Forest End Medical Centre

Quality Report

Forest End Medical Centre, Ringmead, Birch Hill,
Bracknell, RG12 7PG
Tel: 01344 421364
Website: www.foresthealthgroup.co.uk

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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	Requires improvement
Are services safe?	Requires improvement
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Requires improvement
Are services well-led?	Requires improvement

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

Forest End Medical Centre is located in a purpose built medical centre in the Ringmead area of Bracknell in Berkshire. Patients from the practice can also visit the branch site called the Balfron Practice. There are approximately 12,000 patients registered at the practice. We carried out an announced comprehensive inspection on 23 October 2014 at Forest End Medical Centre. During this visit we did not inspect the Balfron Practice. This was the first inspection of the practice since registration with the CQC.

The practice merged with Balfron Practice in 2009 and the patient population has increased significantly since. Since the merger, the practice has made changes to the appointment system in response to patient feedback about the difficulty in making appointments. Despite these changes patients reported in the national and practice surveys and directly to us that they were still finding it very difficult to make appointments. The practice was accessible to patients with limited mobility.

We spoke with eight patients during the inspection. We met with the chair of the patient participation group, two GPs, a trainee GP, three nurses and administration staff.

Forest End Medical Centre practice was rated requires improvement overall.

Our key findings were as follows:

Patients experienced difficulties in booking appointments. Although the practice was aware of the patient concerns and had taken measures to alleviate the problems, not all reasonable steps had been considered to deal with the access problems. Patients were mostly positive about the care they received from GPs and nurses. Some patients were concerned about the continuity of care they received due to seeing different nurses or GPs at different appointments for ongoing treatment or care. Patients told us staff were usually very caring and supportive. The practice had systems to keep patients safe including safeguarding procedures and

Summary of findings

means of sharing information about patients who were vulnerable. Forest End Medical Centre was hygienic and infection control was monitored. However, we found concerns with the storage and disposal of clinical waste.

The practice was failing to meet regulations on Requirements Relating to Workers and Supporting Workers.

There were areas of practice where the provider needs to make improvements.
Importantly, the provider must:

- provide all nurses with Disclosure and Barring Service (DBS) checks and administration staff undertaking chaperone duties
- identify and deliver training and awareness to staff that they require to deliver care safely and to an appropriate standard, including the Mental Capacity Act (2005) and chaperone training.

In addition the provider should:

- introduce a legionella risk assessment and related management schedule
- review staff protocols for diabetic reviews to ensure they are undertaken appropriately
- ensure that medicine reviews for patients on long term medications include patients who may be at risk of not taking medicines they require.
- review, consider and take appropriate action in response to patient feedback regarding access to appointments. This should include a long term strategy to ensure patient demands are managed and met.

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 safe. Staff understood and fulfilled their responsibilities to raise concerns, report incidents and near misses. Lessons were learned and communicated widely with all staff to support improvement. Information about incidents and events was recorded, monitored, appropriately reviewed and addressed. There were enough staff to keep patients safe. Risks to patients were not always assessed and well managed. There were concerns about the continuity of care due to the use of temporary staff and patients not seeing the same GPs for ongoing conditions. Chaperoning was not always performed by appropriate staff. Disclosure and Barring Checks (DBS) checks (formally Criminal Record Bureau (CRB)) were not undertaken for all nurses who worked at practice.

Are services effective?

Good

The practice is rated as good for effective. Data showed most patient care was at or above average for the locality. NICE guidance was referenced and used routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessment of capacity and the promotion of good health. GPs and nurses received clinical training appropriate to their roles. However, training for all staff was not always identified and monitored as staff did not receive training such as chaperoning and awareness of the Mental Capacity Act 2005. The practice appraised staff and we saw there were personal development plans for staff. Multidisciplinary working was evidenced.

Are services caring?

Good

The practice is rated as good for caring. Data showed patients rated the practice higher than others for several aspects of their care. Patients said they were treated with compassion, dignity and respect and they were involved in care and treatment decisions. Accessible information was provided to help patients understand the care available to them. We also saw that staff treated patients with kindness and respect ensuring confidentiality was maintained. The practice enabled patient involvement in care and treatment decisions, including referrals. There were services promoted to patients who required emotional or community support services.

Are services responsive to people's needs?

Requires improvement

The practice is rated as requires improvement for responsive. Although the practice had reviewed the needs of their local population, it had not put in place a plan to secure service

Summary of findings

improvements in regards to access to appointments following an increase to the patient population. Patient feedback indicated that access to a named GP and continuity of care was a problem, although urgent appointments were usually available the same day. The practice was appropriately equipped to treat patients and meet their needs. Accessible information was provided to help patients understand the complaints system. There was evidence of shared learning from complaints with staff.

Are services well-led?

Requires improvement

The practice is rated as requires improvement for well-led. The practice had a vision and a strategy to deliver quality care for its patients. However, this did not reflect the changing demands of the patient population. There was a leadership structure documented. Most staff felt supported by management and were able to report concerns to managers or partners. The practice had a number of policies and procedures to govern activity. Governance meetings were held regularly and involved all staff. The practice proactively sought feedback from patients and had an active patient participation group (PPG). Patient feedback suggested there were problems with the appointment system, and despite some efforts to address this, patients satisfaction with the appointment system remained low. All staff had received inductions and staff received regular performance reviews and attended staff meetings and events. Monitoring of training was not sufficient. Risks relating to the practice and staff checks were not always identified, assessed and managed properly.

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

Staff knew how to recognise signs of abuse in older patients. The practice used computerised tools to identify patients with complex needs. Care plans were developed for patients at risk of admission to hospital. The practice had a monthly gold standard framework meeting which covered palliative care. We found that GPs, but not all nurses, were aware of the Mental Capacity Act (MCA) 2005 regarding consent for patients who may lack mental capacity to make decisions about their care and treatment. Flu jabs were offered to patients over 75. This included patients receiving the vaccinations in nursing homes. Patients over 75 had a named GP. The practice and services had been adapted to meet the needs of patients with mobility problems. We saw that the waiting area and treatment rooms were able to accommodate patients with wheelchairs. Accessible toilet facilities were available.

People with long term conditions

Requires improvement

There was no system for identifying all patients who required prescription reviews because patients who were not taking their prescribed medicines may not be called in for a review. Staff we spoke with told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. We noted a large number of protocols covering clinical care for specific conditions such as chronic obstructive pulmonary disease (COPD) and asthma. These reflected national best practice. The practice used computerised tools to identify patients with multiple health needs in order to provide the support they needed. The GPs told us they led in specialist clinical areas such as diabetes, heart disease and asthma and the practice nurses supported this work which allowed the practice to focus on specific conditions. Eighty eight percent of patients with health conditions reported they were well cared for in the 2013 practice survey. The practice checked that all routine health checks were completed for long-term conditions. However, diabetes outcome data identified issues in diabetes care, which were not responded to appropriately. The practice participated in a long term conditions meeting run every three weeks by the CCG. There was health promotion material available in the waiting area and on the website. This included a weight management service, diabetes management, flu immunisation and sexual health advice. The patient participation group (PPG) organised health promotion events to share information on family health, dementia and diabetic care. These events were well attended by local patients.

Summary of findings

Families, children and young people

Good

Staff knew how to recognise signs of abuse in children. Not all staff had Disclosure and Barring Service checks. The practice provided a coil fitting and implant service. There were ad hoc meetings with community midwives and a monthly meeting which covered child protection. We found that GPs were aware of the Gillick competency for assessing the ability of patients under 16 to consent to treatment. Performance for national chlamydia screening was very high for the practice. The manager told us the practice performance was the second highest for uptake of Chlamydia screen in Berkshire. Uptake for child immunisations was close to the national average. A minor illness nurse had been employed by the practice to try and meet the demand of patients, especially children, attending for minor illnesses. We saw that the waiting area and treatment rooms were able to accommodate patients with prams and buggies. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities.

Working age people (including those recently retired and students)

Requires improvement

Health checks were offered to new patients over the age of 40. The practice also offered NHS health checks to all its patients aged 40-75. Smoking cessation support clinics were available to patients. There was health promotion material available in the waiting area and on the website. This included a weight management service and sexual health advice. The patient participation group (PPG) organised health promotion events to share information and provide education for patients. This included topics such as family health. These events were well attended by local patients. The practice had a system to identify if a patient was a carer. Appointments were available from 8am to 6.30pm on weekdays. The practice opened for extended hours appointments up until 8pm on a Monday evening. There was an online appointment booking system and repeat prescription service. This benefitted patients who worked full time. Patients told us it was very difficult getting through on the phone to make an appointment at 8am and if they did not get through at that time, they found it difficult to get an appointment.

People whose circumstances may make them vulnerable

Good

Staff knew how to recognise signs of abuse in vulnerable adults and children who may be at risk of abuse. The chaperone service was provided. There was a system for flagging vulnerable patients to staff. The practice kept a register of all patients with learning disabilities they were offered an annual physical health check which was provided during an extended appointment. Staff told us that translation services were available for patients who did not have

Summary of findings

English as a first language. The practice website could be translated into over 50 languages. The computerised patient record system identified patients with communication difficulties who may need support to make an appointment. The practice had been adapted to meet the needs of patients with mobility problems. We saw that the waiting area and treatment rooms were able to accommodate patients with wheelchairs. Accessible toilet facilities were available.

People experiencing poor mental health (including people with dementia)

Good

Patients with dementia had medical records which clearly outlined their health concerns and a list of current medicines. A care plan was also available within the record. One GP partner reported they had a close working relationship with the local community mental health team and said this had developed because the practice offered a service for patients with mental health problems in-house. We found that GPs, but not all nurses, were aware of the Mental Capacity Act (MCA) 2005 regarding consent for patients who may lack mental capacity to make decisions about their care and treatment. Longer appointments were available for patients who needed them, such as those suffering from poor mental health.

Summary of findings

What people who use the service say

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey and a survey of 380 patients undertaken by the practice's patient participation group. The evidence from all these sources showed patients were reasonably satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the national patient survey showed 68% of patients said the last GP they saw or spoke to was good at treating them with care and concern and 84% said the last nurse they saw or spoke to was good at treating them with care and concern. The practice scores on consultations showed 76% of GPs and 82% of nurses were good at listening to them and 75% saying the GP gave them enough time. The feedback around consultations with GPs was below national average but was higher than national average for nurses. Eighty eight per cent of patients with health conditions reported they were well cared for in the 2013 practice survey.

Patients completed CQC comment cards to provide us with feedback on the practice. We received 22 completed cards and the majority were positive about the service experienced. Patients said they felt the practice offered a helpful and caring service. They said staff treated them with dignity and respect. Six comments were less positive and this feedback related to treatment and access to the practice. We also spoke with nine patients on the day of our inspection. Most told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. However, there were concerns about the continuity of care and treatment provided due access or not being able to see the same GP.

The practice survey identified that 42% of patients said they could not get an appointment within the two days of contacting the practice. The national GP survey findings showed only 61% of patients described their experience of making an appointment as good. Sixty eight per cent said they could get through easily on the phone to book an appointment. Several patients we spoke with told us they found it difficult to book an appointment even in advance. Some patients were also complimentary about the appointment system, noting the online booking system worked well.

Areas for improvement

Action the service MUST take to improve

- provide all nurses with Disclosure and Barring Service (DBS) checks and administration staff undertaking chaperone duties
- identify and deliver training and awareness to staff that they require to deliver care safely and to an appropriate standard, including the Mental Capacity Act (2005) and chaperone training.

Action the service SHOULD take to improve

- introduce a legionella risk assessment and related management schedule
- review staff protocols for diabetic reviews to ensure they are undertaken appropriately
- ensure that medicine reviews for patients on long term medications include patients who may be at risk of not taking medicines they require.
- review, consider and take appropriate action in response to patient feedback regarding access to appointments. This should include a long term strategy to ensure patient demands are managed and met.

Forest End 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, a practice manager and practice nurse.

Background to Forest End Medical Centre

Forest End Medical Centre is located on two sites and has a patient population of approximately 12,000. Forest End Medical Centre has treatment and consultation rooms on the ground floor with wheelchair access in reception. There are four partners, two salaried GPs and locums working at the practice. There is one male and five female GPs. The nursing team consists of five practice nurses and one healthcare assistant. They are supported by an administrative and reception team. Forest End Medical Centre is a training practice.

The practice has a General Medical Services (GMS) contract. GMS contracts are subject to direct national negotiations between the Department of Health and the General Practitioners Committee of the British Medical Association.

This was a comprehensive inspection.

We visited the Forest End Medical Centre**,** Ringmead, Birch Hill, Bracknell, RG12 7PG as part of this inspection.

We did not visit the other site at Skimped Hill Health Centre, Skimped Hill Lane, Bracknell, RG12 1LH called Balfron Practice. The practice has opted out of providing out of hours services to their patients. There are arrangements in place for services to be provided when the practice is closed and these are displayed at the practice and on the website.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme. This provider had not been inspected before and that was why we included them.

How we carried out this inspection

Before visiting we checked information about the practice such as clinical performance data and patient feedback. This included information from the clinical commissioning group (CCG), Bracknell Forest Healthwatch, NHS England and Public Health England. We visited Forest End Medical Practice on 23 October 2014. During the inspection we spoke with GPs, nurses, the practice manager, reception staff, patients and a representative of the patient participation group (PPG). We looked at the outcomes from investigations into significant events and audits to determine how the practice monitored and improved its performance. We checked to see if complaints were acted on and responded to. We looked at the premises to check the practice was a safe and accessible environment. We looked at documentation including relevant monitoring tools for training, recruitment, maintenance and cleaning of the practice.

- Is it safe?
- Is it effective?

Detailed findings

- 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 living in vulnerable circumstances
- People experiencing poor mental health (including people with dementia)

The practice population had low economic deprivation and lower than average long term health conditions. The age spread of patients largely matched the national population profile. There was a slightly higher proportion of patients from the age of 40-55 years old.

Requires improvement

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve quality in relation to patient safety. For example, reported incidents, national patient safety alerts as well as comments and complaints received from patients. Staff we spoke with were aware of their responsibilities to raise concerns, and how to report incidents and near misses.

We reviewed safety records, incident reports and minutes of meetings where these were discussed for the last year. This showed the practice had managed these consistently over time and so could evidence a safe track record over the long term.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. Records were kept of significant events that had occurred during the last two years and these were made available to us. We saw from meeting minutes that significant events were reviewed at monthly clinical meetings. A second review was undertaken to ensure all changes were successfully implemented. There was evidence that appropriate learning had taken place and that the findings were disseminated. All staff attended meetings on a monthly basis and relevant significant events were shared with staff who did not attend clinical team meetings. The manager also held individual meetings with relevant staff when significant events needed to be discussed. The practice held periodic reviews of significant events. Staff including receptionists, administrators and nursing staff were aware of the system for raising issues to be considered at the meetings and felt encouraged to do so.

Significant event forms were available to staff. Once completed these were sent to the practice manager who showed us the system used to oversee how these were managed and monitored. There were 16 significant events recorded electronically in 2014/15. They were well documented recording the nature of the event, those present at discussion, clear outcomes and actions and the majority had dated reviews which occurred to check the actions had taken place. We reviewed a sample of the significant events from the previous year and all had been followed up with two or three reviews. Several of the significant events related to the prescribing errors. We asked the practice manager if there were any trends identified to deduce if the prescribing system needed changing. They told us no trends had been identified and no changes had been made to the prescribing system as a result of individual significant events.

National patient safety alerts were received and acted on. We saw audits were undertaken to check how many patients were on specific medicines when there was a relevant alert.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. Practice training records made available to us showed that all staff had received training on safeguarding. However, GP training certificates in safeguarding children indicated only level two training had been provided and the GP safeguarding lead had level three safeguarding. GPs are required to undertake level three training. We were shown correspondence with a training provider which indicated that the training certificates were incorrect and the content of the training received was level three. We asked members of medical, nursing and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in older patients, vulnerable adults and children. They were also aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact the relevant agencies in and out of hours. Contact details were easily accessible to all staff.

The practice had a dedicated GPs appointed as leads in safeguarding vulnerable adults and children. All staff we spoke with were aware who these leads were and who to speak to in the practice if they had a safeguarding concern.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information so staff were aware of any relevant issues when patients attended appointments; for example children subject to child protection plans.

A chaperone policy was in place and the service was advertised in consulting rooms and in the waiting area. Chaperone training had been undertaken by all nursing staff, including health care assistants. The chaperone policy stated that if a nurse or GP was not available then a member of administration staff could be a chaperone and

they would be trained outside the consulting room immediately before performing the role. This was not adequate training and administration staff did not have Disclosure and Barring Service checks.

Patient's individual records were written and managed in a way to help ensure safety. Records were kept on an electronic system called EMIS web which collated all communications about the patient including scanned copies of communications from hospitals. The practice had a protocol which ensured that all members of a family were flagged on the electronic system if there was a child protection issue. This ensured all staff were alerted to the circumstances of these patients whenever they attended or contacted the practice.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators. We found that they were stored securely and only accessible to authorised staff. 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 audits where the use of medicines was reviewed and we noted that actions were taken in response to the audits. For example, there had been an audit due to an alert regarding a medicine used for heart disease.

Vaccines were administered by staff using directions that had been produced in line with legal requirements and national guidance. Two members of the nursing staff were qualified as prescribers. They received support from the practice to ensure they were able to prescribe safely.

There was a protocol for repeat prescribing which was in line with national guidance and was followed in practice. This helped to ensure that patients' repeat prescriptions were still appropriate and necessary. Patients were recalled for medicine reviews with a GP every six months. The practice made extensive use of telephone reviews which would be triggered by a request for a prescription. There was no system for identifying patients who were under-using or not taking their medicines as prescribed. This was because reviews were only triggered through a request for a medicine or through monitoring prescribing data from the Quality Outcomes Framework (QOF). GPs told us 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.

Cleanliness and infection control

We observed the practice to be clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. The practice had a lead for infection control. We saw evidence the practice carried out infection control audits and any improvements identified for action were completed on time. We saw some minor damage to desks posed a potential risk of infection in treatment and consultation rooms because the damage prevented appropriate cleaning.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement control of infection measures. For example, colour coded sharps bins were available to use and staff were able to describe how they would use these in order to comply with the practice's infection control policy. There was also a policy for needle stick injuries which staff could access. Hand hygiene techniques signage was displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms. We saw full sharps containers were removed and stored securely.

The practice did not have a policy for the management, testing and investigation of legionella (a germ found in the environment which can contaminate water systems in buildings). The practice had not determined whether a risk assessment was required based on the storing of water.

Equipment

Staff we spoke with told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. We found that equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was

Requires improvement

Are services safe?

routinely tested and displayed stickers indicating the last testing date was September 2013. A schedule of testing was in place. We saw a log of calibration testing for the practice and all equipment was calibrated in April 2014.

Staffing and recruitment

Records we looked at contained evidence that some recruitment checks had been undertaken on employees. For example, proof of identification, references, qualifications and registration with the appropriate professional bodies. However, Disclosure and Barring Checks (DBS) checks (formally Criminal Record Bureau (CRB)) were not undertaken for all nurses who worked at practice.

Staff told us there were always enough staff on duty to ensure patients were kept safe. They told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. The practice had recruited a minor illness nurse to see patients who did not need to see a GP for their illnesses. This was aimed at supporting patients with specific needs and making more appointments available for patients who needed to see their GP. A partner and the manager told us the practice was trying to recruit full time GPs but this was proving difficult due to a lack of qualified staff applying for the vacant roles. The practice was using locums regularly. Some patients told us the inability to see the same GP at different appointments caused inconsistency in their care. Only 20% of patients from the GP national survey reported they could see the GP of their choice when booking an appointment.

Monitoring Safety & 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 checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy.

Some risks were assessed and managed. For example, there was a control of substances hazardous to health (COSHH) risk assessment for the storage of chemicals. Fire protocols were followed, such as testing the alarm system and regular fire drills.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. We saw records showing 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). All the staff we asked knew the location of this equipment and records we reviewed confirmed they were checked regularly.

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. Processes were also in place to check emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

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. The document also contained relevant contact details for staff to refer to. For example, contact details of a heating company to contact in the event of failure of the heating system.

A fire risk assessment had been undertaken that included actions required to maintain fire safety. We saw records that showed staff were up to date with fire training and that regular fire drills were undertaken.

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 treatment approaches. They were familiar with current best practice guidance accessing guidelines and from local commissioners. Staff were kept up to date with relevant clinical guidance, including from the National Institute for Health and Care Excellence (NICE), by receiving emails from the practice manager who determined which guidance it was important to disseminate. We noted a number of protocols covering clinical care for specific conditions such as chronic obstructive pulmonary disease (COPD) and asthma. These reflected national best practice. The protocols were reviewed by the GPs and nurses who made additions or changes. The staff we spoke with and evidence we reviewed confirmed these actions were aimed at ensuring that each patient was given support to achieve the best health outcome for them. From our discussions with the GPs and nurses we found that staff completed, in line with NICE guidelines, assessments of patients' needs and these were reviewed when appropriate. The practice used computerised tools to identify patients with complex needs who had multidisciplinary care plans documented in their patient record.

The GPs told us they led in specialist clinical areas such as diabetes, heart disease and asthma and the practice nurses supported this work which allowed the practice to focus on specific conditions.

National data from the Quality Outcomes Framework (QOF) showed the practice was in line with referral rates to secondary and other community care services for most conditions. The practice was not operating a peer review process for referrals with the exception of trainees and locums whose referrals were reviewed. One GP partner told us the practice used alternatives to hospital treatment wherever possible, such as a local physiotherapy service provided by the clinical commissioning group (CCG). This has proved successful in rehabilitating patients and avoiding the need for an onward referral to orthopaedics or operative intervention.

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

We reviewed the medical records of patients with a dementia diagnosis. The electronic record clearly described the patient's health concerns and a list of current medicines. A care plan was available within the notes. This contained relevant details such as contact information, other healthcare and social professionals involved and carer's details.

Management, monitoring and improving outcomes for people

Staff from across the practice had key roles in the monitoring and improvement of outcomes for patients. These roles included data input, clinical review scheduling, child protection alerts management and medicines management. The information staff collected was then collated by the practice manager and deputy practice manager to support the practice to carry out clinical audits.

We looked at 16 audits undertaken since 2012. The leads for specific clinical areas took responsibility for auditing those areas. The GP trainers and trainees decided between them which audits were appropriate for the trainees to do. Nurses were involved in relevant audits and the learning from these was shared with them. We found the majority of audits undertaken were completed cycles where the audit had been repeated to ensure any learning was acted upon. There was a well presented audit on the use of a specific medicine for polycystic ovarian syndrome with both audit cycles recorded and evidence of information and outcomes sharing. Another well documented audit by trainee GP was the use of a medicine in obese pregnant women. We found of the practice had undertaken a number of mini prescribing audits that were in response to safety alerts or were required by the CCG. Nurses carried out audits periodically on coil and implants insertions to monitor the service. Some audits were the result of discussions and decisions made in clinical meetings. Audit outcomes were shared in clinical meetings.

The practice reviewed its performance using the Quality and Outcomes Framework (QOF). QOF is a national performance measurement tool. The practice achieved an overall score of 96.6% in the 2012/13 QOF results. Most clinical indicators from the QOF showed the practice was

Good

Are services effective?

(for example, treatment is effective)

performing well in caring for patients with long term health conditions and 88% of patients with health conditions reported they were well cared for in the 2013 practice survey. The practice had a relatively poor performance in the QOF indicators for control of blood pressure in diabetic patients. We examined a random sample of five patients on the diabetes register where blood pressure was not controlled. Of the five patients, there were two where high blood pressure had been recorded by the practice nurse with no action was taken in response to the findings, such as a GP appointment arranged for the patients. No audit had been undertaken in response to the QOF findings related to high blood pressure in diabetics. This would have identified whether staff were following the correct protocols in diabetic care or if further training was required. A GP partner explained one reason for this QOF data was that the practice was very low on exception reporting (if patients refuse to see a GP or cannot receive a medicine due to health problems, they can be exempted from QOF data). The QOF results showed the practice had very low exception reporting. The GP partner explained that patients would be discussed at a clinical meeting before an exception code was put on their record.

Staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. This was only completed for patients with long term conditions during health checks or when repeat prescription requests were received six months after an initial prescription. There was a risk that some patients may not have their medicines reviewed at appropriate intervals. For example, those who did not take their prescribed medicines. The practice checked that all routine health checks were completed for long term conditions such as diabetes and the latest prescribing guidance was being used. The IT system flagged up relevant medicines alerts when the GP went to prescribe medicines.

Effective staffing

Practice staff included GPs, nurses, managerial and administrative staff. We reviewed staff training records and noted that staff were up to date with attending courses such as safeguarding and annual basic life support. However, we found there was inadequate training provided to some staff who performed chaperone roles and some staff did not have an adequate awareness of the Mental Capacity Act. An appropriate skill mix was noted amongst the GPs. 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 every five years undertakes a fuller assessment called revalidation. Only when revalidation has been confirmed by NHS England can the GP continue to practice and remain on the performers list with the General Medical Council).

Staff undertook annual appraisals which identified learning needs with documented action plans. Staff confirmed that the practice was proactive in providing training identified for nurses and GPs. As the practice was a training practice, trainee GPs were offered extended appointments and had access to a senior GP throughout the day for support. Feedback from those trainees we spoke with was positive. A GP who undertook a coil fitting and implant service underwent the recertification processes for providing this service.

Practice nurses had defined duties they were expected to perform and were able to demonstrate they were trained to fulfil these duties. For example, nurses who administered vaccines were proactive at reordering stock, checking that vaccinations were in date and ensuring other medical stock was maintained. Nurses with specialisms such as diabetic care were able to demonstrate they had appropriate training to fulfil these roles.

Working with colleagues and other services

The practice worked with other service providers to meet patients' needs and manage complex cases. Blood results, X ray results, letters from the local hospital including discharge summaries, out of hours providers and the 111 service were received both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and taking action on any issues arising from communications with other care providers on the day they were received. The GP reviewing 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.

A GP partner described the close working relationships the practice had with the local community mental health team (CMHT). They explained that these had developed because the practice offered a service for patients with mental health problems in-house which meant that when they do refer someone to the CMHT it is accepted as someone with genuine needs and dealt with promptly. The GP gave an example of a patient who was having frequent self-harm

episodes and the GP had given standing weekly appointments to in order to offer the patient extra support. The GP confirmed that this had proved very helpful in stabilising the situation.

The practice participated in a long term conditions meeting held every three weeks by the CCG. This was a virtual teleconference involving the community matron, a mental health representative from the local authority and district nurses. Patients discussed included those recently discharged from hospital and those personally identified by the staff involved. The practice has ad hoc meetings with community midwives and monthly meetings on both child protection issues and palliative care. The GPs used email to discuss cases with consultants from local hospitals.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local 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.

The practice had systems in place to provide staff with the information they needed. An electronic patient record on a computer system called EMIS web was used by all staff 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.

Staff told us the practice shared information with local services such as district nurses and midwives. The computerised patient record system enabled staff to share patient information securely and quickly.

Consent to care and treatment

We found that GPs were aware of the Mental Capacity Act (MCA) 2005 regarding consent for patients who may lack mental capacity and the Gillick competency for assessing the ability of patients under 16 to consent to treatment. A partner told us about an example of a patient with learning disabilities who required an elective operation. The GP clearly explained how they applied the principles of the MCA in this case. The GP undertook cognitive assessments as part of his assessment of capacity. They also demonstrated familiarity with the different types of power of attorney. Some nurses we spoke with did not understand the key parts of the legislation and were not sure how to implement it in their practice. There was no protocol on the MCA for staff to refer to in order to follow the principles of the Act.

Patients with learning disabilities were given extended review appointments with the GP once a year. Prior to the appointment the patients or their carers were asked to fill part of the assessment to assist them in their involvement of the health review. GPs told us that patients with dementia were given copies of their care plan. This helped the patients and their carers to be involved and understand the care planning. We noted the formatting of the printed plans could have been more clearly laid out for patients and their families.

A GP partner told us there was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures a patient's verbal consent was documented in the electronic patient notes with a record of the relevant risks, benefits and complications of the procedure. We did not verify this in patients' records.

Health promotion and prevention

Health checks are offered to new patients over the age of 40. If new patients were on repeat prescriptions they were booked an appointment with a GP for review on registration. We were unable to evidence whether this was for patients with any repeat prescription or particular medicines. The practice also offered NHS Health Checks to all its patients aged 40-75.

The practice had numerous ways of identifying patients who needed additional support, and were pro-active in offering additional help. For example, the practice kept a register of all patients with learning disabilities they were offered an annual physical health check which was provided during an extended appointment. The practice had also identified the smoking status of 85% of patients over the age of 16 and 71% were actively offered smoking cessation appointments. Performance for national chlamydia screening was very high for the practice. The manager told us the practice performance was the second highest for uptake of Chlamydia screen in Berkshire. This was particularly relevant as the practice had a young population who tend to be at higher risk of chlamydia. The testing kits were available for patients to take away independently. The practice promoted and undertook HIV

Good

Are services effective?

(for example, treatment is effective)

testing which was displayed clearly in the practice. A GP partner told us about a health promotion meeting held for young families with young children to promote self-care. The practice offered a comprehensive family planning services in house, including coil fitting and implants. A GP partner told us three members of staff fitted coils and five fitted implants in order to offer a very short waiting time. There was an end of life patient register. This included patients in nursing homes. A GP told us flu vaccines were offered and given to patients within their nursing homes.

Patients over 75 had a named GP. GPs did not have strict patient lists for patients under 75. They told us that holding registered lists for all patients would prove difficult due to several GPs working part time. However, one GP told us the practice was working towards individual lists based on patients' needs. The practice provided health checks for patients with severe mental illness.

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 flu immunisations was above average for the CCG. Seventy eight per cent of patients over 65 and 56% of patients eligible who were under 65 received a flu vaccination. Uptake for child immunisations for those under 12 months was 85%, up to 24 months 84% (both slightly under the national average) and for children up to 5 the uptake was 85%.

There was health promotion material available in the waiting area and on the website. This included a weight management service, diabetic wellbeing, flu immunisation and sexual health advice. The patient participation group (PPG) organised health promotion events to share information on family health, dementia and diabetic care. These events were well attended by local patients.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey and a survey of 380 patients undertaken by the practice's patient participation group. The evidence from all these sources showed patients reasonably satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the national patient survey showed 68% of patients said the last GP they saw or spoke to was good at treating them with care and concern and 84% said the last nurse they saw or spoke to was good at treating them with care and concern. The practice scores on consultations showed 76% of GPs and 82% of nurses were good at listening to them and 75% saying the GP gave them enough time. The feedback consultations with GPs was below national average but was higher than national average for nurses.

Patients completed CQC comment cards to provide us with feedback on the practice. We received 22 completed cards and the majority were positive about the service experienced. Patients said they felt the practice offered a helpful and caring service. They said staff treated them with dignity and respect. Six comments were less positive and this feedback related to treatment and access to the practice. We also spoke with nine patients on the day of our inspection. Most told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. However, there were concerns about the continuity of care provided in patients' treatment due access or not being able to see the same GP.

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

We observed staff were careful to protect patients' confidentiality when discussing confidential information. The practice switchboard was located away from the reception desk which helped keep patient information private. Staff spoke to patients quietly at reception to protect their information. This prevented patients overhearing potentially private conversations between patients and reception staff.

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 61% of practice respondents said the GP involved them in care decisions and 71% felt the GP was good at explaining treatment and results. Both these results were below the local average.

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. Patient feedback on the comment cards we received was also positive and aligned with these views. Referrals were forward onto a central referral system run by the local clinical commissioning group (CCG) and patients were offered five choices of provider for their referrals.

Staff told us that translation services were available for patients who did not have English as a first language via a telephone line service. The practice website could be translated into over 50 languages

Patient/carer support to cope emotionally with care and treatment

The survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. The patients we spoke to on the day of our inspection and the comment cards we received were showed staff were supportive.

Notices in the patient waiting room, on the TV screen and patient website also signposted patients to a number of support groups and organisations, such as dementia and carer support, child counselling, bereavement support and child anxiety clinics. The practice's computer system alerted GPs if a patient was also a carer. We were shown the written information available for carers to ensure they understood the various avenues of support available to them.

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The needs of the practice population were understood by staff including the demographics of the local population. Systems were in place to try and address identified needs such as having a high number of young children in the patient population. The practice had a young patient population including many young children. A minor illness nurse had been employed by the practice to try and meet the demand of patients, especially children, attending for minor illnesses. This change was proposed to patients in the 2013 practice survey to gauge patient opinion. Patients were highly supportive of this change.

Due to the number of locums the practice used, there was significant staff turnover. Some patients told us this impacted on continuity of care and accessibility to appointments with a GP of choice. Only 20% of patients reported they could see a GP of choice in the 2014 national survey. Patients who had concerns over continuity of care reported not being able to see the same GP for the same condition. They told us this affected their treatment. The practice manager and a partner told us they were trying to recruit new full time GPs to address these concerns, but they were finding it difficult to recruit GPs that they believed met the standards for their patients.

Longer appointments were available for patients who needed them, such as those suffering from poor mental health and patients with long term conditions. This included appointments with a specialist nurse, such as appointments for diabetes checks. The practice has a contract to cover a local 34 bed nursing home and one of the GPs visited one morning each week to carry out a ward round to see patients. Home visits are provided at the discretion of GPs and according to clinical need. The practice reserved these for older, disabled and terminally ill patients or for emergencies.

The practice had implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from the Patient Participation Group (PPG). Improvements to the practice were implemented such as ensuring alarm cords were working in the disabled toilet.

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

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example, a GP told us EMIS web, the patient record system, alerted staff if a patient was deaf and gave details of who has been given consent by the patient to be spoken with on their behalf. The alert could also include notes not to phone the patient. The system would flag if a patient had communication difficulties or does not speak English. A GP told us Emis web alerted reception staff to vulnerable patients to enable them to consider patients' needs. Parents and guardians had access to baby changing facilities.

The practice and services had been adapted to meet the needs of patients with mobility problems. The doorways were wide and there was space for wheelchairs and mobility scooters to turn.

Access to the service

Appointments were available from 8am to 6.30pm on weekdays. The practice opened for extended hours appointments up until 8pm on a Monday evening. This benefitted patients who worked full time. Staff told us the appointments allocated for Monday evenings were in place of appointments provided in normal working hours, which did not provide additional access to the service, only access at a different time to usual opening hours. The practice had merged with Balfron Practice, based at Skimped Hill in Bracknell, in 2009 and meant the patient population has increased significantly since. The practice had made changes to the appointment system since the merger in response to patient feedback about the difficulty in making appointments. Despite these changes patients reported in the national and practice surveys and directly to us that they were finding it very difficult to make appointments. The national GP survey findings showed only 61% of patients described their experience of making an appointment as good. Sixty eight per cent said they could get through easily on the phone to book an appointment. Several patients we spoke with told us they found it difficult to book an appointment even in advance. Some patients were also complimentary about the appointment system, noting the online booking system

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

worked well. The practice had tried to expand Forest End Medical Centre but they were unable to despite securing funding because the land is shared with a company who did not want the expansion to take place. Other options to increase capacity or alleviate the problems reported by patients have been considered and some action taken to improve the capacity problems reported by patients. Some of these changes had been consulted through the patient survey. However, at the last national survey the practice had still received poor feedback regarding access.

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits and how to book appointments through the website. There were also arrangements in place to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when they were closed, there was an answerphone message giving the telephone number they should ring depending on the circumstances. Information on the out of hours service was provided to patients.

Forest End Medical Centre was situated on the ground floor of the building. 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.

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. There was a designated responsible person who handled all complaints in the practice. We saw that information was available to help patients understand the complaints system online.

We looked at a number of complaints received in the last twelve months and found these were satisfactorily handled and dealt with in a timely way. The practice investigated clinical complaints robustly and sent a thorough response to patients.

The practice reviewed complaints to detect themes or trends. We looked at the report for the last review and no themes had been identified, however lessons learnt from individual complaints had been acted upon. There was information on the local independent advocacy service and local Healthwatch in the waiting area.

Are services well-led?

Requires improvement

(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 vision to deliver high quality care and promote high quality outcomes for patients. Staff we spoke with were clear on the values of patient centred care, confidentiality and respect and dignity. The practice had a strategy for improving the physical space within the practice but this had been prevented from progressing due to the refusal of an extension by an organisation who shared the site. The practice leadership team were aware of the patient dissatisfaction with the access to appointments. The action taken to address this problem included employing a minor illness nurse. The practice was also trying to employ more GPs. However, despite some efforts to address this, patients satisfaction with the appointment system remained low and there was no formal long term plan at the time of the inspection to deal with increasing demand and the access to the practice. Individual issues such as access to the appointment phone lines had been taken to try and address issues.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff. We looked at of policies and procedures. All policies and procedures we looked at were reviewed regularly and were up to date.

The practice held four types of meeting and each occurred monthly; partners meetings, contracts meetings (which focuses on IT, QOF and enhanced services), clinical educational meetings and a multidisciplinary gold standard framework meetings. We looked at minutes from the meetings and found that performance, quality and risks were discussed.

The practice used the Quality and Outcomes Framework (QOF) to measure their 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 meetings and action plans were produced to maintain or improve outcomes. However, we saw one QOF outcome regarding diabetes care was not fully explored to identify what caused the poor performance and improve outcomes for patients.

The practice undertook comprehensive appraisals for staff which included elements of GP's revalidation such as staff peer reviews and this process included administrators. Staff were able to identify and undertake training. However, there was no system to identify and monitor core training for all staff related to their roles. For example, some staff who performed chaperone training did not have appropriate training.

The practice had completed a number of clinical audits led by staff who specialise in clinical areas. The GP trainers and trainees decided between them which audits are appropriate for the trainees to do. We saw audit outcomes were shared with the staff group and were repeated to ensure change occurred to improve the service where necessary.

The practice did not have robust arrangements for identifying, recording and managing all risks. For example, no legionella risk assessment was undertaken at the practice. A risk assessment for staff that required DBS checks had not identified that nurses or administration staff undertaking chaperone duties should have criminal checks undertaken. Significant events and complaints were investigated, shared with staff and learning outcomes were reviewed.

Leadership, openness and transparency

The practice leadership had a clear structure where members of staff knew their responsibilities and roles. For example there was a lead nurse for infection control and a senior partner was the lead for safeguarding. We spoke with eight 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. Staff felt involved in the running of the practice.

We saw from minutes that team meetings were held monthly. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings. We also noted that team away days were held every year.

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

The practice had gathered feedback from patients through its own patient survey, complaints and through national feedback such as the GP national survey. We looked at the results of the practice survey from November 2013 and found 32% of patients suggested that getting through on the phone to book an appointment was difficult. The

Are services well-led?

Requires improvement

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

survey report suggested that exploring online booking systems and advertising phone access at the branch Balfron Practice could improve this feedback. Patients told us they knew about the online booking system and some had started using it. The survey asked patient opinions on potential changes to the practice, such as new style of clinics for patients with long term conditions.

The practice had an active patient participation group (PPG). The PPG contained representatives from various population groups including patients who had or cared for patients with long term conditions, mental health problems and those in vulnerable circumstances. The PPG were involved in drafting and analysing the practice survey. The PPG chair told us the practice worked well with the PPG and considered their feedback in the running of the service. They informed us of changes to the premises at the branch practice and health information events for local patients.

The practice had gathered feedback from staff appraisals, meetings and informally. 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.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at staff files and saw that regular appraisals took place which included a personal development plan. Staff told us that the practice was very supportive of training and that they had designated training days. The practice was a GP training practice. We spoke with two GP trainees who told us they felt supported in their work. GP trainers reviewed the records of trainees as part of their supervision. The practice was not identifying and monitoring all training needs. Not all staff were adequately trained in the Mental Capacity Act 2005 or in performing the role of a chaperone.

Although the practice responded to patient feedback, there was a lack of long term planning to manage the demands of their patients. There was concern among patients that access to practice was poor and the practice had responded with some measures to improve access. However, the partners and the practice manager were aware of concerns regarding capacity of appointments and space in the practice but they had not assessed the options for taking action to remedy the problems. For example, there was no consideration of how other GP practices had managed increases in patient numbers in other areas of the country or within the CCG.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers **The registered person must operate effective recruitment procedures to ensure that employees are of good character and that information required under schedule 3 is available. Regulation 21(a)(i)(b)**

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff **The provider should ensure that staff are appropriately supported by receiving training to enable them to undertake their responsibilities safely and to an appropriate standard. Regulation 23 (1)(a)**