Gladstone Medical Centre

Quality Report

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

Ratings

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

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Gladstone Medical Centre on 12 March 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing well-led, effective, caring and responsive services. It was also good for providing services for five out of the six population groups we report on. It required improvement for providing safe services and for providing care to people whose circumstances may make them vulnerable.

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Patients' needs were assessed and care was planned and delivered following best practice guidance.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.

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

Importantly the provider must:

- Improve the storage arrangements for vaccines and other medicines to ensure these comply with best practice guidelines.
- Carry out an infection control audit to monitor for any risks to staff or patient safety.

In addition the provider should:

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- Review staff knowledge of the Deprivation of Liberty Safeguards (DoLS) legislation as it applies to general practice because it may be relevant to work carried out at a local care home.
- Review and update the business continuity plan to ensure that adequate emergency arrangements are in place.

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. The practice could show us they had a good track record on safety. Staff understood their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement.

Staff were aware of their responsibilities to safeguard vulnerable adults and children. The practice was working closely and efficiently with local safeguarding agencies. However, some clinicians were not clear about the implications of the Mental Capacity Act (2005) including the Deprivation of Liberty Safeguards. This may have been relevant to clinicians' work at a local mental health care home.

Risks to patients who used services were assessed, but the systems and processes to address these risks were not always implemented well enough to ensure patients were kept safe. Medicines and vaccines were not always stored and disposed of in line with best practice guidelines. An infection control audit had not been carried out within the past year to monitor any risks to staff or patient safety. There was a business continuity plan, but this had not been regularly updated and did not contain a current list of who to contact for support during an emergency.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from National Institute for Health and Care Excellence and used it routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. Staff worked with multidisciplinary teams and liaised effectively with other health and care providers to ensure co-ordinated care for their patients.

Staff had received some training appropriate to their role. Further training needs had been identified and appropriate training planned to meet these needs. There was evidence of appraisals and personal development plans for all staff.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed patients rated the practice higher than others for several aspects of care. Patients we spoke with on the day of the visit said they were treated with compassion, dignity and respect and they

Summary of findings

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.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the local Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Information about how to complain was available and evidence showed that the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.

Patients knew they could book appointments in advance or be seen for an urgent appointment with a duty doctor on the same day. However, we received some feedback from patients that there were occasionally long waits to seen by a doctor and that people could not always see their preferred GP. We saw evidence that the practice had reviewed this issue and tried to extend their capacity to see patients as much as possible. The partners now reported that the premises prevented them from extending their services further. They were exploring options for physical expansion of the service via redevelopment or relocation of the premises.

Are services well-led?

Good

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

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in dementia and end-of-life care. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs. All people over the age of 75 years had a named GP and had care plans developed in conjunction with other health and care professionals where necessary.

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. They carried out regular assessments of people diagnosed with long-term conditions to monitor for any changes or risk of deterioration in people's physical health. For example, people with diabetes were invited for regular health checks. The practice performed well in this area with 92% of patients with diabetes having received a foot check in the past year.

Patients who had experienced a hospital admission were identified as a priority and contacted within two days of discharge from hospital for a follow-up appointment with their GP.

All patients with long-term conditions had a named GP. Those with the most complex needs were discussed at multi-disciplinary meetings with other health and care professionals to develop a comprehensive package of care.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk. For example, one of the GP partners acted as the lead in child protection for the practice. They liaised regular with external safeguarding agencies and had received positive feedback about their timely contribution of information for safeguarding case reviews.

A baby clinic offering access to nursing staff and a midwife was held weekly. Children were offered immunisation according to the national schedule. Young people were offered chlamydia screening and information about this service was displayed in the waiting area.

Summary of findings

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students). The practice offered some early morning appointments. Appointments could be made on the telephone and through the practice's website. GPs were available for telephone and online video consultations. All people over the age of forty years were invited for a general health check.

People whose circumstances may make them vulnerable

Requires improvement

The practice is rated as requires improvement for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including those with a learning disability. It offered annual health checks for people with a learning disability and 83% of these had been completed so far in the current year.

People who were recently bereaved were offered additional support and an appointment with a GP. The practice kept a register of people who were acting as carers for friends or relatives. Carers were signposted to local initiatives for extra support.

There was a GP partner acting as a safeguarding lead for the protection of children and vulnerable adults. Staff were aware of this arrangement. However, not all of the GPs could describe the implications Deprivation of Liberty Safeguards (DoLS) legislation as it applies to general practice. This may have been relevant to the care of patients living at a local care home.

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). The practice hosted weekly sessions with psychologists through the Improving Access to Psychological Therapies (IAPT) service. The practice kept a list of people diagnosed with dementia and mental health concerns. The shared computer system alerted reception staff to the fact that these people needed to be seen promptly so that they could be prioritised for appointments.

The practice had carried out an audit of people receiving some medicines for major depressive disorder to identify if they were receiving the recommended physical health checks. This had led to a discussion of best practice at a clinical meeting and a second audit identified that the practice had improved their performance in this area.

Summary of findings

The practice worked closely with a local mental health care home. We spoke with the care home manager who praised the practice in relation to its responsive and timely care of the people living at the service.

Summary of findings

What people who use the service say

We spoke with 15 patients during our visit and received 32 Care Quality Commission comment cards completed by patients who visited the Gladstone Medical Practice during the two weeks before the inspection.

Patients we spoke with made positive comments about the care and treatment they received. They said staff spoke with them appropriately and their privacy and dignity was maintained. They said the surgery was always clean. None of the patients we spoke with had made a complaint, but they were aware of how to do so. They told us they would speak with the practice manager and felt confident that their issues would be addressed.

We saw staff spoke politely to patients. Patients said they were involved in decisions about their care and treatment. All of the CQC comment cards indicated patients were satisfied and happy with the service they received at the practice. They said that staff were caring, friendly, professional, efficient and competent. Patients said they were referred to specialists when required, that the repeat prescription service was efficient and they were usually able to get urgent appointments.

The results of the national patient survey 2014 showed the practice scored the same as the national average at 96% for the proportion of respondents who rated their GP surgery as 'good' or 'very good' and in the top range for the proportion of patients who would recommend their GP practice.

Areas for improvement

Action the service MUST take to improve

- Improve the storage of vaccines so that this complies with Public Health England's Protocol for Ordering, Storing and Handling Vaccines (issued March 2014).
- Carry out an infection control audit to monitor for any risks to staff or patient safety.

Action the service SHOULD take to improve

- Review staff knowledge of the Mental Capacity Act (2005) including the Deprivation of Liberty Safeguards and the role of the general practitioner in monitoring and complying with this legislation.
- Review and update the business continuity plan to reflect the practice's current circumstances.

Gladstone Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our team was led by a CQC Lead Inspector. The team also included a second CQC inspector, a GP Specialist Advisor and a Nurse Specialist Advisor, who were granted the same authority to enter the practice premises as the CQC inspectors.

Background to Gladstone Medical Centre

The Gladstone Medical Centre is located in Neasden in the London Borough of Brent. The practice serves approximately 8,800 people living in the local area. The practice operates from a single site. It is situated in a four-storey building with car parking facilities at the back.

There are three GP partners, two male and one female, working at the practice. The practice manager is also a partner in the practice. There is one salaried GP, a practice nurse and three health care assistants. The practice offers a wide range of services throughout the day. One of the GP partners carries out minor surgery for skin lesions. There are also specific clinics for babies every Wednesday morning and sessions with psychologists who are providing support through the Improving Access to Psychological Therapies (IAPT) service on Fridays. The practice provides a phlebotomy service for all of the people in the local area, regardless of whether or not they are registered with the practice.

The practice is a community teaching practice providing training and mentoring to GP trainees. There are three trainees working at the practice consisting of two GP registrars and one foundation doctor (previously known as a 'senior house officer').

The practice offers appointments on the day and books appointments up to six-weeks in advance. The practice has appointments between 8.00am to 6.30pm on Mondays to Fridays. They also offer extended opening hours between 7.30am and 8.00am on Mondays to Fridays. During the winter they open on a Saturday morning for flu vaccination appointments. Patients are directed to call the local out of hours or 'Barndoc' or '111' service for advice when the practice is closed. Patients could see a clinician in the evenings and on the weekends at a local hub or urgent care centre.

The Gladstone Medical Centre is contracted by NHS England to provide General Medical Services (GMS). They are registered with the Care Quality Commission (CQC) to carry out the following regulated activities: Surgical procedures; Family planning; Diagnostic and screening procedures; Maternity and midwifery services; Treatment of disease, disorder or injury.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Detailed findings

Please note that when referring to information throughout this report, for example any reference to the Quality and Outcomes Framework data, this relates to the most recent information available to the CQC at that time.

How we carried out this inspection

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

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

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

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

Before visiting, we reviewed a range of information that we hold about the practice. We carried out an announced visit on 12 March 2015. During our visit we spoke with a range of staff. We spoke with four GPs, a trainee GP, a practice nurse, three health care assistants, a practice manager, three receptionists and two administrative staff. We spoke with 17 patients who used the service. We also spoke with a range of visiting health and care professionals including a care home manager, community nurse and integrated care co-ordinator. We observed patient and staff interactions in the waiting area. We conducted a tour of the surgery and looked at the storage of medicines and equipment. We reviewed relevant documents produced by the practice which related to patient safety and quality monitoring. We reviewed some patients' care plans and associated notes.

Requires improvement

Are services safe?

Our findings

Safe track record

The practice showed us how they monitored patient safety and could demonstrate they had a good track record for maintaining patient safety. For example, the practice monitored and discussed national patient safety alerts, investigated any adverse incidents and reviewed the content of comments and complaints from patients. There was a weekly clinical meeting where any safety concerns were raised and discussed. This took the form of reviewing individual cases and practice-level systems. There was also an annual review meeting where all of the events and complaints from the previous year were discussed to identify any common themes and monitor the implementation of action plans.

We reviewed safety records, incident reports and minutes of meetings where these were discussed during the past year. The detail in the minutes was relatively limited, but the staff we spoke to were all aware of their responsibilities to raise concerns and knew how to report incidents and near misses. Staff confidently described actions that had been taken to resolve issues that had arisen in the past year. This showed the practice was effectively disseminating action plans and learning points among staff.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. We reviewed the response to a recent case where an alert had been raised with the Care Quality Commission (CQC) regarding the role of a health care assistant in carrying out smear tests and vaccinations. We saw that a clinical meeting had been held to discuss this event and review the actions that had already been taken and to discuss any further measures that might be needed. The practice had taken a range of steps to identify whether or not they were breaching any regulations, had audited the clinical outcomes in relation to the HCA's performance and undertaken a review of the HCA role, including writing a new job description. We were satisfied that the practice was treating the issue with due concern, were taking appropriate steps to resolve the problem and putting in place strategies for preventing any similar role issues from arising again.

We saw that the practice had reported a number of assault incidents from patients. The practice had recognised that all staff were at risk from abusive and violent patients. As such they had purchased a CCTV camera for use in the practice. Staff had also undertaken training and all were aware of the process to follow should there be an incident, such as hand lifting as a sign to call the police.

We saw evidence that complaints were reviewed at either clinical or administrative staff meetings, depending on the nature of the complaint and the level of risk to patient safety. The practice ensured that information was shared with relevant staff through the use of electronic messaging systems. Administrative staff also attended some clinical meetings to ensure that information on good practice was shared between teams. Staff, including receptionists, administrators and nursing staff, told us they knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

National patient safety alerts were disseminated through electronic messaging systems which required clinicians to complete an action to indicate they had reviewed the information. Staff we spoke with also told us these were discussed at clinical meetings. They could cite recent examples, such as an alert regarding malaria medicines, demonstrating that the practice was sharing this information efficiently.

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 some relevant role specific training on safeguarding. This included Level three training for GPs in protection of children and young adults, Level two training for nursing staff and Level one training for reception staff. However, the training record we were given to review showed that not all of the GPs and reception staff had completed a course in safeguarding vulnerable adults. We subsequently checked six staff files and could see that training in safeguarding adults had either been completed within the past year or staff were booked onto a course which covered both the Mental Capacity Act and safeguarding adults. Therefore we were satisfied that the practice had taken action to ensure staff received adequate safeguarding training.

Requires improvement

Are services safe?

The staff we spoke with knew how to recognise signs of abuse in older people, vulnerable adults and children. They were aware of their responsibilities to monitor for signs of abuse and knew how to share information with senior staff at the practice. There was a noticeboard on the first floor with contact details for local safeguarding agencies for staff to refer to, if necessary.

The practice had appointed a dedicated GP to take the lead in safeguarding vulnerable adults and children. The GP could demonstrate they had the necessary training to enable them to fulfil this role. The majority of staff we spoke with were aware that this GP was the lead, or knew they could speak to their direct line manager for advice on where to raise their concerns.

The GP responsible for safeguarding issues at the practice was liaising regularly with the local Multi-Agency Safeguarding Hub (MASH) and with a community nurse who was co-ordinating child protection issues in the local area. The GP told us they were providing timely information for any case reviews. The community nurse spoke with us on the day of our inspection. They told us they had built a good working relationship with GPs at the practice. The practice had received feedback showing that they were one of the best performing practices in the local area for completing forms containing information on safeguarding patients requested by the MASH.

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

There was a chaperone policy, which was visible on the waiting room noticeboard, but was not displayed 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, and reception staff were available to act as chaperones. Receptionists told us that people did occasionally request this service. Staff had not received training in chaperone procedures, but we saw that this training was booked for May 2015. Not all of the reception staff had had the relevant Disclosure and Barring Service (DBS) checks required for staff who act as chaperones. The practice manager had already identified this issue and the DBS checks were underway at the time of the inspection. The practice manager confirmed that staff who did not have current DBS checks and training would not be working as chaperones until these were completed.

Medicines management

The practice must improve the way they manage medicines.

We checked medicines stored in the treatment rooms and medicine refrigerators. Temperatures inside the fridges were monitored using a thermometer with a probe cable inside the fridge. Records indicated that temperatures remained within the minimum and maximum recommended range (between two and eight degrees Celsius). However, the Public Health England's Protocol for Ordering, Storing and Handling Vaccines (issued March 2014) recommends the use of two thermometers, or if one thermometer is used then a monthly check should be considered to confirm accurate calibration. Monthly calibration checks were not taking place.

This Protocol stipulates that specialist vaccine fridges must be used. The fridges at the practice were not lockable and were stored in consulting rooms which were not always locked. We also noted one of the fridges in a consulting room in the basement included a freezer shelf inside the fridge instead of a separate freezer with an external door. Specialist vaccine fridges do not contain freezer shelves because of the risk of vaccines reaching inappropriate temperatures when they are stored close to the shelf.

We also reviewed the storage of other medicines. We found medicines, including emergency drugs, were generally stored appropriately and securely. Processes were in place to check medicines were within their expiry date and suitable for use. All of the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations. However, we saw one cupboard where there were two boxes of medicines which had been issued to a named individual and were therefore being kept in this cupboard inappropriately.

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.

Requires improvement

Are services safe?

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 premises to be clean and tidy. There was a cleaner working on the site during our inspection who was following a cleaning schedule and using appropriately colour-coded equipment.

The practice had recently recruited a practice nurse following a gap in nursing provision between August and December 2014. The nurse was scheduled to undertake infection control training with a view to taking the lead in this area. However, because an infection control lead had not been in place throughout the previous year, the annual infection control audit had not been carried out. The last infection control audit had taken place in June 2013.

There were arrangements in place for the safe disposal of medical waste. For example, there were colour-coded sharps bins in all of the consulting rooms. However, the appropriate coloured bin was not in place in all areas. For example, the nurse and health care assistants' rooms had orange-lidded bins. There should also have been yellow-lidded bins for the safe disposal of sharps contaminated with medicines, such as vaccines.

All staff received induction training about infection control specific to their role. We spoke to staff about their understanding of protocols that needed to be followed to ensure the risk of infection was minimised. All staff had good levels of knowledge about the infection control protocols. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe when they would need to use these.

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 a policy for the management, testing and investigation of legionella (a bacterium that can grow in contaminated water and can be potentially fatal). We saw that the practice carried out an annual risk assessment for legionella with the last one having been carried out in August 2014.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date of January 2015. A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example the date for an annual calibration of weighing scales was set for January 2016.

Staffing and recruitment

The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks through the Disclosure and Barring Service (DBS). However, we noted that some reception staff had started working as chaperones before their DBS check had been completed. We discussed this with the practice manager who assured us staff would now only be working as chaperones after their DBS was completed.

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

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included annual and monthly checks

of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. Policies and protocols were shared in a computer folder on each work station's desktop. Staff had been instructed to check this daily for any updates or alerts. One of the administrative staff was also responsible for directing staff to look at particular policies, protocols or alerts via electronic messaging.

There were systems in place to protect the confidentiality of patient records. Records were all stored in locked cabinets on the top floor. Staff had received training in information governance and could describe the measures in place to protect patient confidentiality.

There were systems in place to respond to changing risks to patient, including deteriorating health or medical emergencies. For example, the practice monitored repeat prescribing for people receiving medication for mental health issues at a local care home. Patients who had been admitted to hospital were contacted by the practice to arrange for a follow-up appointment to fully understand any changes in need.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that the staff had received training in basic life support. Emergency equipment was available including oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). Staff knew the location of this equipment and records confirmed that it was checked regularly.

Emergency medicines were available in a box and staff knew of their location. These included those for the treatment of cardiac arrest and anaphylaxis. 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. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. However, the plan had been produced in 2006, had not been updated and did not contain relevant contact details for suppliers.

The practice had carried out a fire risk assessment that included actions required to maintain fire safety. The alarms were regularly tested and staff practised fire drills.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. National data showed that the practice was in line with referral rates to secondary and other community care services for all conditions.

There were weekly clinical meetings where guidance and performance in relation to topics such as prescribing and referral rates were discussed. Brief minutes from these meetings were kept, but these did not necessarily document when these discussions had taken place. However, the staff we spoke with all confirmed that new guidance was discussed at these meetings in order to ensure that patients received support to achieve the best health outcome for them. They could cite examples of guidelines which had been recently reviewed such as the two-week wait referral system for patients with suspected cancer. The practice also created their own guidance to encourage best practice. For example, they had developed guidelines for the management of patients with anaemia.

The practice used computerised tools to identify patients with complex needs who had multidisciplinary care plans documented in their case notes. We were shown the process the practice used to review patients recently discharged from hospital. The practice aimed to contact patients within two days of receiving a notification from the hospital to arrange a review appointment with their GP.

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

Management, monitoring and improving outcomes for people

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, and managing child protection alerts. The information staff collected was then collated by the practice manager and GP partners to support the practice to carry out clinical audits.

The practice showed us two examples of clinical audits that had taken place between 2013 and 2014. In one case an audit had been carried out of patients taking medicines to treat depressive disorders. These patients required regular blood pressure checks and a yearly echocardiogram (ECG) to monitor for side effects. The initial audit (October 2013) found that 52% of patients had had an ECG and 62% had their blood pressure recorded in the past year. An improvement target of 90% was set and the issue was discussed at a clinical meeting to give directions to GP on how to improve their monitoring of these patients. A second audit was carried out in October 14. This demonstrated that although the target had not been met, there had been a significant improvement in patient monitoring (72% for ECG and 76% for blood pressure recording).

The practice used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. (QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). The practice could show us they performed consistently well in the QOF and had historically met the majority of the targets set. The data reviewed showed they were also performing well this year. For example, 92% of patients with diabetes had been called to have a foot examination within the past year. This exceeded the target set in the QOF of 90%. Clinical staff continually checked that all routine health checks were completed for other long-term conditions such as chronic obstructive pulmonary disease (COPD) and asthma. Patients were sent letters and called on the phone to remind them to attend for relevant health checks.

There was a protocol for repeat prescribing which was in line with national guidance. Reception staff had recently attended a training course to maintain standards for people receiving repeat prescriptions. Staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP.

There were relatively fewer numbers of older age patients registered at this practice compared to the national

Good

Are services effective?

(for example, treatment is effective)

average and the practice did not use the gold standards framework for end-of-life care. There was a palliative care register and cases were reviewed at clinical meetings to discuss the care and support of patients and their families. The practice did not hold routine meetings with the local palliative care team, but did contact them when required. One of the GP partners told us that patients receiving palliative care were contacted by the practice every two weeks to monitor their care. We spoke with two patients who had been recently bereaved. They told us they had received excellent support from the practice for themselves and for their relatives during the palliative care phases of their illness.

The practice also participated in local benchmarking run by the CCG. This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area. This benchmarking data showed the practice had outcomes that were comparable to other services in the area. For example, the practice reviewed quarterly prescribing reports as part of the Clinical Commission Group's (CCG) Quality, Innovation, Productivity and Prevention Programme (QIPP). One of the GP partners showed us information they had received about the practice's performance for antibiotic prescribing. The practice was performing better in this area compared to many other local practices.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff had attended some relevant courses such as annual basic life support and safeguarding children.

New members of staff received an induction pack which was also stored on a shared computer drive. This induction pack included an outline timetable for completion of certain tasks such as reviewing health and safety policies. New clinical staff had a minimum of a two-week induction period during which time they were regularly supervised during appointments.

There was a good skill mix among the doctors. For example, one of the GPs had completed a diploma course in diabetes management and another was trained to carry out minor surgery for skin lesions. Another GP had recently attended a training course in disease-modifying anti-rheumatic drugs (DMARDs) to support the effective care of patients with rheumatoid arthritis. The practice nurse had been recently recruited and was being trained to fulfil defined duties. For example, the nurse would be taking the lead for infection control following training and was in the process of training to become an independent prescriber.

All GPs were up to date with their yearly continuing professional development requirements and all either had been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

All staff undertook annual appraisals that identified learning needs from which action plans were documented. Our interviews with staff confirmed that the practice was proactive in providing training for relevant courses. For example, all of the reception staff we spoke with referred to a recent course they had attended on the safe and effective management of patient requests for repeat prescriptions. They told us this had improved their confidence and skills in this area.

As the practice was a training practice, doctors who were training to be qualified as GPs were offered extended appointments and had access to a senior GP throughout the day for support. We spoke with one of the trainees who told us that a GP partner reviewed their performance in relation to every appointment throughout the day in a way which supported their professional development.

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

Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and manage those of patients with complex needs. It received blood test results, X-ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. One of the administrative staff team was responsible for monitoring all of this information as it was received. They processed any patient information on the day that it was received and distributed it to relevant members of the clinical team. This member of staff was following a protocol to identify patients with urgent concerns who needed attention from the GPs

promptly. Urgent concerns were referred to the doctor on duty to follow up on the same day. All staff we spoke with understood their roles and felt the system in place worked well. There were no instances identified within the last year of any results or discharge summaries that were not followed up appropriately.

The practice held multidisciplinary team meetings on a monthly basis to discuss the needs of complex patients, for example those with end-of-life care needs. Children on the at risk register were discussed at separate meetings with the health visitor. We spoke with a range of health care professionals who regularly liaised with the clinicians at Gladstone Medical Centre. For example, we spoke with a local integrated care co-ordinator, a district nurse, a community nurse leading safeguarding concerns, and a manager from a local mental health care home. They all told us they had regular and effective discussions with the GPs at this practice. GPs responded to requests to see patients, actively referred patients to their services to ensure patients received appropriate care, provided timely information to help keep patients safe, and were available for face-to-face and telephone discussions when required.

The manager from a local mental health care home told us doctors visited the care home regularly. Doctors attended annual care plan review meetings where the people living at the service, their relatives, social workers and other health professionals were all present to discuss that person's care needs.

Information sharing

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. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

The practice used several systems to communicate with other providers. For example, information from out-of-hours GP providers and hospitals was received via email, post and fax. Documents were attached or scanned into the electronic patient records on the same day that they were received and were escalated for the attention of appropriate clinicians at the practice.

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. (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 was not currently using the Choose and Book system for making referrals as they had experienced some difficulties with this system in the past, but the practice was due to start offering this service again in April 2015. (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).

Consent to care and treatment

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

One of the GPs took the lead for safeguarding vulnerable adults. This GP had recently attended training in relation to the use of the Mental Capacity Act 2005 and the Children Acts 1989 and 2004. This GP worked to ensure that staff understood their roles and responsibilities in relation to these Acts. For example, 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. Clinical staff gave some examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision.

However, not all staff understood their responsibilities in relation to working with young people. 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). But reception staff were not aware that young people could book their own appointments without being accompanied by an older adult.

This practice worked closely with a local mental health care home. We discussed the use of the Deprivation of Liberty Safeguards (DoLS) with clinicians. Some clinicians were unclear about recent developments in this area and their responsibilities in relation to DoLS authorisations.

Health promotion and prevention

Good

Are services effective?

(for example, treatment is effective)

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 practice also offered NHS Health Checks to all its patients aged 40 to 75 years. 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 83% had completed a physical health check in the past year.

The practice also had systems for identifying 'at risk' groups so that they could offer additional support. For example, the practice aimed to follow up people who had been discharged from hospital within two days and practice records showed that this system had been successfully completed for 99% of people.

We noted a culture among the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering opportunistic chlamydia screening to patients aged 18 to 25 years and referring people who were at risk of developing diabetes to a lifestyle clinic for dietary advice. There were also displays in the waiting area to inform people about ill-health prevention strategies such as travel vaccinations and chlamydia screening.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Performance sometimes fell below national averages for some vaccination or immunisation targets. For example, data for 2013/2014 showed that uptake of the measles, mumps and rubella vaccine (MMR) in children aged 24 months and aged five years was relatively low (46% and 40% respectively). However, we saw that the practice had made efforts to reach targets by sending out regular reminder letters to those who had not attended.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey (2014), an internal survey of 250 patients sent out to patients by the practice manager in 2014, and feedback from the practice's patient participation group (PPG). The evidence from all these sources showed patients were generally satisfied with their GP practice. The results of the national patient survey 2014 showed the practice scored the same as the national average at 96% for the proportion of respondents who rated their GP surgery as 'good' or 'very good' and in the top range for the proportion of patients who would recommend their GP practice.

Patients completed CQC comment cards to provide us with feedback on the practice. We received 32 completed cards and all were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. We also spoke with 17 patients on the day of our inspection. They all told us they were satisfied with the care provided and that their dignity and privacy was respected by staff at the practice.

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 follow the practice's confidentiality policy when discussing patients' treatments so that confidential information remained private. The practice switchboard was located in the same room as the patient waiting area. In response to patient and staff suggestions, a system had been introduced to allow only one patient at a time to approach the reception desk. 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.

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

There was a visible notice in the patient reception area stating the practice's zero tolerance for abusive behaviour. Receptionists told us referring to this had helped them diffuse potentially difficult situations.

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. They generally rated the practice favourably in these areas. For example, data from the 2014 national patient survey showed 83% of practice respondents said the GP involved them in care decisions and 88% felt the GP was good treating them with care and concern. Both these results were above average compared to the results for the overall Clinical Commissioning Group (CCG) area (78% and 81% respectively).

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 felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. Patient feedback on the comment cards we received was also positive and aligned with these views.

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

Patient/carer support to cope emotionally with care and treatment

Staff told us families who had suffered bereavement were called by their usual GP. This call was either followed by a

Good

Are services caring?

patient consultation at a flexible time and location to meet the family's needs and/or signposting to a support service. Patients we spoke with who had experienced bereavement told us that the practice manager and GPs had been supportive during the time of their loss.

The practice's computer system alerted GPs if a patient was also a carer so that they could offer impromptu support or advice during appointments. We were shown the written information available for carers to ensure they understood the various avenues of support available to them.

During patient registration the practice noted down details of carers. This was to ensure that they were offered all the relevant information about carer support.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

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

The practice offered a range of services to meet the needs of their local population. There was a baby clinic every Wednesday and access to psychologists working in the Improving Access to Psychological Therapies service on Fridays. One of the GP partners carried out minor surgery for skin lesions. The practice currently provided a phlebotomy service for all of the people in the local area, regardless of whether or not they were registered with the practice.

The practice was also developing its service in areas where it had identified that there were additional needs. For example, the practice was developing a local protocol for patients using warfarin and other anti-coagulants. They were planning to provide blood testing facilities for patients registered at the practice and give access to this service to all people living in the local area, regardless of registration.

The practice received feedback from patients through a range of sources. The practice manager commissioned a yearly survey and monitored responses to the 'Friends and Family Test'. This is a short survey which all GP practices are asked to use in order to collect patient feedback. The practice had data from the Friends and Family Test for the past two months. A total of 127 responses had been received during this time. 87% (110/127) of people had reported that they would recommend the practice to others.

The practice had an active Patient Participation Group (PPG). The PPG is a group of patients registered with the practice who have an interest in the services provided. We met with two representatives from the PPG during our inspection. They told us they met regularly and were consulted about the smooth running of the practice. We saw minutes from a meeting where the results from the annual patient survey were discussed in order to identify strategies for improvement.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. The practice was sensitive to the needs of the relatively diverse ethnic mix in the local area and had systems in place to support people to access their own and other healthcare services effectively. For example, the practice had access to interpreter services and had displayed information for asylum seekers about how GP services worked in the UK in 21 different languages on its website. The practice found that they had relatively high numbers of new patients registering and leaving the practice. Therefore there was a dedicated member of the administrative team working on the registration process to ensure the timely sharing of information within the practice and with other providers.

The premises had some adaptations to meet the needs of patient with disabilities. For example, there was a wheelchair ramp at the back of the building with access to the consulting rooms at the basement level. The waiting area on this level was large enough to accommodate wheelchairs and there were accessible toilet facilities.

The waiting areas in the basement and on the ground floors were used by families with young children. We saw that there were some child-friendly adaptations. For example, a TV in the waiting area in the basement had been set to children's channel. There were toys in some of the consulting rooms. However, baby changing facilities were not available in the toilets, although the practice manager told us that people were invited to use spare consulting rooms as private areas to change their babies.

Access to the service

Face-to-face appointments were available from 7.30am to 6.30pm on weekdays. The practice was also open on Saturday mornings during the winter for flu vaccination appointments. The practice also offered appointments over the phone and via video call.

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. Patients could book appointments up to six weeks in advance and some appointments were available on the day for patients who needed to be seen more quickly. Patients were

Good

Are services responsive to people's needs?

(for example, to feedback?)

directed to call an alternative provider or the '111' service for advice when the surgery was closed. People could also be seen at the Willesden Hub Centre or at the urgent care centre at the local Hospital.

Patients who were at risk for any reason, for example, because of the impact of a long-term condition, were identified and flagged on the computer systems so that they could be prioritised for appointments. Patients who were housebound or too ill to be seen at the surgery could request a home visit. The practice also provided support to a local mental health care home. We spoke with the care home manager who told us the GPs were responsive to the needs of the people living at the service. For example, people living at the service were prioritised for an appointment with the GP and reception staff had responded to specific advice on how to work with people experiencing a mental health crisis. Doctors visited the care home as necessary.

Patients were generally satisfied with the appointments system. Patients knew that they could see a doctor on the same day if they needed to. However, some patients mentioned that it could be difficult to book an appointment in advance and that sometimes they waited a long time before being seen. The data from the last annual survey also showed there were relatively low levels of satisfaction as regards waiting times (40% satisfied) and also relatively low numbers of patients reported that they had access to their GP of choice (46% had seen their GP of choice). In order to understand this issue, we reviewed the appointments system on one of the practice's computers. We noted that there was a four week wait to book an appointment in advance with any GP.

The practice manager and clinicians had reviewed this issue and we saw notes from a meeting where the matter was discussed with the PPG. There was a general consensus that the practice had already taken steps to increase capacity through the use of extended hours and GP trainees. They had recognised the need to expand the service, but were limited by the size of the current premises. They had started initial discussions with the local Clinical Commissioning Group (CCG) about relocating the practice in a larger building or extending the current premises.

Listening and learning from concerns and complaints

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

Information about the complaints system was displayed on the practice website. However, this information was not displayed in the waiting area. People 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 six complaints which had been received in the past year. The practice kept a record of the investigations made and the responses sent to patients. The practice reviewed complaints annually to detect themes or trends and to check that learning points had been identified and implemented effectively.

We found that each complaint had been responded to in good time. A variety of actions were taken by the practice manager and clinicians to improve the quality of the service in response to any complaints. For example, the practice manager had convened a multi-disciplinary meeting with clinicians and administrative staff to discuss a complaint about waiting times and how to support people with mental health needs to be seen promptly by a clinician. A discussion had taken place on how best to prioritise and support people whose circumstances may make them vulnerable throughout the appointments process. This had led to a new protocol for providing GP access to vulnerable patients through the use of an alert system on the computer records.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. The practice's statement of purpose described this vision in detail. The practice vision and values included providing confidential and safe care to all people irrespective of their social or cultural background, promoting the involvement of patients in making decisions about their own treatment, and the promotion of good health through the provision of education and information.

We spoke with 15 members of staff and they shared these values and knew what their responsibilities were in relation to these. We looked at minutes of the practice meetings and saw that staff discussed and shared the values on a regular basis to ensure they all worked towards them. We observed that members of the clinical and staff teams interacted well with each other and there were no barriers to communication across the teams. The practice promoted shared values and effective teamwork through the use of staff events such as a Christmas party and celebrating staff members' birthdays at work.

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 of any computer within the practice. Staff told us that they were instructed to review these protocols and policies on a daily basis to check for any updates. There was also a member of the administrative team who alerted staff via electronic messaging to any urgent updates.

The practice held monthly governance meetings. We looked at minutes meetings and found that performance, quality and risks had been discussed.

There was a clear leadership structure with named members of staff in lead roles. For example, one of the senior partners was the lead for safeguarding and the newly recruited nurse was in the process of training to become the infection control lead. The practice manager was the lead for all administrative and managerial issues. The staff we spoke with were all clear about their own roles and responsibilities. The majority of staff told us they felt valued, well supported and knew who to go to in the practice with any concerns. However, there was one member of staff we spoke with reported not feeling valued.

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. For the period 2013/2014 the practice had achieved 863 points out of 900. We saw that QOF data was regularly discussed at team meetings and action plans were produced to maintain or improve outcomes.

The practice had an on-going programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. For example, the practice had audited patients who were taking medicines to treat major depressive disorders to check they had been monitored for physical side effects.

The practice had arrangements for identifying, recording and managing risks. For example, the practice had reported a number of assault incidents from patients. Staff had received training on how to manage abusive patients and a CCTV camera had been installed.

The practice could show they had maintained a good record on patient safety over time. However, the practice had not always put in place actions which would minimise risks to patient safety in line with national guidance. For example, vaccine and other medicines storage arrangements did not meet current safety standards and the business continuity plan had not been kept up to date.

Leadership, openness and transparency

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. Reception staff told us they occasionally attended the clinical meetings in order to ensure the sharing of information across teams.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example, disciplinary procedures, induction policy, training, and the management of sickness which were in place to support staff. The practice manager was responsible for human resource policies and procedures. We were shown a staff handbook that was available to all staff, these included sections on equality and harassment and bullying at work. Staff we spoke with knew where to

Are services well-led?

Good

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

find these policies, if required. In cases where there had been disagreements among staff, or the practice manager had needed to take action to discipline any member of staff, we saw that this was carefully documented and in line with their stated policy.

The practice manager told us they were working towards developing an improved culture of openness and transparency and that they were using the Care Quality Commission's (CQC) guidance on the 'Duty of Candour' to lead on this issue.

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

The practice had gathered feedback from patients through the use of an internal patient survey, the investigation of complaints and the use of the Friends and Family Test. The practice had an active patient participation group (PPG). The PPG included representatives from various population groups. It comprised equal numbers of men and women from diverse cultural backgrounds including British, Chinese, Indian, Pakistani, Israeli and Jamaican representatives.

We spoke with two members of the PPG. They told us that the practice was open and welcomed their suggestions. 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 were displayed on a noticeboard on the first floor.

The practice gathered feedback form staff during meetings, appraisals and social gatherings. Staff told us the management team listened to their concerns and responded to requests for additional training or other suggestions to improve the running of the practice.

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

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at six staff files and saw that regular appraisals took place which included a personal development plan. New members of staff received induction information and were supervised by senior members of staff during their initial appointments.

The practice was a GP training practice. There were three trainees working at the practice at the time of our inspection. We spoke with one of the trainees who told us they were well supported by the GP partners who regularly reviewed their clinical performance.

The practice had a number of systems in place to encourage continuous improvement. The practice had completed reviews of significant events and other incidents and shared learning points with staff at meetings to ensure the practice improved outcomes for patients. The practice pro-actively supported research into best practice in primary care. The practice was a member of the local Clinical Research Network (CRN) and was hosting recruitment for a diabetes research study at the time of our inspection.

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 We found that the practice had not protected people against the risks associated with the unsafe use and management of medicines by means of making the appropriate arrangements for the safe keeping of medicines. This was because vaccines and other medicines were not stored in line with national guidance. This was in breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12(f) and (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.