

Burnett Edgar Medical Centre

Inspection 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 location

Good 

Are services safe?

Requires improvement 

Are services effective?

Good 

Are services caring?

Good 

Are services responsive?

Good 

Are services well-led?

Good 

Overall summary

This practice is rated as Good overall. (Previous rating November 2015 – Good)

The key questions at this inspection are rated as:

Are services safe? – Requires improvement

Are services effective? – Good

Are services caring? – Good

Are services responsive? – Good

Are services well-led? – Good

We carried out an announced comprehensive inspection at Burnett Edgar Medical Centre on 16 November 2018 as part of our inspection programme.

At this inspection we found:

- The practice had systems to manage risk so that safety incidents were less likely to happen. When incidents did happen, the practice learned from them and improved their processes.
- The practice routinely reviewed the effectiveness and appropriateness of the care it provided. It ensured that care and treatment was delivered according to evidence-based guidelines.
- Staff involved and treated patients with compassion, kindness, dignity and respect.
- Patients found the appointment system easy to use and reported that they were able to access care when they needed it.

- There was a focus on continuous learning and improvement at all levels of the organisation.

We saw an area of outstanding practice:

- Doctors at the practice worked closely with the Integrated Care Community (ICC) to set up a community-based support group for patients with neurological conditions called Café Neuro, and a Wellness Group which used yoga, healthy eating advice, and relaxation techniques involving Virtual Reality headsets to encourage patients to lower stress levels and improve their overall wellbeing.

However, we saw some areas where the practice must make improvements:

- Ensure systems and processes are operated effectively
For details, please refer to the requirement notice at the end of the report.

We also saw some areas where the practice should make improvements:

- Perform an analysis of themes from significant events to look for trends;
- Include details of safeguarding procedures in the locum pack.

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

Population group ratings

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

Our inspection team

Our inspection team was led by a Care Quality Commission (CQC) lead inspector. The team included a GP specialist adviser.

Background to Burnett Edgar Medical Centre

Burnett Edgar Medical Centre is registered with the Care Quality Commission to provide primary care services. The practice provides services to approximately 4,300 patients from one location:

- Central Drive, Walney Island, Barrow In Furness, Cumbria, LA14 3HY

The practice is based in a purpose-built surgery which opened in 1989. It has level-entry access and a car park for patients to use. It is the only GP practice on Walney Island and the majority of the patient population live on the island.

The practice has 13 members of staff, including two GP partners (both male), one long-term locum GP (female), two practice nurses (female), two healthcare assistants (one of whom is also a secretary), a practice manager, a medicines manager/receptionist, a secretary, two reception staff and an apprentice receptionist.

The practice is part of Morecambe Bay clinical commissioning group (CCG). Information taken from Public Health England placed the area in which the practice was located in the fourth most deprived decile. In general, people living in more deprived areas tend to have greater need for health services. The practice population reflects the national average in terms of age distribution.

The surgery is open from 8.30am to 8.45pm on Monday and 8.30am to 6.30pm Tuesday to Friday. Telephones were answered from 8am until closing time, Monday to Friday. Appointments with a GP were from:

- Monday – 9-11am, 3-6pm, and 6.30-8.45pm
- Tuesday to Friday – 9-11am and 3-6pm

Appointments with a nurse were available from 9am to 12pm, Monday to Friday, as well as:

- Monday – 1.30pm to 4.30pm
- Tuesday – 1.30pm to 5pm
- Wednesday – 2pm to 5pm
- Thursday – 1.30pm to 5pm
- Friday – 2.30pm to 4.30pm

The practice provides services to patients of all ages based on a General Medical Services (GMS) contract agreement for general practice. The service for patients requiring urgent medical attention out of hours is provided by the NHS 111 service and Cumbria Health On Call (CHOC).

Are services safe?

We rated the practice as requires improvement for providing safe services.

Safety systems and processes

The practice had systems to keep people safe and safeguarded from abuse but some of these required improvement.

- The practice had appropriate systems to safeguard children and vulnerable adults from abuse. The practice held monthly safeguarding meetings with health professionals including midwives and health visitors. Learning from safeguarding incidents was available to staff. There was a safeguarding lead and all staff knew how to identify and report concerns. However, the lead GP for safeguarding was not clear when asked about what training had been done and was not clear about current safeguarding practice. The practice was therefore not well-placed to promote good practice or provide advice and support to other staff. Safeguarding procedures were not referred in the locum pack. On the day of inspection we saw evidence that administration and nursing staff had undertaken safeguarding training but the training matrix did not show that GPs had done safeguarding training recently. Since the inspection, we were sent certificates to show that GPs at the practice had completed child safeguarding training at a level appropriate to their role in the past 12 months, but there was still no evidence of adult safeguarding training having been completed in the last three years. Other staff we spoke to on the day of inspection were clear about their role regarding safeguarding, and information about how to raise concerns and contact telephone numbers for local safeguarding agencies were available on a staff noticeboard.
- Staff who acted as chaperones were trained for their role and had received a Disclosure and Barring Service (DBS) check. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable.) All staff were risk assessed to determine whether or not they required a DBS check before starting their role.
- Staff took steps, including working with other agencies, to protect patients from abuse, neglect, discrimination and breaches of their dignity and respect.

- The practice carried out appropriate staff checks at the time of recruitment and on an ongoing basis. However, only verbal references had been taken for locum GPs.
- There was an effective system to manage infection prevention and control, however the training matrix we saw on the day of inspection showed some staff had not had training in this area in the past three years.
- The training records we saw on the day of inspection showed some staff had not had fire safety in the past three years, contrary to the practice's own staff training policy.
- The practice had arrangements to ensure that facilities and equipment were safe and in good working order.
- Arrangements for managing waste and clinical specimens kept people safe.

Risks to patients

There were systems to assess, monitor and manage risks to patient safety.

- Arrangements were in place for planning and monitoring the number and mix of staff needed to meet patients' needs, including planning for holidays, sickness, busy periods and epidemics.
- There was an effective induction system for staff, tailored to their role.
- The practice was equipped to deal with medical emergencies and staff were suitably trained in emergency procedures.
- Staff understood their responsibilities to manage emergencies on the premises and to recognise those in need of urgent medical attention. Clinicians knew how to identify and manage patients with severe infections including sepsis.
- When there were changes to services or staff the practice assessed and monitored the impact on safety.

Information to deliver safe care and treatment

Staff had the information they needed to deliver safe care and treatment to patients.

- The care records we saw showed that information needed to deliver safe care and treatment was available to staff.
- The practice had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.
- Clinicians made timely referrals in line with protocols.

Are services safe?

Appropriate and safe use of medicines

The practice had systems for appropriate and safe handling of medicines.

- The systems for managing and storing medicines, including vaccines, medical gases, emergency medicines and equipment, minimised risks.
- Staff prescribed and administered or supplied medicines to patients and gave advice on medicines in line with current national guidance. The practice had reviewed its antibiotic prescribing and taken action to support good antimicrobial stewardship in line with local and national guidance. Antibiotic prescribing was comparable to CCG and England averages.
- Patients' health was monitored in relation to the use of medicines and followed up on appropriately. Patients were involved in regular reviews of their medicines.

Track record on safety

The practice had a good track record on safety, however there were areas for improvement.

- There were risk assessments in relation to safety issues. A health and safety risk assessment was not seen on the day of inspection, but this was completed and forwarded to us subsequently.

- The practice monitored and reviewed safety using information from a range of sources. However, on the day of inspection the practice could not provide an audit of minor surgery. One was subsequently forwarded to us following this inspection.

Lessons learned and improvements made

The practice learned and made improvements when things went wrong.

- Staff understood their duty to raise concerns and report incidents and near misses. Leaders and managers supported them when they did so.
- There were adequate systems for reviewing and investigating when things went wrong. The practice learned and shared lessons, identified themes and took action to improve safety in the practice. However, there was no review of themes of significant events. When we reviewed the significant events reported in the practice we found that there were themes that could be identified, such as incorrect patient information being inputted into records.
- The practice acted on and learned from external safety events as well as patient and medicine safety alerts.

Please refer to the evidence tables for further information.

Are services effective?

We rated the practice and all of the population groups as good for providing effective services overall .

(Please note: Any Quality and Outcomes Framework (QOF) data relates to 2017/18. QOF is a system intended to improve the quality of general practice and reward good practice.)

Effective needs assessment, care and treatment

The practice had systems to keep clinicians up to date with current evidence-based practice. We saw that clinicians assessed needs and delivered care and treatment in line with current legislation, standards and guidance supported by clear clinical pathways and protocols.

- Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.
- We saw no evidence of discrimination when making care and treatment decisions.
- Staff used appropriate tools to assess the level of pain in patients.
- Staff advised patients what to do if their condition got worse and where to seek further help and support.

Older people:

- Older patients who were frail or may have been vulnerable received a full assessment of their physical, mental and social needs. The practice used an appropriate tool to identify patients aged 65 and over who were living with moderate or severe frailty. Those identified as being frail had a clinical review including a review of medication.
- Patients aged over 75 were invited for a health check. If necessary they were referred to other services such as voluntary services and supported by an appropriate care plan.
- The practice followed up on older patients discharged from hospital and ensured that their care plans and prescriptions were updated to reflect any extra or changed needs.
- Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs.

People with long-term conditions:

- Patients with long-term conditions had a structured annual review to check their health and medicines

needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.

- Staff who were responsible for reviews of patients with long term conditions had received specific training.
- The practice had arrangements for adults with newly diagnosed cardiovascular disease including the offer of high-intensity statins for secondary prevention. People with suspected hypertension were offered ambulatory blood pressure monitoring and patients with atrial fibrillation were assessed for stroke risk and treated as appropriate.
- The practice was able to demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension.
- The practice hosted and led a monthly multidisciplinary meeting for patients with respiratory conditions and complex needs. Respiratory patients received an assisted discharge from hospital, led by the practice, and referrals for them were fast-tracked to the respiratory advanced practitioner in the community. A pilot of this scheme showed no patients had been readmitted to hospital within 30 days of discharge.

Families, children and young people:

- Childhood immunisations were carried out in line with the national childhood vaccination programme. Uptake rates were above the target percentage of 90% for immunisations.
- The practice had arrangements to identify and review the treatment of newly pregnant women on long-term medicines. These patients were provided with advice and post-natal support in accordance with best practice guidance.
- The practice had arrangements for following up failed attendance of children's appointments in secondary care or for immunisation.

Working age people (including those recently retired and students):

- The practice's uptake for cervical screening was comparable to local and national averages in 2017/18.
- The practice's uptake for breast and bowel cancer screening was comparable to the national average in 2017/18.

Are services effective?

- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40-74. There was appropriate follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.

People whose circumstances make them vulnerable:

- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may have made them vulnerable.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.

People experiencing poor mental health (including people with dementia):

- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder by providing access to health checks, interventions for physical activity, obesity, diabetes, heart disease, cancer and access to 'stop smoking' services. There was a system for following up patients who failed to attend for administration of long term medication.
- When patients were assessed to be at risk of suicide or self-harm the practice had arrangements in place to help them to remain safe.
- The number of patients diagnosed with dementia who had their care reviewed in a face to face meeting in the previous 12 months was above the national average.
- The number of patients diagnosed with schizophrenia, bipolar affective disorder and other psychoses who had a comprehensive, agreed care plan documented in the previous 12 months was above the national average.
- The practice specifically considered the physical health needs of patients with poor mental health and those living with dementia.
- Patients at risk of dementia were identified and offered an assessment to detect possible signs of dementia. When dementia was suspected there was an appropriate referral for diagnosis.

Monitoring care and treatment

The practice routinely reviewed the effectiveness and appropriateness of the care provided. Where appropriate, clinicians took part in local and national improvement initiatives, such as the clinical commissioning group's (CCG) Quality Improvement Scheme.

- In 2017/18 the practice had achieved 97.7% of the total number of 559 QOF points available, compared to the CCG average of 97.9% and the national average of 96%. Overall the practice exception reporting rate was much lower than local and national averages at 5.1% (CCG average 9.5%, national average 9.6%).
- The practice used information about care and treatment to make improvements.
- The practice participated in the local Quality Improvement Scheme (QIS), and there was some evidence of examples of identification of audit subjects and subsequent review. However, there was no systematic approach to the choice of audit topic to support practice wide improvement. Audit topic was driven by Individual GPs choice rather than a planned coordinated approach.

Effective staffing

Staff had the skills, knowledge and experience to carry out their roles.

- The practice understood the learning needs of staff and provided protected time to meet them. However, while most staff had completed mandatory training relevant to their role, we saw that some staff had not. The training matrix seen on the day of inspection did not show that all staff had completed mandatory annual training, as stipulated by the practice's training policy, since 2015. This was not clinical training, but training related to safety, such as fire safety and adult safeguarding.
- Despite this, staff had appropriate knowledge for their role, for example, to carry out reviews for people with long term conditions, older people and people requiring contraceptive reviews.
- Staff whose role included immunisation and taking samples for the cervical screening programme had received specific training and could demonstrate how they stayed up to date.
- The practice provided staff with ongoing support. This included an induction process, one-to-one meetings, appraisals, coaching and mentoring, clinical supervision and support for revalidation. At the last inspection a

Are services effective?

recommendation was made to the practice to improve the process for offering appraisals to staff, and we saw on this inspection that the recommendation had been followed.

- There was a clear approach for supporting and managing staff when their performance was poor or variable.

Coordinating care and treatment

Staff worked together and with other health and social care professionals to deliver effective care and treatment.

- We saw records that showed that all appropriate staff, including those in different teams and organisations, were involved in assessing, planning and delivering care and treatment.
- The practice shared clear and accurate information with relevant professionals when deciding care delivery for people with long term conditions and when coordinating healthcare for care home residents. They shared information with, and liaised, with community services, social services and carers for housebound patients and with health visitors and community services for children who had relocated into the local area.
- Patients received coordinated and person-centred care. This included when they moved between services, when they were referred, or after they were discharged from hospital. The practice worked with patients to develop personal care plans that were shared with relevant agencies.
- The practice ensured that end of life care was delivered in a coordinated way which took into account the needs of different patients, including those who may have been vulnerable because of their circumstances.

Helping patients to live healthier lives

Staff were consistent and proactive in helping patients to live healthier lives.

- The practice identified patients who may be in need of extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.
- Staff encouraged and supported patients to be involved in monitoring and managing their own health, for example through social prescribing schemes.
- Staff discussed changes to care or treatment with patients and their carers as necessary.
- The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking and tackling obesity campaigns.

Consent to care and treatment

The practice obtained consent to care and treatment in line with legislation and guidance.

- Clinicians understood the requirements of legislation and guidance when considering consent and decision making.
- Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.
- The practice monitored the process for seeking consent appropriately.

Please refer to the Evidence Tables for further information.

Are services caring?

We rated the practice as good for caring.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- Feedback from patients on the day of inspection was positive about the way staff treat people.
- Staff understood patients' personal, cultural, social and religious needs.
- The practice gave patients timely support and information.
- The practice's National GP Patient Survey results were generally in line with local and national averages for questions relating to kindness, respect and compassion.

Involvement in decisions about care and treatment

Staff helped patients to be involved in decisions about care and treatment. They were aware of the Accessible Information Standard (a requirement to make sure that patients and their carers can access and understand the information that they are given.)

- Staff communicated with people in a way that they could understand, for example, communication aids and easy read materials were available.

- Staff helped patients and their carers find further information and access community and advocacy services. They helped them ask questions about their care and treatment.
- The practice identified carers and supported them.
- The practice's national GP patient survey results were in line with local and national averages for questions relating to involvement in decisions about care and treatment.

Privacy and dignity

The practice respected patients' privacy and dignity.

- When patients wanted to discuss sensitive issues or appeared distressed reception staff offered them a private room to discuss their needs. The practice operated a confidentiality card system that enabled patients to relay personal or sensitive information, or request a private conversation, without needing to speak at reception.
- Staff recognised the importance of people's dignity and respect. They challenged behaviour that fell short of this.

Please refer to the evidence tables for further information.

Are services responsive to people's needs?

We rated the practice, and all of the population groups, as good for providing responsive services .

Responding to and meeting people's needs

The practice organised and delivered services to meet patients' needs. It took account of patient needs and preferences.

- The practice understood the needs of its population and tailored services in response to those needs.
- Telephone GP consultations were available which supported patients who were unable to attend the practice during normal working hours.
- The facilities and premises were appropriate for the services delivered.
- The practice made reasonable adjustments when patients found it hard to access services.
- The practice was actively encouraging patients to engage with online services. At a patient's request, a GP would spend 30 minutes with the patient going through their online record with them to explain and explore the process. Approximately 100 patients (2% of the patient list) had signed up for online services so far.
- The practice provided effective care coordination for patients who were more vulnerable or who had complex needs. They supported them to access services both within and outside the practice.
- Care and treatment for patients with multiple long-term conditions and patients approaching the end of life was coordinated with other services.
- Doctors at the practice worked closely with the Integrated Care Community (ICC) to set up groups to support patients with various conditions. For example, they had established a community-based support group for patients with neurological conditions called Café Neuro, and a Wellness Group which used yoga, healthy eating advice, and relaxation techniques involving Virtual Reality headsets to encourage patients to lower stress levels and improve their overall wellbeing.

Older people:

- All patients over 75 had a named GP who supported them in whatever setting they lived, whether it was at home or in a care home or supported living scheme.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs.

- The practice had established links with three local care homes and carried out regular visits to patients who lived there.

People with long-term conditions:

- Patients with a long-term condition received an annual review to check their health and medicines needs were being appropriately met. Consultation times were flexible to meet each patient's specific needs.
- Hour-long appointments were available for the review of patients with long-term conditions.
- The practice held regular meetings with the local multidisciplinary team to discuss and manage the needs of patients with complex medical issues.

Families, children and young people:

- We found there were systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances. Records we looked at confirmed this.
- Appointments were blocked out for children who needed to be seen urgently.

Working age people (including those recently retired and students):

- The needs of this population group had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. Extended opening hours appointments and repeat prescriptions were available to order online.
- Evening and weekend appointments could be booked through the practice.
- The practice used a text messaging service for appointment reminders, information on the service such as the practice newsletter, and also to enable patients to give direct feedback.

People whose circumstances make them vulnerable:

- The practice held a register of patients living in vulnerable circumstances, including carers and those with a learning disability.
- People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode.

Are services responsive to people's needs?

People experiencing poor mental health (including people with dementia):

- Staff interviewed had a good understanding of how to support patients with mental health needs and those patients living with dementia.
- Patients with dementia were invited to attend for an annual review, to help ensure their needs were being met appropriately. A memory clinic was also hosted at the practice each month.
- Clinical staff actively carried out opportunistic dementia screening, to help ensure patients were receiving the care and support they needed to stay healthy and safe.
- Alerts had been placed on the clinical system to 'flag' patients with dementia, so clinicians could take this into account during a consultation.

Timely access to care and treatment

Patients were able to access care and treatment from the practice within an acceptable timescale for their needs.

- Patients had timely access to initial assessment, test results, diagnosis and treatment.
- Waiting times, delays and cancellations were minimal and managed appropriately. Feedback we received on patient comment cards was positive about access to appointments. Patients with the most urgent needs had their care and treatment prioritised.

- The practice's GP Patient Survey results were above local and national averages for questions relating to access to care and treatment.
- The practice offered urgent "Red Card" appointments. These were shorter, same-day appointments that could be booked if patients felt they had a single, specific issue they wanted to discuss with a doctor.
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Listening and learning from concerns and complaints

The practice took complaints and concerns seriously and responded to them appropriately to improve the quality of care.

- Information about how to make a complaint or raise concerns was available.
- The complaint policy and procedures were in line with recognised guidance. The practice learned lessons from individual concerns and complaints and from analysis of trends. It acted as a result to improve the quality of care.

Please refer to the evidence tables for further information.

Are services well-led?

We rated the practice as good for providing a well-led service.

Leadership capacity and capability

Leaders had the capacity and skills to deliver high-quality, sustainable care.

- Leaders were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges and were addressing them.
- Leaders were visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership.
- The practice had effective processes to develop leadership capacity and skills, including planning for the future leadership of the practice.

Vision and strategy

The practice had a clear vision and credible strategy to deliver high quality, sustainable care.

- There was a clear vision and set of values. The practice had a realistic strategy and supporting business plans to achieve priorities.
- Staff were aware of and understood the vision, values and strategy and their role in achieving them.
- The strategy was in line with health and social care priorities across the region. The practice planned its services to meet the needs of the practice population.
- The practice monitored progress against delivery of the strategy.

Culture

The practice had a culture of high-quality sustainable care.

- Staff stated they felt respected, supported and valued. They were proud to work in the practice. Staff we spoke to told us they felt well-supported.
- The practice focused on the needs of patients.
- Leaders and managers acted on behaviour and performance inconsistent with the vision and values.
- Openness, honesty and transparency were demonstrated when responding to incidents and complaints. The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour.
- Staff we spoke with told us they were able to raise concerns and were encouraged to do so. They had confidence that these would be addressed.

- There were processes for providing all staff with the development they needed. This included appraisal and career development conversations. All staff had received regular annual appraisals or supervision in the last year. Staff were supported to meet the requirements of professional revalidation where necessary.
- There was an emphasis on the safety and well-being of all staff.
- The practice actively promoted equality and diversity. Staff felt they were treated equally.
- There were positive relationships between staff and teams.

Governance arrangements

There were clear responsibilities, roles and systems of accountability to support good governance and management.

- Structures, processes and systems to support good governance and management were clearly set out, understood and effective. The governance and management of partnerships, joint working arrangements and shared services promoted co-ordinated person-centred care.
- Staff were clear on their roles and accountabilities including in respect of safeguarding and infection prevention and control, although the lead GP for safeguarding was unclear about the level of training they had received.
- Practice leaders had established policies, procedures and activities to ensure safety. However, We found that some of the GPs had not completed some of the requirements as outlined in the practice's training policy. For example, fire safety training and basic life support were showing as having last been completed in October 2015, despite being deemed annual training in the practice's policy.

Managing risks, issues and performance

There were clear and effective processes for managing risks, issues and performance.

- There was an effective, process to identify, understand, monitor and address current and future risks including risks to patient safety.
- The practice had processes to manage current and future performance. Practice leaders had oversight of safety alerts, incidents, and complaints.

Are services well-led?

- Clinical audit had been carried out at the practice and there was evidence of action to change practice to improve quality. However, there was no systematic audit programme and some audits showed only data and lacked analysis.
- The practice had plans in place and had trained staff for major incidents.
- The practice considered and understood the impact on the quality of care of service changes or developments.

Appropriate and accurate information

The practice acted on appropriate and accurate information.

- Quality and operational information was used to ensure and improve performance. Performance information was combined with the views of patients.
- Quality and sustainability were discussed in relevant meetings where all staff had sufficient access to information.
- The practice used performance information which was reported and monitored. The practice participated in local quality improvement schemes and monitored their performance through this.
- The information used to monitor performance and the delivery of quality care was accurate and useful. There were plans to address any identified weaknesses.
- The practice used information technology systems to monitor and improve the quality of care.
- The practice submitted data or notifications to external organisations as required.
- There were robust arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

Engagement with patients, the public, staff and external partners

The practice involved patients, the public, staff and external partners to support high-quality sustainable services.

- A full and diverse range of patients', staff and external partners' views and concerns were encouraged, heard and acted on to shape services and culture. There was an active patient participation group.
- The service was transparent, collaborative and open with stakeholders about performance.
- There was a practice newsletter to communicate with patients.

Continuous improvement and innovation

There were systems and processes for learning, continuous improvement and innovation.

- There was a focus on continuous learning and improvement.
- Staff knew about improvement methods and had the skills to use them.
- The practice made use of internal and external reviews of incidents and complaints. Learning was shared and used to make improvements.
- Leaders and managers encouraged staff to take time out to review individual and team objectives, processes and performance.

Please refer to the evidence tables for further information.

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 the service provider was not meeting. The provider must send CQC a report that says what action it is going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Systems or processes were not operated effectively to assess, monitor and improve the quality of the services provided and to mitigate the risks relating to health, safety and welfare of services users. There was evidence that practice policies related to staff training were not being adhered to by all staff. The practice could not assure itself that all of its staff were up to date with safeguarding practice and procedures for the area. A robust system of clinical audit was not in operation at the practice. This was in breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.