responsive services to this population group. The age profile of patients at the practice showed a significant number of those of working age but the services available did not fully reflect the needs of this group. Although the practice offered extended opening hours for appointments two mornings each week patients could not book

Summary of findings

appointments online and patient feedback showed this group of patients found difficulty accessing appointments. Health promotion advice was offered and there was an abundance of accessible health promotion material available through the practice.

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 registers of patients living in vulnerable circumstances including those with a learning disability and carers. It offered annual health checks for patients with a learning disability and over 50% of these patients had received an annual health check.

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

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). Eighty eight per cent of patients experiencing poor mental health had received an annual health check. The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those with dementia. A consultant in Psychiatry visited the practice to support GPs in caring for patients with poor mental health. The practice carried out advance care planning for patients with dementia.

The practice offered advice to patients experiencing poor mental health on how to access various support groups and voluntary organisations.

Summary of findings

What people who use the service say

The results of the national patient survey carried out in 2014 showed that patients were not as positive in their views about Cookham Medical Centre compared to other practices in the area. However, we noted that the survey had been undertaken during a period of significant staff change and the practice had stabilised during the last year. The survey showed that patients gave a positive rating about the care they received. Eighty four per cent said the GPs were good or very good at treating them with care and concern and 80% said the GPs were good at involving them in decisions about their care. Both of these ratings were above the local clinical commissioning group average. Patients were less positive regarding access to appointments with GPs and nurses. When asked if they were able to speak to or see a GP of their choice only 45% rated this aspect of the service as good or very good and 62% said they found the practice opening hours satisfactory. The survey had been completed by 122 patients.

The practice patient participation group (PPG) had also completed a survey in 2014. Two hundred and sixty nine patients responded to the survey and the results showed similar concerns regarding appointment availability. Forty six per cent of patients reported difficulty in obtaining a routine appointment to see a GP. Patients were positive regarding the telephone triage (assessment of urgency of need) service the practice offered with 82% saying they found this service met their needs.

During our inspection we spoke with 14 patients and reviewed four comment cards completed by patients in the two weeks prior to our visit. Patients we spoke with and the comments on the cards were positive about the care and treatment offered by the GPs and nurses at the practice. The majority of responses also showed patients were appreciative of the caring and supportive attitude of reception and administration staff. Patients told us they were given advice about their care and treatment which they understood and which met their needs. They described the GPs and nurses as kind and told us they always had enough time to discuss their medical concerns. We received some comments relating to difficulties in obtaining convenient appointments for patients who worked. However, the majority of patients told us they felt the practice had improved in recent months.

Areas for improvement

Action the service MUST take to improve

- Implement a cleaning specification for the practice and monitor cleaning standards. Reduce the risk of cross infection from cleaning equipment by ensuring appropriate segregation of such equipment and undertake a Legionella risk assessment.
- Ensure systems are in place to identify, assess and manage risks to the health, safety and welfare of patients and others and maintain appropriate records that support such systems.

Action the service SHOULD take to improve

- Ensure that records of all pre-employment checks required by legislation are retained.
- Expand the number of completed clinical audit cycles to monitor clinical quality and systems to identify where action could be taken.
- Consider improved access to appointments for patients of working age and expand the availability of online access to services.
- Review and undertake a risk assessment to determine which emergency medicines should be held in the practice.

Cookham Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector**.** The team included a GP advisor and an expert by experience. Experts by experience are members of the team who have received care and experienced treatment from similar services.

Background to Cookham Medical Centre

Cookham Medical Centre is located in a purpose built practice which has been extended over the last 20 years to provide services to approximately 7,800 patients. The practice is in a semi-rural location and a number of health professionals and other services visit the practice to offer local access. There are four GP partners and a salaried GP. Three of the GPs are female and two male. The practice holds a Personal Medical Service (PMS) contract to deliver care and treatment. (PMS contracts are negotiated with the local area team of NHS England).

The practice has a higher than average number of patients over the age of 40 and fewer younger patients under the age of 35. The practice serves a population which is more affluent than the national average. The practice has been accredited to provide training to GP trainees.

The practice has opted out of providing out-of-hours services to its own patients. There are arrangements in place for patients to access care from an out-of-hours provider, NHS 111.

We visited the practice at Cookham Medical Centre, Lower Road, Cookham Rise, Maidenhead, Berkshire, SL6 9HX.

Why we carried out this inspection

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

We carried out this comprehensive inspection of the practice, on 11 March 2015, 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 was 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. The practice had not been inspected before and that was why we included them.

How we carried out this inspection

Prior to the inspection we contacted the Windsor, Ascot and Maidenhead Clinical Commissioning Group (CCG), NHS England area team and local Healthwatch to seek their feedback about the service provided by Cookham Medical Centre. We also spent time reviewing information that we hold about this practice.

The inspection team carried out an announced visit on 11 March 2015. We spoke with 14 patients, including five members of the patient participation group (PPG), and eight staff. We also reviewed four comment cards from patients who had shared their views and experiences.

As part of the inspection we looked at the management records, policies and procedures, and we observed how

Detailed findings

staff interacted with patients and talked with them. We held discussions with a range of practice staff including GPs, nursing staff, managers and administration and reception staff.

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

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

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

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

Requires improvement

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. For example staff found some out of date medical equipment used for taking cervical smears and this was reported. Action had been taken to improve the checking processes and reorganise the stock control for these items and other equipment that carried use by dates to avoid reoccurrence and reduce the risk of inadvertently using out of date equipment.

We reviewed safety records, incident reports and minutes of meetings where these were discussed for the last year. For example, we reviewed minutes of a meeting where medicine safety alerts had been discussed. These showed us that the practice had identified patients who were taking the medicines subject to the alert and taken appropriate action to adjust the medicine or cease it. The minutes also showed us that the practice repeated checks to ensure medicines that had been subject to alerts earlier in the year had not been prescribed since. This showed the practice had managed these consistently and could show evidence of a safe track record.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. There were records of significant events that had occurred during the last years and we reviewed these. Significant events was a standing item on the clinical team meeting agenda and we saw that reviews of actions from past significant events took place every six months. We saw that incidents that had been recorded since November 2014 were scheduled for review in April 2015. There was evidence that the practice had learned from these and that the findings were shared with relevant staff.

Staff were aware of the process to report concerns to the practice manager who would then complete an incident form. We reviewed the summary of incidents and saw records were completed in a comprehensive and timely manner. We saw evidence of action taken as a result. For example, when a patient had been returned to the care of their GP before hospital care had been completed, the practice used a reporting system called 'clinical concerns' to ensure the patient was seen again at hospital to complete their treatment. The incident had been recorded and discussed with all GPs to ensure they were aware of the clinical concerns system and used it when appropriate. Where patients had been affected by something that had gone wrong, in line with practice policy, they were given an apology and informed of the actions taken.

National patient safety alerts were disseminated by the practice manager and scheduled for discussion at clinical meetings. The practice manager documented the action required arising from alerts in the minutes of the meeting. This showed that actions were identified and followed through.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed that all staff had received relevant role specific training on safeguarding. We asked members of medical, nursing and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information about safeguarding concerns and where to find the information that would enable them to contact the relevant agencies. Contact details were easily accessible on flow charts displayed on staff noticeboards, in the practice policies file and on the practice intranet.

The practice had appointed a dedicated GP as lead in safeguarding vulnerable adults and children. They had been trained 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. GPs were aware of when their safeguarding update training was due to support their appraisal and revalidation programme. One of the GPs we spoke with gave us a recent example of a referral to the local child safeguarding team which was appropriately dealt with. We were also given an example of a referral for a vulnerable

elderly patient. GPs showed strong awareness of the need to safeguard vulnerable patients of all ages and referred to safeguarding teams or other professionals, such as the community mental health team, appropriately.

There was a system to highlight vulnerable patients on the practice's electronic records. For example, children subject to child protection plans and GPs showed us examples of these.

There was a chaperone policy, which was visible in the waiting room 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). All nursing staff, including health care assistants, had been trained to be a chaperone. The practice had made a decision to only use members of the practice nursing team or a GP as chaperones. The practice training plan included training some administration staff in chaperone duties later in 2015. We discussed this with the practice manager and they were aware that extending the chaperone role to administration staff would require a risk assessment.

Medicines management

We checked medicines that were kept in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. We were given an example of an incident where staff had been required to follow the policy when a fridge was found to have failed.

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

We saw records of practice meetings with the clinical commissioning group (CCG) medicines management advisor. These showed how the practice had worked towards and achieved medicines management targets. The record set out the practice performance and indicated areas where the practice could improve. GPs told us the action identified had been taken and that they expected to achieve medicines management targets for the year. We noted that the practice was achieving the local targets for prescribing of antibiotics.

The nurses and the health care assistant administered vaccines using directions that had been produced in line with legal requirements and national guidance. We saw up-to-date copies of both sets of directions and evidence that nurses and the health care assistant had received appropriate training to administer vaccines. A member of the nursing staff was qualified as an independent prescriber and she ensured she maintained up to date knowledge in the specific clinical areas of expertise for which she prescribed.

There was a system in place for the management of high risk medicines, which included regular monitoring in line with national guidance.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times. There was a system in place to highlight when patients taking repeat medicines needed their medicine regime reviewing. We looked at notes of a recent meeting where the GPs had been reminded of the need to complete these reviews. The notes set out an action plan for GPs to follow to ensure medicine reviews were undertaken.

Cleanliness and infection control

The standards of cleaning at the practice were inconsistent. The treatment rooms were clean as were some of the consulting rooms. However, we found an accumulation of dirt and debris in two of the consulting rooms. The practice did not have a cleaning schedule in place. There was no formal system of monitoring cleaning and completion of cleaning tasks was not recorded. The practice could not be assured that appropriate standards of general cleanliness were being maintained. There was inadequate separation of cleaning equipment and materials. Equipment used for cleaning general areas could have been used in treatment rooms and thus lead to a minor risk of cross infection.

The practice had a lead GP for infection control. The staff training plan included an expectation that staff would complete role appropriate training in infection control. We reviewed the results of the last infection control audit. This showed us that clinical processes to reduce the risk of cross

infection were being followed. The audit had not identified the absence of cleaning schedules of the inconsistent standards of general cleaning being achieved. There was no evidence of the audit being discussed with the practice team.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff told us they used personal protective clothing when assisting GPs with minor surgery procedures.

Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms.

The practice had not carried out a risk assessment for the management, testing and investigation of legionella (a bacterium that can grow in contaminated water and can be potentially fatal). Completion of such a risk assessment is a requirement for all public buildings. The practice had not followed current guidance from the Health and Safety Executive (HSE) by failing to assess the risk of infection from legionella.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. A schedule of testing was in place. We saw evidence of calibration of relevant equipment. For example weighing scales and blood pressure measuring devices.

There were records confirming that fire alarm systems and firefighting equipment had been maintained in accordance with manufacturer's instructions. However, we were unable to locate other important maintenance records. For example, we could not evidence that the heating systems had been maintained.

Staffing and recruitment

We reviewed seven staff files in detail. We found that records of appropriate recruitment checks being undertaken prior to employment were held for staff who had been recruited since the practice became subject to regulation. An application for a criminal records check with the Disclosure and Barring Service (DBS) had been completed in early February 2015 for a nurse who had worked at the practice for over ten years. The results of the check were awaited. The practice had accepted DBS clearance from previous employers for two other members of the nursing team. Both DBS were under three years old. The practice recruitment and selection policy made no reference to accepting DBS checks from previous employers. However, there were copies of three DBS applications that had been sent for processing.

The personnel records also showed us that proof of identification was not held on file for two members of staff. However, we saw that all staff were using NHS security cards to access the practice computer system and that they had produced appropriate proof of identification to be issued with these security cards (known as SMARTCARDS). Two of the personnel files we reviewed did not contain copies of references. The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff but this had not been followed consistently in the past when recruiting new staff.

Staff contracts we reviewed showed that staff were expected to fulfil a specific number of hours of duty. The hours specified were set to ensure that enough staff were on duty to meet patient needs and maintain safe levels of staffing. There was also an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual leave. For example we noted that a member of the nursing team was also trained to cover the absence of medical secretaries. 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.

We reviewed a comprehensive GP trainee and locum manual. This contained information for locums on a range of topics. For example, practice policies and procedures, effective prescribing and the procedure to follow when referring a patient to another service. Locum GPs were therefore supported with relevant information to carry out their duties. We were told, and the patient website confirmed, that when locum GPs were employed, they were usually GPs who knew the practice and the patients.

Requires improvement

Are services safe?

Monitoring safety and responding to risk

The practice had some 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 environment, medicines, and equipment. The practice also had a health and safety policy. However, we noted that the practice had not completed a risk assessment for the control of substances hazardous to health (COSHH). The practice may not have identified risks associated with potentially dangerous substances or planned how to deal with any spillages of these substances. Staff would not be aware of the appropriate, and safe, way of cleaning up such a spillage.

Staff told us the practice manager carried out a regular walk through the premises and would, on most days, check that staff had the equipment necessary to carry out their roles and that all equipment and systems were working properly. We reviewed the planned building and equipment improvement programme for the practice. This identified risks arising from the environment and timetabled action to address the risks. For example, the plan identified the need to replace some grouting and seals on tiles behind sinks in clinical areas to reduce the risk of dirt gathering in these areas. We saw this work was scheduled for the end of March. The GPs had reviewed and agreed the plan.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (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. Records showed that the emergency oxygen was checked regularly. We found the defibrillator in working order and were told that it was checked. However, there were no records of this check taking place.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. The practice did not routinely hold stocks of medicines for the treatment of an overdose of opioids and should risk assess whether this medicine should be held. Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

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

The practice had a fire risk assessment that was nearly ten years old and had not been reviewed or updated. We noted that an updated fire risk assessment had been ordered from an approved contractor. An up-to-date fire risk assessment was not therefore available. Records showed that staff were undertaking online fire training and that fire marshal training had been commissioned from an approved supplier.

We discussed the risks associated with service and staffing changes (both planned and unplanned) and found the practice had appropriate arrangements in place to maintain appropriate staffing levels to maintain safe delivery of services.

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. Guidelines were accessed from the National Institute for Health and Care Excellence (NICE), GP desktop and from local commissioners. We reviewed an electronic file into which the GP trainer placed summaries of recently issued best practice guidance. GPs and nurses accessed this file and we were shown how they did so. Once they had reviewed the updated guideline they completed an electronic 'sign off'. The GP trainer followed up with staff who had not reviewed the guidelines. The evidence we saw confirmed that summary guidelines were designed to ensure that each patient received support to achieve the best health outcome for them.

The GPs told us they led in specialist clinical areas such as dermatology and minor surgery. GPs we spoke with were very open about asking for and providing colleagues with advice and support. The nurses we spoke with told us they could obtain prompt support from a GP when required and that the duty GP was always available to assist if they had concerns about a patient they were treating.

We reviewed prescribing data from the local clinical commissioning group (CCG). The practice had fully participated in all the elements of the local prescribing incentive scheme 2013/14. It achieved two out of three areas of the scheme including meeting the insulin prescribing guidance. We reviewed minutes of the meeting held with the CCG pharmacy advisor in August 2014 and saw the practice had developed an action plan to address the areas of prescribing where they were not, at that time, meeting local targets.

The practice identified two per cent of patients with complex needs who were at greater risk of admission to hospital as part of a local scheme to reduce avoidable admission to hospital. The practice ensured all these patients had a care plan in place. If any of the patients identified were admitted to hospital the GPs followed up their admission within three days of receiving the hospital discharge letter. We saw an example of the care plans in place and found them to be comprehensive. It showed us that patients with complex medical needs had a named GP to support continuity of care.

The most recent national data and local CCG data showed the practice referral rates to hospital services were mostly in line with other practices in the area. We noted that the age profile of the registered patients was older than most practices in the area and the prevalence of long term conditions at the practice was higher. For example, the prevalence of coronary heart disease and cancer were the highest in the CCG. The practice did not undertake an internal referral review process and relied upon external review to assess whether referrals were made appropriately.

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

Management, monitoring and improving outcomes for people

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, managing child protection alerts and medicines management. Data from external sources including the CCG and NHS England was also used to review performance. For example nurses used data to review the success of their cervical smear taking.

The practice showed us five clinical audits that had been undertaken in the last year. Two of these were completed audits where the practice was able to demonstrate the changes resulting since the initial audit. For example, the audit of anti-psychotic medicine prescribing showed a 40% reduction in use of these medicines prescribed for patients living in nursing homes. The practice did not have an annual audit plan and the number of clinical audits we saw was limited.

We evidenced that audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). (QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). For example, there were audits of local prescribing targets. Audits of patients taking medicines subject to a safety alert were reported at the practice clinical meetings and we saw the GPs were following up ensure action required from safety alerts was

Good

Are services effective?

(for example, treatment is effective)

taken. Minutes of meetings showed that QOF reviews were discussed by GPs and nurses. For example, one set of minutes showed how many patients required an asthma review and identified the need to increase the recall of patients with this long term condition.

There was a protocol for repeat prescribing which was in line with national guidance. In line with this, staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. We reviewed minutes of a meeting where GPs had been reminded of the requirement to complete annual medicine reviews and the number of outstanding reviews had been identified for action. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines.

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

One of the GPs undertook minor surgical procedures in line with their registration and NICE guidance. The GP had maintained their expertise in this area by attending update training. They had completed an update in 2014 which they passed with distinction. We saw that minor surgical procedures were subject to annual audit and that the audit for 2014 showed that there had been no complications arising from procedures and all results from tissue samples removed during minor surgery had been followed up.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as annual basic life support. There were two male GPs and three female GPs. We noted a good skill mix among the doctors. Two GPs held diplomas in obstetrics and gynaecology and one had recently completed a minor surgery update. 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. New staff joining the practice were placed on a probationary contract. Upon completion of their probationary period they met with their manager to review their progress before entering the appraisal programme. We saw records of both appraisal and probationary review meetings in staff personnel files. Our discussions with staff confirmed that the practice was proactive in providing training. The practice had invested in an online training package in 2014. Funding to attend relevant courses that benefitted both the member of staff and the practice was made available and the practice made full use of the CCG protected learning sessions. The practice manager kept records of staff training certificates in the personnel files and there was a training plan in place. We saw that two practice nurses had attended a multi topic professional update seminar in late 2014. This included control of infection and best practice in care of diabetics along with numerous other clinical topics.

The practice was a training practice, doctors who were training to be qualified as GPs were offered extended appointments and had access to a senior GP throughout the day for support. We received positive feedback from the trainee GP we spoke with. They told us that they could access advice from any of the GPs and held regular review sessions with the GP trainer. A second GP in the practice had applied to become a GP trainer. One of the practice goals was to become recognised as centre of excellence for training.

Practice nurses were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties. For example, on administration of vaccines and cervical cytology. Those with extended roles for example seeing patients with diabetes and prescribing were also able to demonstrate that they had appropriate training to fulfil these roles.

Staff files we reviewed and learning from complaints and significant events showed that where poor performance had been identified appropriate action had been taken to manage this.

Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and manage those of patients with complex needs. It received blood test results, X ray results, and letters from the local hospital including discharge

Good

Are services effective?

(for example, treatment is effective)

summaries, out-of-hours GP services and the 111 service both electronically and by post. Staff in the practice were clear about their responsibilities in passing on, reading and acting on any issues arising from communications with other care providers on the day they were received. 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 had a system for GPs to cover each other in dealing with results and discharge summaries when the patient's usual GP was not in the practice.

The practice was commissioned for the new enhanced service and had a process in place to follow up patients discharged from hospital. (Enhanced services require an enhanced level of service provision above what is normally required under the core GP contract). We saw that the policy for actioning hospital communications was working well in this respect.

The practice held multidisciplinary team meetings every month to discuss patients with complex needs, for example those with end of life care needs or children on the at risk register. These meetings were attended by district nurses, palliative care nurses and health visitors and decisions about care planning were documented in notes of each of the meetings. We reviewed two sets of these notes and these showed that each patient's needs were discussed in detail and action required to support care clearly described.

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 over 90% of NHS referrals last year 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 that this system was easy to use.

For emergency patients, there was a policy of providing a printed copy of a summary record for the patient to take with them to A&E. One GP told us this task was straightforward using the electronic patient record system. The practice has also signed up to the electronic Summary Care Record and planned to have this fully operational by 2015. (Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours).

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

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice. For example, when an elderly patient required an injection the GP detailed how they had explained the need for the injection to the patient but was unsure the patient had fully understood. The GP followed the required process to ensure that the decision was in the patient's best interests and this involved those considered significant to the patient, such as relatives. The decision was appropriately recorded.

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.

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

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

Good

Are services effective?

(for example, treatment is effective)

Health promotion and prevention

The practice was aware of the local health priorities. For example, achieving earlier diagnosis of dementia and improving care for diabetics.

It was practice policy to offer a health check with the health care assistant or practice nurse 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 had numerous ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice kept a register of all patients with a learning disability and all patients in this group were offered an annual physical health check. We saw that the practice had completed over 50% of these health checks and had clearly recorded when the patient declined the offer. The practice had also identified the smoking status of 86.2% of patients over the age of 16 and actively offered smoking cessation clinics to these patients. Data showed that approximately 90% of smokers had been offered smoking cessation advice. This was above the CCG average. Similar mechanisms of identifying 'at risk' groups were used for patients who were obese and those receiving end of life care. These groups were offered further support in line with their needs. There was a visiting dietician service and the practice had access to refer patients for exercise classes.

The practice's performance for cervical smear uptake was 81.5%, which exceeded the national target. A member of the administration staff was responsible for issuing reminders to patients who did not attend for their screening. If the patient did not respond or continued to fail to attend the patient's details were passed to the GPs and nurses to follow up personally. National chlamydia, mammography and bowel cancer screening programmes were offered. We saw test kits for chlamydia screening were available for patients who did not wish to ask for the test. Patient's confidentiality in taking up this screening programme was therefore respected.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance for most immunisations was above average for the CCG although the take up of the measles mumps and rubella (MMR) immunisation was slightly below the CCG average and did not meet the national 90% target. There was a clear policy for following up non-attenders.

The practice had a range of health promotion leaflets in display racks throughout the practice. Noticeboards were used to signpost patients to relevant support organisations such as an advocacy service or carer support. We noted that the practice was promoting services to support carers and a notice with details of the Berkshire carers organisation was prominently displayed.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We observed that staff were careful to maintain confidentiality of patient information. There was a confidentiality policy and all staff had signed an agreement to maintain patient information in confidence. A member of the reception team told us that they had a room available to hold discussions with patients in private when requested. The practice switchboard was located away from the reception desk in a separate office this prevented patients overhearing potentially private conversations between patients and reception staff. We saw this system in operation during our inspection and noted that it enabled confidentiality to be maintained.

The evidence from national survey of 122 respondents and the local survey of 269 patients showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the national patient survey showed 80% of practice respondents said the GP was good at listening to them and giving them enough time. All of the patients we spoke with on the day of inspection and the comment cards we received were positive about this aspect of their care and treatment. We noted that the patient surveys had been carried out during the time of transition between two GPs leaving the practice and two joining. Patient views about their care and treatment were improving since the practice had recruited a full team of permanently employed GPs. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring.

We observed all consultations and treatments were carried out in the privacy of a consulting room. Disposable curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that the consultation and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example, data from the national patient survey showed 80% of practice respondents said the GP involved them in care decisions and 93% said they had trust and confidence in their GP. These results were in line with or better than the rest of the CCG. GPs we spoke with told us they involved patients in preparing care plans and we saw examples of this.

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

Patient/carer support to cope emotionally with care and treatment

The patients we spoke with on the day of our inspection and the comment cards we received showed patients were consistently happy with the level of emotional support they received from GPs and nurses. Some patients told us how the GPs had spent time supporting them following a bereavement and maintained contact with them to assist in the longer term. Others commented on how the GPs helped them come to terms with a serious short term medical condition and explained the processes involved in treatment or hospital admission. Some of the patients we spoke with had long term medical conditions. They were complimentary about both the GPs and the nurses giving them emotional as well as clinical support in coming to terms with their long term diagnosis. All of the patients we spoke with, the comment cards we received and the survey results we reviewed showed patients felt the GPs and nurses gave them sufficient time to discuss their health and social needs. Many patients commented that they never felt rushed when seeing the GPs and nurses.

Notices and leaflets held throughout the practice gave advice on how to access a number of support groups. Similar information was available on the waiting room TV screen and on the patient website. The practice's computer system alerted GPs if a patient was also a carer. We received examples of the written information available for

Good

Are services caring?

carers to ensure they understood the various avenues of support available to them. We observed reception staff providing patients with advice on local services and doing so in a friendly and professional manner.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patient's needs and had systems in place to maintain the level of service provided. The needs of the majority of the practice population were understood and systems were in place to address identified needs in the way services were delivered. For example the frequency of visiting local care homes had been adjusted to ensure patients living in care homes received a responsive service.

We saw minutes of meetings where the practice had discussed plans and actions to meet local health priorities. For example, increasing the early detection and diagnosis of dementia. The practice also benefitted from visits of specialists in the field of mental health to support the needs of patients experiencing poor mental health. A talking therapy service was available at the practice.

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG). The PPG had evaluated the attributes of upgraded telephone systems and the practice purchased a telephone system the PPG recommended to meet patient demand for telephone access.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example, patients with a learning disability and patients living in care homes. Annual health checks were offered to patients with a learning disability and care homes were visited on a scheduled basis. The practice and the patient participation group recognised the practice had a significant number of patients over retirement age but had only 13 carers on their carers register. Planning was underway to encourage patients with caring responsibilities to register as carers to enable the practice to offer them support.

The practice had access to translation services but staff told us they had not had cause to use the service. Very few patients were registered with the practice whose first language was not English.

A range of training courses were available through an e-learning package the practice implemented in 2014. This included equality, diversity and human rights training. The staff training programme showed us there was an expectation for staff to undertake this training in 2015. Two members of staff had already completed the course.

All consulting and treatment rooms were situated on the ground floor of the building. The corridors were wide enough to accommodate both wheelchairs and mobility scooters with sufficient room for patients using these to turn. This made movement around the practice easier and helped to maintain patients' independence.

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.

Access to the service

The practice was open every week day from 08:30am to 6:30pm. Pre-bookable appointments were available from 08:30am to 5:20pm each day and patients requiring urgent care and treatment were seen after the last booked appointment. The practice offered extended opening hours on two mornings each week from 7:30am when appointments with both GPs and the health care assistant were available. The practice did not restrict patients to seeing a named GP, although patients could request to see a GP of their choice.

Access to appointments catered for most population groups but was limited for those who worked. Patients we spoke with during our inspection and comments from the practice survey reflected this. Some comments we received related to a large number of patients commuting to their place of work. These patients found it difficult to attend the practice between 08:30am and 5:20pm when the majority of appointments were available. The practice did not provide online booking of appointments which also restricted access for patients in this group. However, telephone consultations were available and some patients told us they found these very helpful.

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If

Good

Are services responsive to people's needs?

(for example, to feedback?)

patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients.

Longer appointments were also available for patients who needed them and those with long-term conditions. This also included appointments with a named GP or nurse. Home visits were made to five local care homes on a fortnightly visiting rota, by a named GP and to those patients who needed one.

Patients relayed some concerns regarding the appointment system. These were mostly in relation to the limited availability of appointments for those who worked. Comments received from patients showed that those in urgent need of treatment had often been able to make appointments on the same day of contacting the practice. Some patients told us they had been given an appointment within an hour of making contact with the practice. We noted that a number of patients referred to an improvement in availability of appointments in recent months and we saw that the practice had invested in a new telephone system to improve access to appointment booking.

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 responsible for handling complaints in the practice.

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

We looked at the complaints received since April 2014. We found they were appropriately handled and dealt with in a timely way. The practice showed openness and transparency in dealing with the compliant. No complaints had been escalated to the Ombudsman.

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 published a patient charter that underpinned their delivery of patient care. The charter set out the practice aims of providing the highest possible patient care in a timely manner and care that was personalised to each patient's needs.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the practice. We looked at six of these policies and all six policies and procedures we looked at had been reviewed and were up to date.

The practice GPs shared responsibility for leadership of the practice. However some took lead roles for specific aspects of delivery of care, treatment and management of the practice. For example, there was a lead GP for infection control, a GP lead for QOF and the senior partner was the lead for safeguarding. We spoke with seven members of staff and they were all clear about their own roles and responsibilities. They all told us they felt well supported and said they could approach the practice manager or any of the GPs with any concerns. The practice benefitted from a largely stable team of staff many of whom had been employed for over ten years. Members of staff who had joined the practice in the last year told us they had received good support when joining the practice and continued to enjoy that support once they had settled in. They told us that the practice manager brought new staff of all disciplines together for their coffee break during their first few weeks in the job and this fostered good teamwork throughout the practice.

The practice manager was also responsible for policies and procedures relevant to identifying, assessing and managing health and safety risks. We found the main health and safety policy contained a supporting range of risk assessments. These included risk assessments for access and egress and manual handling. The practice manager also sent us a master risk assessment for the practice which had been completed in January 2014. However, we noted that the practice had not always monitored and assessed all risks. For example, completing a legionella risk assessment or assessing which emergency medicines should be stored in practice.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed it was performing in line with national standards. We saw that QOF data was regularly discussed at team meetings and the lead GP ensured staff took action to maintain or improve outcomes. There was some evidence of audits informing patient care and treatment. However, only two of the audits were completed cycles and the practice did not have an annual audit plan.

Leadership, openness and transparency

We saw from minutes that team meetings were held regularly, at least bi monthly. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues as and when they arose.

The practice manager was responsible for human resource policies and procedures. We reviewed policies on confidentiality and the recruitment which were in place to support staff. The practice did not have a staff handbook but all personnel policies were available for staff in both a policies file and in electronic form. For example, the policies on equality, harassment and bullying at work. Staff we spoke with knew where to find these policies if required.

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

The practice gathered feedback from patients through the national patient survey and local surveys undertaken in conjunction with the patient participation group PPG. Complaints were also reviewed and used to inform improvements in the way services were delivered. GPs and the practice manager were aware that the responses to the last national survey had not been as positive as in the past. Action had been taken to recruit new partners and review the availability of GP appointments in response to the concerns shown in the survey. Patients we spoke with on the day of inspection and comment cards we reviewed showed that a number of patients had noticed improvement in the practice during the last few months.

The practice had a very active patient participation group (PPG) which had been in existence for over five years. The PPG met regularly and contributed to the preparation of an annual patient survey. Once the survey was completed the PPG reviewed the results with the practice and actively supported the practice in responding to the issues the survey raised. For example a recent patient survey showed that patients were not happy with the telephone system as

Are services well-led?

Good

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

they felt it did not assist them in making contact with the practice. Members of the PPG had taken part in the evaluation of alternative telephone systems and made a recommendation to the practice on which system they felt best met patient needs. The practice had purchased the system the PPG recommended.

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

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at four staff files of staff who had been in post for over a year. These showed that appraisals took place. However, some had been missed during periods of management change. Staff we spoke with told us they had received appraisals and that they valued the opportunity to formally discuss their work performance and training needs with the manager or the GPs. Staff told us that the practice was very supportive of training. We reviewed the practice training records and saw staff had been very active in using online training resources in the last year. Staff also told us they had future training planned. For example, role appropriate training in control of infection was required for all.

The practice invited guest speakers to attend clinical meetings to update GPs on current issues and protocols relating to specific disease areas. For example there were copies of presentations made on cancer care and orthopaedic medicine held on an electronic file available to GPs and nurses at the practice. Staff told us they made use of protected learning time to cover a range of training issues. For example, confidentiality and IT training had been covered in the last year. There was evidence that the GPs and the practice manager appointed in 2014 placed a strong emphasis on maintaining a trained and up-to-date team.

The practice was a GP training practice approved to provide training to doctors who were already qualified and were in final preparation for becoming GPs. The practice was subject to regular accreditation to maintain their training status and a second GP was awaiting confirmation that they could become a trainer. We spoke with the GP in training and they told us they received good support from their trainer and from the practice team.

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 1. Care and treatment must be provided in a safe way for service users. 2. Without limiting paragraph (1), the things which a registered person must do to comply with that paragraph include— h. assessing the risk of, and preventing, detecting and controlling the spread of, infections, including those that are health care associated. Regulation 12(1)(2)(h) This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The registered person did not ensure such systems or processes were in place to enable the registered person, in particular, to— 2. a. assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services); b. assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity;

This section is primarily information for the provider

Requirement notices

d. maintain securely such other records as are necessary to be kept in relation to-

(i) the management of the regulated activity

Regulation 17 (a)(b)(d)(i).

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.