Long Barn Lane

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	Requires improvement
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?	Requires improvement

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We inspected Long Barn Lane Surgery on 21 January 2015. This was a comprehensive inspection. We also inspected the branch surgery of the practice at Southcote clinic.

We rated the practice as requiring improvement. Many aspects of the services delivered were good but improvements must be made to improve safety. General cleaning standards were unsatisfactory and not consistently monitored, blank prescriptions were not recorded when issued to GPs, the treatment room in use at the branch surgery was not adequate and policies and procedures designed to identify, assess and manage risk were not kept up to date.

Our key findings were as follows: The practice provided good care and treatment to its patients. National data showed the practice performed well in managing long term conditions. Staff were aware of the needs of their patients including those experiencing income deprivation. The practice was responsive to potentially vulnerable patients. There was a strong leadership team and an open culture which was inclusive. Patients were consulted to assist the leadership team in making improvements to the service. The practice was aware that some patients found it difficult to access the service by telephone and online appointment booking was being promoted. Improvements were required to maintain appropriate standards of cleanliness, manage prescriptions, ensure treatment rooms were fit for purpose and ensuring policies and procedures relating to health and safety were kept up-to-date.

There are areas of practice where the provider needs to make improvements.

The areas where the provider must make improvements are:

- monitoring of general cleaning at both the main surgery and branch clinic to ensure appropriate standards of cleanliness are achieved.
- review the suitability of the treatment room at Southcote clinic to ensure it is fit for purpose.

Summary of findings

- to carry out monitoring of fridge temperatures for the fridge in use at Southcote clinic.
- undertake consistent reviews of all policies relating to the identification, assessment and management of risk to ensure these remain up to date and accurate.
- to introduce a recording and tracking system for blank prescription forms and prescription pads

The areas where the provider should make improvement are:

- increasing the range of audits completed and introduce an audit plan.
- developing a clear plan for medical staffing to secure the long term future of the practice
- signing, dating and identifying a review timetable for the practice nursing protocols

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 must make improvements. Staff understood their responsibilities to raise concerns, and to report incidents and near misses. Most risks to patients who used services were assessed and the systems and processes to address these risks were implemented. However, the treatment room in use at the Southcote clinic branch surgery was not fit for purpose. Cleaning standards at both the main surgery and the branch surgery were not consistently monitored and the standards of cleaning were unsatisfactory. The recording of issue of blank prescriptions should be improved.

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 NICE and used it routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included appropriate assessment of individual need and promoting good health. Staff had received training appropriate to their roles and any further training needs were identified via the appraisal process. Staff worked with multidisciplinary teams.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice highly for several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information to help patients understand the services available was easy to understand. We also saw that staff treated patients with kindness, respect and maintained confidentiality.

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 NHS Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients said they found it easy to make an appointment with a GP and that there was continuity of care, with urgent appointments available the same day.

Summary of findings

Are services well-led?

Requires improvement

The practice is rated as requires improvement for being well-led. There was a business plan in place and this had been developed by a strong leadership tem comprising the lead GP, practice manager and senior practice nurse. All staff were aware of their responsibilities and felt well supported by management. The practice had a number of policies and procedures to identify, assess and manage risks to health, safety and welfare but, it was unclear at what frequency these should be reviewed. The practice proactively sought feedback from patients and had an active patient participation group (PPG). All staff had received inductions and regular appraisals. There were management systems in place to monitor quality and assess risk but these were not operated consistently. Risk assessments of the suitability of the branch surgery premises had not been undertaken and the monitoring of day to day cleaning had not been carried out consistently.

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

Requires improvement

The provider was rated as requiring improvement for safe and well led. The concerns which led to these ratings apply to everyone using the practice, including this population group. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older patients. The practice offered proactive, personalised care to meet the needs of the older patient in its population. End of life care was co-ordinated by working with a multidisciplinary team. Home visits were available for older people.

People with long term conditions

Requires improvement

The provider was rated as requiring improvement for safe and well led. The concerns which led to these ratings apply to everyone using the practice, including this population group. This group of patients were identified as requiring regular health reviews and there were systems in place to ensure they attended for their review. Data showed the practice performance in caring for patients with diabetes was above average for the area. There were emergency processes in place and referrals were made for patients whose health deteriorated suddenly. Longer appointments and home visits were available when needed. The practice strove to co-ordinate the care for those patients with the most complex needs by combining their annual reviews thus avoiding the need for multiple visits to the practice. GPs worked with relevant health and care professionals to deliver multidisciplinary packages of care.

Families, children and young people

Requires improvement

The provider was rated as requiring improvement for safe and well led. The concerns which led to these ratings apply to everyone using the practice, including this population group.There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk. For example, those on the looked after register. Immunisation rates were relatively high for all standard childhood immunisations. Staff and parents we spoke with told us children were treated in an age-appropriate way and were recognised as individuals. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with midwives and health visitors. The practice operated a system of combining new baby health checks with first immunisations which had increased the take up of first immunisations.

Summary of findings

Working age people (including those recently retired and students)

Requires improvement

The provider was rated as requiring improvement for safe and well led. The concerns which led to these ratings apply to everyone using the practice, including this population group.The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible and flexible. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflected the needs for this age group.

People whose circumstances may make them vulnerable

Requires improvement

The provider was rated as requiring improvement for safe and well led. The concerns which led to these ratings apply to everyone using the practice, including this population group. The practice held a register of patients with a learning disability and had started offering these patients annual health checks in the last year. There was a carers register and information available for carers on how to access voluntary groups that offered support for carers. The practice accepted referrals from a local organisation which supported patients who were homeless or living in hostels.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. It had told vulnerable patients about how to access various support groups and voluntary organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours. There was recognition of the higher than average income deprivation amongst the registered patient population. Patients with known social and income deprivation issues were encouraged to use the services of the health and social care centre nearby. Interpreter services were available to the patients whose first language was not English.

People experiencing poor mental health (including people with dementia)

Requires improvement

The provider was rated as requiring improvement for safe and well led. The concerns which led to these ratings apply to everyone using the practice, including this population group. Data showed the practice performed well in reviewing the physical health needs of patients diagnosed with a long term mental health problem. The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those with dementia. Care planning for patients with dementia was underway.

Summary of findings

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

Summary of findings

What people who use the service say

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey and a survey of 80 patients undertaken by the practice and discussed with the Patient Participation Group. The evidence from all these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the national patient survey showed the practice received positive feedback for treating patients with care and concern. The practice satisfaction scores on consultations showed 90% of practice respondents said GPs were good at listening to them and 96% said the nurses were good at listening to them. These results were in line with or better than the local average. The survey also showed 92% said the last GP they saw and 97% said the last nurse they saw was good at giving them enough time. These results were also slightly better than the local average. The practice received positive feedback regarding how GPs and nurses treated patients with care and concern and this was in line with the CCG average.

The practice survey had been completed by 80 patients and we saw an action plan had been developed with the PPG to respond to the findings and comments. For example, feedback showed some patients with long term conditions wanted more information on how to manage their condition. The practice had increased the availability of self care information.

Areas for improvement

Action the service MUST take to improve

- monitor general cleaning at both the main surgery and branch clinic to ensure appropriate standards of cleanliness are achieved.
- review the suitability of the treatment room at Southcote clinic to ensure it is fit for purpose.
- carry out monitoring of fridge temperatures for the fridge in use at Southcote clinic.
- undertake consistent reviews of all policies relating to the identification, assessment and management of risk to ensure these remain up to date and accurate.
- introduce a recording and tracking system for blank prescription forms and prescription pads

Action the service SHOULD take to improve

- increase the range of audits completed and introduce an audit plan.
- develop a clear plan for medical staffing to secure the long term future of the practice
- sign, date and identify a review timetable for the practice nursing protocols

Long Barn Lane

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector**.** The team included a GP and a Practice Nurse Advisor.

Background to Long Barn Lane

Long Barn Lane Surgery is a small family run practice. The practice also offers services from a branch located at Southcote clinic. Approximately 5,500 patients are registered with the practice. A range of services including management of long term conditions, childhood immunisations and health screening programmes are offered. The practice refers patients requiring minor surgical procedures and fitting of contraceptive coils to GPs at neighbouring practices with appropriate expertise in these procedures. The practice is located in a part of Reading with the highest levels of income deprivation in the area.

The practice had gone through, and continued to experience, a period of change in GPs. Attempts to recruit a new partner had been made following the retirement of a long serving GP partner in mid-2014. Thus far this recruitment drive had proven unsuccessful. Salaried GPs had also left the practice and the current senior partner had increased their commitment to the practice. The practice is currently staffed by the senior GP partner, a partner who offers administrative support and absence cover, a part time salaried GP and three long term locum GPs. There is a mix of both male and female GPs. Two practice nurses work at the practice and the GPs and nurses are supported by the practice manager and a team of reception and administration staff. Services are offered via a personal medical services (PMS) contract. (PMS contracts are negotiated between the practice and the local team of NHS England). This was a planned comprehensive inspection and the practice had not been inspected previously.

The CQC intelligent monitoring placed the practice in band six. The intelligent monitoring tool draws on existing national data sources and includes indicators covering a range of GP practice activity and patient experience including the Quality Outcomes Framework (QOF) and the National Patient Survey. Based on the indicators, each GP practice has been categorised into one of six priority bands, with band six representing the best performance band. This banding is not a judgement on the quality of care being given by the GP practice; this only comes after a CQC inspection has taken place.

Services are provided from: Long Barn Lane Surgery, 22 Long Barn Lane, Reading, RG2 7SZ and Southcote Clinic, Coronation Square, Southcote, Reading, RG30 3QP. Both locations were visited during the inspection.

The practice has opted out of providing out of hours services to their patients. There are arrangements in place for out of hours services to be provided by the WestCall out of hours service when the surgery is closed. These are displayed at the practice, in the practice information leaflet and on the website.

Why we carried out this inspection

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

We carried out a comprehensive inspection of this service on 21 January 2015 under Section 60 of the Health and

Detailed findings

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

This practice had not been inspected before and that was why we included them.

How we carried out this inspection

Before visiting Long Barn Lane Surgery we reviewed a range of information we hold. We also received information from local organisations such as NHS England, Healthwatch and the South Reading Clinical Commissioning Group (CCG). We carried out an announced inspection visit on 21 January 2015. During our inspection we spoke with patients and a range of staff, including GPs, practice nurses, the practice manager, reception and administration staff.

In addition to speaking with six patients we reviewed 10 comment cards that had been completed by patients in the two weeks prior to our inspection. We also met with two members of the practice patient participation group (PPG).

We looked at the outcomes from investigations into significant events and audits to determine how the practice monitored and improved its performance. We checked to see if complaints were acted on and responded to. We looked at the premises to check the practice was a safe and accessible environment. We looked at documentation including relevant monitoring tools for training, recruitment, maintenance and cleaning of the premises.

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

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

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

- Older 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)

The practice is situated in an area of Reading which has the highest deprivation levels. The practice served a population with more patients under the age of 50 compared to others in the area. The branch surgery at Southcote clinic served a similar patient population and was open for three clinics each week.

Requires improvement

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents and national medicines alerts as well as comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. Staff had access to significant event forms and they knew where to access them.

We looked at records confirming that significant events were reviewed and lessons learnt recorded. Complaints had been investigated and responded to in line with the practice complaints policy and procedure.

Issues identified from risk assessments were discussed by the leadership team and action planned to address them. For example, legionella control measures were in place and fire alarm and fire safety equipment was being upgraded. The practice demonstrated a safe track record by identifying and addressing safety concerns.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. There were records of significant events that had occurred during the last two years and we reviewed those relating to 2014 in detail. Significant events were discussed by the leadership team as they arose. Staff were briefed on the events that related to their areas of responsibility and any event relevant to the full practice team was discussed at practice meetings. Learning from significant events was shared by this briefing or team meeting route.

Staff, including receptionists, administrators and nursing staff were very clear on their responsibilities to report and record incidents. All the staff we spoke with told us they would report an incident immediately to the practice manager and complete a significant event report form. They told us they were encouraged to report incidents. We reviewed the eight incidents recorded in 2014 and saw records were completed in a comprehensive and timely manner. We saw that one incident relating to the time taken to advise a patient to collect a prescription had resulted in staff retraining.

National patient safety alerts were disseminated by the practice manager to both GPs and the practice nurses. The senior practice nurse ort practice manager took action on any alerts relating to medical or general equipment. GPs worked with the medicines management advisors from the CCG to ensure action required from medicine alerts was taken.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young patients and adults. Training records we reviewed confirmed all staff had received relevant role specific training on safeguarding. We asked GPs, practice nurses and administration staff about their training. Staff knew how to recognise signs of abuse in older patient, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. The contact details for the relevant agencies were easily accessible. A copy of a chart setting out the reporting process was displayed next to most computer stations or on notice boards throughout the practice.

The practice had appointed a dedicated GP as lead for safeguarding vulnerable adults and children. They had been trained and could demonstrate they had the necessary training, to level three for safeguarding children, to enable them to fulfil this role. All staff we spoke to were aware who the lead was and who to speak to in the practice if they had a safeguarding concern.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments. For example, children on the looked after register.

There was a chaperone policy, which was visible on the waiting room noticeboard and in consulting rooms. All staff who undertook chaperone duties had been appropriately trained. The practice carried out a criminal records check, via the disclosure and barring service (DBS), for all staff. Staff understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely

and were only accessible to authorised staff. There was a clear policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. The practice staff followed the policy. There was a record of checking fridge temperatures at the Long Barn Lane Surgery. A small amount of immunisations were held in a fridge at the branch surgery located at Southcote clinic. The temperature of this fridge had not been monitored because practice staff attended this location for three short clinics each week. The practice could not be sure that the fridge had been operating at the correct temperatures to maintain the medicines safely. We discussed this with the senior practice nurse and administration of immunisations at this location was suspended immediately.

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

We saw records of practice meetings with the local medicines management pharmacists and these showed us that the practice that the practice was active in improving their prescribing. It had identified that repeat prescribing could be improved and was signed up to a 'Practice Pharmacist' pilot scheme which would involve a pharmacist working at the practice for two sessions a week throughout February 2015.

The nurses administered vaccines using directions that had been produced in line with legal requirements and national guidance. We saw up-to-date copies of these directions and evidence that nurses had received appropriate training to administer vaccines.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were signed for on receipt. However, the practice manager had recognised that a tracking system was required to account for the release of prescriptions to GPs. Blank prescriptions were held in the practice manager's office which was not accessible to patients and others.

Cleanliness and infection control

The practice had a lead for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. We saw evidence that the lead had carried out audits of infection control in the last two years. Improvements identified from the last audit were either completed or programmed. For example, refurbishment of the treatment room at Long Barn Lane Surgery was due to commence in the second week of February. We saw that orders had been placed for this work and contingency arrangements enabling the nurses to continue with treatments whilst the works were undertaken were in place. There was evidence that the practice management team had discussed the findings of the audit and planned works accordingly.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use. There was a procedure in place for receipt of specimens. 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.

There were cleaning schedules in place and the cleaners completed checklists to confirm they had completed the tasks included on the schedule. However, we found treatment rooms and consulting rooms had an accumulation of dirt and debris below treatment couches, on some window ledges, on curtain rails and other surfaces. The free standing curtain in the consulting room at the branch surgery was dirty and there was no plan for it to be washed. The monitoring of cleaning standards had not identified that general cleaning had not been achieved to the required standards. The failure to achieve appropriate standards of general cleanliness was evident at both the main and branch sites of the practice and there was a low risk of cross infection

The practice had a legionella risk assessment in place (legionella is a germ found in the environment which can contaminate water systems in buildings). Processes were carried out to manage, test and investigate the water systems in the practice to reduce the risk of legionella developing. We saw records that confirmed the practice was carrying out regular checks to reduce the risk of infection to staff and patients.

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 we reviewed the records that confirmed this. A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example weighing scales and blood pressure monitors. We saw that when equipment failed calibration tests it was withdrawn from use and replaced immediately.

We found that the practice did not have a height adjustable couch in any of the treatment or consulting rooms. A height adjustable couch can be lowered to enable patients with a physical disability to access it and staff to examine and treat patients more easily.

Staffing and recruitment

Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment for staff recruited since the practice became subject to regulation. For example references, qualifications, registration with the appropriate professional body and criminal records checks through the Disclosure and Barring Service (DBS). Copies of proof of identity checks had not been retained although we saw recruitment checklists that confirmed proof of identity had been seen before staff commenced working at the practice. We also saw that all staff used coded identity cards to access the practice computer system. Staff had produced evidence of their proof of identity to obtain their cards. The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff.

We reviewed the practice locum pack and the checks the practice had undertaken when recruiting locum GPs. These showed us that appropriate checks had been undertaken and that locum GPs were given relevant information to enable them to commence working at the practice. When locum GPs were recruited via a locum agency the practice manager assured themselves that the agency had undertaken appropriate checks and they obtained copies of key information such as the GMC reference number and DBS check.

We saw there was a rota system in place for all staff 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. For example, a member of the reception/ administration team was trained to cover the absence of the secretary thus ensuring referrals continued to be processed during the secretary's absence.

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe.

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 checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. However, these checks were not operated consistently. When we visited the branch surgery at Southcote Clinic we found the nurse treatment room was not safe to use. There was insufficient space for the nurse to carry out treatments safely. The room was 'doubling up' as a storage facility with large boxes on cupboards. The sharps box, containing used syringes, was kept on the floor where it could have been kicked over or a child could place their hand inside. The practice had not risk assessed the suitability of this room. We discussed our findings immediately with the practice leadership team and the room was taken out of use. The practice also had a health and safety policy. The health and safety policy was supported by a range of risk assessments. For example, equipment safety, manual handling and safe access and egress. Health and safety information was available to staff. There was a fire risk assessment in place as well as checks of fire safety equipment and fire safety training for staff.

Arrangements to deal with emergencies and major incidents

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

There were different arrangements in place for dealing with emergencies at the main practice site compared to the

branch surgery. If an emergency arose at the branch surgery the emergency services were called by dialling 999 and basic life support used to maintain the patient until the emergency services arrived.

Emergency medicines were available in a secure area at the main practice site and all staff knew of their location. They included medicines for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. 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 and recovery plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was described and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, adverse weather and access to the building. The document also contained relevant contact details for staff to refer to. For example, contact details of the telephone company to call if the telephone system failed.

The practice had carried out a fire risk assessment in 2014 that included actions required to maintain fire safety. We saw that the risk assessment identified the need to upgrade and replace some of the fire alarm and fire safety equipment. The practice manager showed us the orders that had been placed to replace the equipment identified and these evidenced that the work to upgrade fire safety was due to start in the week after our inspection.

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, from local commissioners and via training updates. The leadership team met informally every week and a clinical team meeting was held every month. New guidelines were discussed and disseminated to the rest of the practice team. We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate.

The lead GP oversaw all specialist clinical areas such as diabetes, heart disease and asthma. The senior practice nurse led most of this work and had prepared a set of nursing protocols to underpin nurse practice. GPs and nurses we spoke with were very open about asking for and providing colleagues with advice and support. They all told us they could seek advice and support from the senior partner and the senior practice nurse as and when they required.

We reviewed the data on the practice performance against local prescribing targets and saw the practice achieved 80% of the targets in 2013/14. The practice identified the need to improve further in 2014/15 and data we saw showed performance had improved. The practice was commencing a pilot scheme, supported by a CCG pharmacy advisor, to review and improve their repeat prescribing performance. The practice sought and obtained external support to further improve their prescribing.

The practice had a system in place to review patients recently discharged from hospital. GPs reviewed all discharge notes and planned follow up appointments with patients based on the information received. Data showed us that the practice had care plans in place for 91% of patients diagnosed with a mental health problem. This was significantly higher than the local average. The data also showed the practice performed better than other local practices in completing most physical health checks and health screening for this group of patients. However, the target for cervical screening for this group of patients was not being met.

National data showed that the practice referral rates to secondary and other community care services for all conditions were slightly above the local average. All GPs we spoke with used national standards for the referral of patients with suspected cancers to ensure these patients were seen within two weeks. The practice took part in the CCG reviews of referral rates. The GP and senior practice nurse told us referrals were made to the local team that worked with patients to avoid re-admission to hospital.

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

Management, monitoring and improving outcomes for people

Staff had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, managing patient alerts and medicines management. The data staff placed on patient records was used to inform auditing and clinical performance reviews.

We saw that six clinical audits had been completed within the last year. One of these audits showed us that changes to prescribing safer medicines had been completed. Another audit of repeat prescribing showed us that the practice was taking action to improve this and we saw that a pilot pharmacist scheme to further review repeat prescribing was scheduled to take place in February 2015. These audits were limited mostly to reviewing prescribing and national care targets. There was no overall programme of audit to identify, plan and monitor improvements to clinical care. There was no evidence that audits GPs carried out to support their appraisal and revalidation were shared with the other GPs and staff within the practice.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. For example, 93% of patients with diabetes had an annual dietary review. The hospital admission rate for patients diagnosed with diabetes was lower than both the local and national rates. The practice met all the minimum standards for QOF in asthma and chronic obstructive pulmonary disease (lung disease). This practice was not an outlier for any QOF clinical targets. The practice had achieved over 98% of the clinical targets included in QOF and this was higher than most other practices within the CCG.

Good

Are services effective?

(for example, treatment is effective)

The senior practice nurse had developed a set of nursing protocols designed to ensure consistent safe delivery of nursing care and treatment. These protocols were wide ranging and included for example, the procedures to follow when taking cervical smears and providing emergency contraception. We were told these protocols had been developed during the last two years. However, the protocols were not signed, dated or identified for regular review and update.

Effective staffing

Practice staffing included GPs, practice nurses, practice manager and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as annual basic life support. The GP workforce at the practice comprised two partners, a part time salaried GP and locum GPs working regular clinical sessions. We heard that the practice was actively seeking to recruit a further partner. Previous attempts had proven unsuccessful. The number of GP sessions worked each week was in line with other practices of a similar patient population. The senior practice nurse had been identified for professional development and a nurse practitioner course for this member of staff was under consideration. If this qualification was pursued the nurse would be able to offer a wider range of treatments to patients.

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

Most staff undertook appraisals that identified learning needs. Neither the practice manager nor senior practice nurse had had received an appraisal in 2014. Both told us that they worked closely with the senior GP enabling regular supervision and identification of their training needs. Administration staff we spoke with told us they had received an appraisal in 2014 and records we saw confirmed this. The practice should standardise the frequency of appraisal by completing annual appraisals for all staff. Our discussions with staff confirmed that the practice was proactive in providing training and funding for relevant courses, for example the senior practice nurse had completed training to enable them to support patients with long term condition such as diabetes.

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

Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and manage 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. The practice had a system in place for administration staff to place all correspondence relating to patient care in an electronic file for the lead GP partner to review. The lead GP read all correspondence and allocated this to the other GPs or dealt with it personally. We noted that there was no contingency arrangement in place for this duty to be delegated when the lead GP was not on duty. We reviewed a significant event where a GP had prepared a prescription for a patient following receipt of a test result and the patient had not been contacted to collect the prescription. We saw that the practice had learnt from this and reinforced the system of following up instructions from GPs. The practice had a process in place to follow up patients discharged from hospital.

The practice held multidisciplinary team meetings every month to discuss the needs of patients with complex needs, for example those with end of life care needs or children on the at risk register. These meetings were attended by district nurses, health visitors and palliative care nurses and decisions about care planning were documented in the patient's records. We heard that the meetings were structured to discuss the needs of patients receiving end of life care and at risk children at the start of the agenda. This enabled the palliative care nurse and health visitor to be involved in these discussions. Staff felt this system worked well and remarked on the usefulness of the forum as a means of sharing important information.

We spoke with the visiting midwife during our inspection. They told us that working arrangements with the practice

Good

Are services effective?

(for example, treatment is effective)

ran smoothly. They also described the practice staff as helpful in preparing the clinic room and ensuring all the equipment and records needed to hold the clinic were in place ready for the clinic to start.

Information sharing

The practice used both electronic and manual systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. Electronic systems were also in place for making referrals, and the practice made 90% of referrals last year through the Choose and Book system. (The Choose and Book system enables patients to choose which hospital they will be seen in and to book their own outpatient appointments in discussion with their chosen hospital). Staff reported that this system was easy to use and cover arrangements were in place to ensure referrals were processed when the secretary was on holiday or away from the practice.

The practice had a system in place to provide staff with the information they needed. An electronic patient record was used by all staff to coordinate, document and manage patients' care. Staff with responsibility for maintaining records were fully trained on the system. This software enabled scanned paper communications, such as those from hospital, to be saved on the electronic patient record for future reference.

The practice had signed up to the electronic Summary Care Record and had completed the process of placing records on the national database for those patients who had given consent to this. (Summary Care Records provide healthcare staff treating patients in an emergency or out-of-hours with faster access to key clinical information). Medical data (for example, record of allergies) would be securely shared, for those patients who had consented, with other providers of health care to support delivery of emergency care. For example, when a patient attended a hospital accident and emergency department.

Consent to care and treatment

GPs and nurses were able to describe the actions they would take if they felt a patient did not have the capacity to make a decision to receive care or treatment. The descriptions showed that care and treatment would not be administered until such time as the patient, or a person legally acting on their behalf, had understood and consented to the treatment. However, GPs and nurses we spoke with identified that it would be useful to undertake training on the Mental Capacity Act 2005 to further improve their knowledge. Staff were aware of the Children Acts 1989 and 2004 and their duties in fulfilling it.

Care planning was underway for patients with a learning disability and those with dementia. The GPs we spoke with demonstrated a clear understanding of Gillick competencies. (These help clinicians to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment).

We noted that the practice did not carry out minor surgical procedures or fit contraceptive coils. Written consent was therefore, not required for these procedures. We saw evidence that the practice obtained written consent before childhood immunisations were administered.

Health promotion and prevention

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 had started offering these patients an annual physical health check in 2014. All of these health checks were due for completion by March 2015. The practice had also identified the smoking status of 97% of patients over the age of 16 and referred patients who smoked to smoking cessation clinics. Data showed that 97% of patients who smoked had been offered smoking cessation advice. Similar mechanisms of identifying 'at risk' groups were used for patients who were obese. Referral to exercise classes and dietary advice was offered to this group of patients. The practice actively promoted the benefits of flu immunisation and data showed take up of flu immunisations by patients who had a stroke and those with heart disease was higher than the local average. The practice referred to the local Sure Start childrens' centre when parents sought advice for their young children.

Last year's performance for childhood immunisations met the national targets and there was a system in place to follow up those that did not attend. The practice combined the new baby health check with first immunisations and this had increased the uptake of the first childhood immunisations. The practice's performance for cervical smear uptake was slightly below the local average. The CCG wide take up of cervical smears was not meeting the national target. There was a system in place to follow up women who did not attend for their cervical smear. The

Good

Are services effective?

(for example, treatment is effective)

practice offered chlamydia, mammography and bowel cancer screening. Some of the patients we spoke with told us they received reminders to attend for health checks and health screening.

In addition to offering verbal advice on healthy lifestyles the GPs and nurses accessed online information which they were able to print off for patients. A range of leaflets were available in the practice entrance lobby and in the waiting room. These included information on sensible drinking, the benefits of stopping smoking and spotting signs of memory loss. In addition a noticeboard had been provided with dedicated information for carers including how to contact the local carers support group. The patient website carried a link to the 'Live well' site of NHS Choices and there was a page offering family health advice. This included sections specific to men's and women's health and the benefits of health screening.

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, a survey of 80 patients undertaken by the practice's patient participation group (PPG). The evidence from all these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the national patient survey showed the practice was rated good or very good for questions relating to care and support. The practice was either better or in line with other practices in the CCG for its satisfaction scores on consultations with doctors and nurses with 96% of practice respondents saying the nurses were good at listening to them. Ninety two per cent said the GP was good at giving them enough time and 90% said the GP was good at listening to them.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 10 completed cards and the majority were positive about the service experienced. Patients said they felt the practice offered a caring service and that the GPs and nurses gave patients time to discuss their health concerns and treatment. They said staff treated them with dignity and respect. Three comments were less positive but the comments related to the appointment system and not the care patients had received. We also spoke with six patients on the day of our inspection. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. 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 saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. Incoming calls were taken by reception and administration staff that were separated from the waiting room and patients attending reception by glass partitions which helped keep patient information private. We observed that staff taking calls from or making calls to patients were careful to use dates of birth to identify the patient and not repeat names when there was a possibility their conversations could be overheard by others.

There was a clearly visible notice in the patient waiting room promoting the availability of a room for breastfeeding mothers. We saw that this room was equipped with baby changing facilities and offered both mother and baby privacy from the rest of the practice. The room was also available for patients who wished to hold a private discussion with reception staff.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients mostly felt involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. Eighty five per cent of patients said GPs and 87% said nurses were good at involving them in care or treatment decisions on the national patient survey. These results were similar to the CCG average. Patients we spoke with on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. This included decisions about referrals which they said were explained clearly and dealt with promptly. They also told us they felt listened to and supported by staff and had 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.

We discussed care planning for patients with long term conditions with GPs and nurses. There was evidence that patients in this group were involved in planning their care. Some of the patients we spoke with had long term conditions and they told us they understood the importance of their regular health reviews and responded to reminders to attend for these. However, we noted that responses to the practice patient survey showed patients in this group wanted more information relating to their conditions. The practice had taken action by providing more written information on long term medical conditions. Data showed us that the care of patients with diabetes was among the best in the CCG. We also discussed care plans

Good

Are services caring?

for patients at risk of admission to hospital. We found that the GPs and nurses had developed these plans without involvement of the patient. Once completed they were sent to the patient to retain and for comment. The practice should involve this group of patients in developing their care plans.

Patient/carer support to cope emotionally with care and treatment

Patients were positive about the emotional support provided by the practice The comment cards we received detailed a similar response. For example, these highlighted that GPs responded with care and understanding when they needed help and provided support when required.

Notices in the patient waiting room and information on the patient website also told patient how to access a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer and highlighted patients who may be vulnerable. We saw a display of information available for carers to ensure they understood the various avenues of support available to them. The computer system also alerted staff to patients who needed rapid access to GP advice and to those that needed longer appointments. The GPs and nurses we spoke with told us they frequently supported patients who were dealing with social or financial issues and they offered these patients the opportunity to visit the nearby health and social care centre.

The lead GP partner knew many of their patients well having worked at the surgery for many years. They told us that all patients who had suffered a bereavement received a letter and when they knew the patient would benefit from a phone call of support this was made. The GP offered a consultation if the patient requested this.

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. For example, patients who could benefit from social services or benefits advice were recommended to visit the nearby health and social care centre.

The practice engaged with the Clinical Commissioning Group (CCG) by attendance at CCG meetings. We saw that the practice was involved in local initiatives such as care planning for admission prevention. The practice leadership team told us of discussions with other practices in the CCG relating to working more closely together to provide a wider range of services for patients. There was evidence that the practice referred patients requiring minor surgical procedures to a GP with surgical expertise at a nearby practice

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG). For example the telephone system had been upgraded to include a call waiting system and a noticeboard had been established with specific information for patients who were also carers.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. The practice was located in an area of high income deprivation and we heard how patients requiring advice from social services or benefits advice were referred to a health and social care centre nearby. The practice also accepted referrals from an organisation that supported homeless people.

The practice had access to face to face, online and telephone translation services. We saw that the appointment check in screen carried a translation facility with over ten languages featured. The patient website also had a translation facility containing 80 languages.

The practice was situated on the ground and first floors of the building with most services for patients on the ground floor. Patients who found it difficult to manage stairs were seen by the GPs and nurses in consulting and treatment rooms on the ground floor. There was sufficient space in corridors for patients with mobility scooters and wheelchairs. This made movement around the practice easier and helped to maintain patients' independence.

We saw that the waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice. There was a baby changing facility which was also available for breastfeeding mothers.

Access to the service

The practice was open from 8am to 1pm and 2pm to 6.30pm every weekday. Between 1pm and 2pm patients could access urgent medical advice and support via the telephone. Booked appointments were available from 8:30am to 5.30pm on weekdays and the GPs offered telephone consultations or urgent appointments thereafter.

Information was available to patients about appointments on the practice website and in the practice leaflet. This included how to arrange urgent appointments and home visits and how to book appointments through the website. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Information on both the out-of-hours service and the availability of the local walk in centre was provided to patients.

The practice recognised, from patient feedback, that telephone access to book appointments was proving difficult. As a result of the last patient survey a call queuing system had been made available on two of the practice telephone lines. The practice was promoting the use of online appointment booking to reduce the demand on the incoming telephone lines.

Longer appointments were available for patients who needed them and those with long-term conditions. This also included appointments with a named GP or nurse. We saw that the time allocated for annual or periodic reviews of patients with long standing medical conditions was adjusted depending on the nature of the review. For example, a review for a patient with COPD (lung disease) was scheduled to take 30 minutes. GPs placed an alert on

Good

Are services responsive to people's needs?

(for example, to feedback?)

the patient record for those patients that they recognised needed double appointments. This enabled staff booking the appointment to allocate sufficient time for these patients to be seen.

Patients were mostly satisfied with the appointments system. They confirmed that they could see a doctor on the same day if they needed to and they could see another doctor if there was a wait to see the doctor of their choice. Some patients we spoke with and those that completed comment cards told us that they sometimes needed longer for their appointments. These patients appeared unaware that there was a facility to book longer appointments if they wished to discuss more than one health problem. The lead GP held three one hour long clinics at the branch surgery in Southcote clinic each week. Patients attending these clinics were not required to book appointments. We were told that feedback from patients at the branch surgery was positive because they knew they would be seen by the GP if they visited during the clinic hours. Patients who lived near the branch surgery were able to book appointments at the main practice if they needed to be seen when the branch surgery was closed.

The practice's extended opening hours on both Monday and Tuesday every week ran until 8pm. The practice was also open one Saturday morning each month. These clinics were particularly useful to patients with work commitments and staff told us they promoted these appointments for patients that worked or were unable to attend the practice during the working day.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. The practice manager and lead GP handled all complaints in the practice.

We saw that information was available to help patients understand the complaints system. The complaints procedure was displayed in the waiting room, referred to on the patient website and in the patient information leaflet. None of the patients we spoke with had ever needed to make a complaint about the practice. Most of these patients did not know the procedure to make a complaint.

We looked at eight complaints received in the last 12 months and found these were dealt with in a timely way and full responses sent to the patient once the complaint had been investigated. All eight complaints were handled in accordance with the practice complaints procedure.

The leadership team reviewed complaints annually to detect themes or trends. Lessons learned from individual complaints had been acted upon. For example, additional checks had been put in place to ensure prescriptions were sent to the pharmacy chosen by the patient for collection of their medicine.

Are services well-led?

Requires improvement

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

Our findings

Vision and strategy

The practice had core values to deliver high quality care, in a timely manner and promote good outcomes for patients. We saw staff working to these values. For example, if patients found it difficult to organise a hospital appointment through the choose and book system staff would assist them to ensure they received their care. We reviewed a strategic plan for the next two years. This set out how the practice wished to develop and work in partnership with both patients and other providers of health and social care. The practice had made a clear statement of their intention to remain a small family friendly practice.

The strategy document recognised the need to develop staff, for example enabling nurses to increase their skills, and to succession plan for future retirements.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff in indexed folders held in the practice manager's office. Staff told us they could access these policies easily. Some of the policies were available electronically via any computer within the practice. The practice manager told us that there was further work to do in adding all policies to the electronic file and in making this available to all staff. We looked at nine of the practice policies and procedures. Four of the policies we looked at contained a review date and we saw they had been reviewed in accordance with the date stated. The other five policies did not include a timetable for review and it was unclear whether they remained current and reflected the procedures in operation at the practice. The practice must ensure policies are reviewed and reflect practice procedures.

Some quality assurance and control procedures were not operated consistently. The procedures for checking fridge temperatures were followed at the main practice site but not at the branch surgery. Reviewing suitability of premises was carried out at Long Barn Lane but not at Southcote clinic. For example the suitability of the treatment room had not been assessed at Southcote clinic. Monitoring of cleaning standards had not been carried out regularly or consistently.

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead nurse for infection control and the lead partner was the lead for safeguarding. We spoke with seven members of staff and they were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed it was performing in line with national standards. We saw that QOF data was regularly discussed by the management team and action plans were produced to maintain or improve outcomes.

Leadership, openness and transparency

The practice leadership team comprised the lead partner, practice manager and senior practice nurse. We saw that the team worked closely together and that the three members of the team offered robust support to each other and the wider practice team. The minutes of team meetings we reviewed showed the full practice team met on nine occasions a year during the training events organised by the clinical commissioning group (CCG). Staff we spoke with told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at any time and also at team meetings.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example the disciplinary procedure and maternity leave policies which were in place to support staff. We reviewed the staff handbook that was available to all staff. The handbook included sections on managing stress at work and equal opportunities. We saw that the handbook had been reviewed in December 2014. The next review was schedule for December 2015. Staff we spoke with knew where to find these policies if required. There were separate policies relating to harassment and bullying and whistleblowing. There was no consistent system for reviewing policies to ensure they were up to date and accurate.

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

The practice had gathered feedback from patients through patient surveys, meetings with the patient participation group (PPG) and by reviewing complaints. We looked at the

Are services well-led?

Requires improvement

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

results of the practice patient survey and the action plan arising from it which had been agreed with the PPG. The PPG had been active and remained stable for the last two years. The two members of the PPG we met with told us they felt listened to and that the practice acted upon feedback from the group and from patients who took part in surveys. We saw that the practice had upgraded the telephone system to add call waiting to two incoming telephone lines. This action had been identified in the post survey action plan.

Feedback from staff was obtained through informal day to day discussions with members of the leadership team, appraisals and practice meetings. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. One member of staff told us that they had undertaken training in processing choose and book referrals to enable them to cover colleagues in their absence. Staff told us they felt involved and engaged in the practice and that ideas they had for improving outcomes for both staff and patients would be considered and if possible acted upon.

The practice had a whistleblowing policy which was available to all staff in the policies and procedures files.

Some staff we spoke with were not familiar with the term whistleblowing, However, all staff we spoke with told us they would not hesitate to report any concerns they had regarding the conduct of their colleagues if the need arose.

Management lead through learning and improvement

Staff told us the practice supported them to maintain their professional development through training and day-to-day support. We looked at four staff files and saw that regular appraisals took place which included a personal development plan. However, some staff told us they had not received an appraisal in the last year. Staff told us that the practice was very supportive of training. We saw that staff took part in training organised by the CCG. For example all staff in post took part in the safeguarding children training at a CCG training event and attended safeguarding of vulnerable adults training when a trainer visited the practice.

The practice had completed reviews of significant events and other incidents and these were shared with staff at meetings or via their line manager to ensure the practice improved outcomes for patients

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The registered person did not protect service users against the risks associated with the unsafe use and management of medicines, by means of the making of appropriate arrangements for the obtaining, recording, handling, using, safe keeping, dispensing, safe administration, and disposal of medicines used for the regulated activity. Regulation 12 (g). This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

This section is primarily information for the provider

Requirement notices

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