Medina Healthcare

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Medina Healthcare on 26 March 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing well-led, effective, caring and responsive services. It was also good for providing services for the older people, people with long term conditions, families, children and young people, working age people, people whose circumstances may make them vulnerable and people experiencing poor mental health. It required improvement for providing safe services.

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

- Risks to patients were assessed and well managed.
- Patients' needs were assessed and care was planned and delivered following best practice guidance.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management.
- The practice was visibly clean and there were systems in place to maintain an appropriate standard of cleanliness and hygiene.
- The practice was rated highly by patients for the respect they were shown and for the kindness and consideration shown by reception staff.
- The practice provided GP appointments at times that met the needs of their patients with same day appointments or telephone consultations. Some appointments were available until 6.45pm for patients who could not attend during working hours.

Summary of findings

- The latest GP patient survey showed that 93% of the patients that responded rated their overall experience of the practice as good or very good.
- The practice GPs met with other health professionals every month to keep each other informed of any safeguarding issues or vulnerable patients.

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

Importantly the provider must;

- Ensure that procedures for the management of infection control include; an annual infection control statement, a complete audit of the premises and a risk assessment and policy for the management of Legionella. Also that a system is in place to monitor the cleaning of carpets and privacy curtains.

In addition the provider should;

- Ensure staff have the opportunity to update their training in subjects such as information governance, equality and diversity and fire safety within the timescales set by the practice as mandatory.
- Ensure that regular clinical audit cycles are re-established to demonstrate change and improvements made.
- Although complaints were shared with staff groups involved there was no recorded forum for discussion to show that all complaints had been openly shared for learning.

Professor Steve Field (CBE FRCP FFPH FRCGP)

Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

The practice is rated as requires improvement for safe.

Staff understood and fulfilled their responsibilities to raise concerns, and report incidents and near misses.

Emergency medicines and associated equipment was available for use and regularly checked to ensure it was in date and suitable for use. Arrangements were in place to deal with emergencies and major incidents. A detailed business continuity plan was in place to deal with any event which may cause disruption to the service.

There were enough staff to keep people safe. The practice had recruitment procedures in place which appeared to be consistently followed.

However there was a lack of systems in place for the prevention and control of infections. There were no procedures in place to monitor and record the cleaning of carpets and privacy curtains.

Are services effective?

Good

The practice is rated as good for effective.

Our findings at inspection showed the practice delivered care and treatment in line with recognised best practice. They worked with other health professionals to ensure a complete service with the right treatment outcomes for their patients.

The provider had a number of systems and processes in place to ensure that standards of care were effectively monitored and maintained. However we found that a number of clinical audit cycles had been completed in the past but this had not been sustained in more than a year.

Patients were supported to manage their own health and were treated by appropriately trained staff. Staff received the necessary support, training and development for their role and extended duties. However we found some gaps in refresher staff training in areas such as information governance, fire safety and health and safety.

Are services caring?

Good

The practice is rated as good for caring.

The patients we spoke with and the comment cards we received were positive about the care provided. Patients told us they were treated with respect and their privacy and dignity was maintained. Care was taken to ensure patients' confidentiality was protected.

Summary of findings

Patients said they were given sufficient time to discuss their problem or treatment options and were referred to other health care professionals when needed.

Arrangements were in place to support patients who were nearing the end of their life and regular contact was maintained with palliative care teams and other healthcare professionals.

Are services responsive to people's needs?

Good

The practice is rated as good for responsive.

The practice reviewed the needs of their local population and worked with other services to improve the service for patients. Patients reported good access to the practice with urgent appointments available the same day.

The practice was equipped to treat patients and meet their needs. There was an accessible complaints system with evidence demonstrating that the practice responded quickly to issues raised.

Are services well-led?

Good

The practice is rated as good for being well-led.

There was a clear leadership and staff felt supported by the GPs and practice management. The practice had a number of policies and procedures to govern activity and systems in place to monitor and improve quality and identify risk.

The practice proactively sought feedback from patients, which it acted on. The practice had an active patient participation group.

Staff had received induction, regular performance reviews and felt communication throughout the practice was good.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated good for the care of older people. The practice was successful in a bid to be part of an over 75 years project in two of the nursing homes they visit. This involved bi annual care plan reviews of all residents and GPs and practice chronic disease management nurses offered educational sessions to care home staff.

The practice held multi-disciplinary palliative care meetings each month to discuss the health and social care needs of patients with complex medical needs and those at end of life.

The practice supported the hospital rehabilitation team for up to 20 patients in two homes to enable early discharge from hospital. This was provided through a weekly round and responding to acute need. Regular visits to these homes had improved communication and efficiency.

People with long term conditions

Good

The practice is rated as good for the care of people with long term conditions. The practice was aware of those patients with long term conditions and had processes in place to make urgent referrals to secondary care should it be necessary or when longer appointments or home visits were needed. All these patients had structured annual reviews to check their health and medication needs were being met.

The practice maintained good communication with community and specialist services where appropriate, for support in the management of patients with long term conditions.

Practice nurses provided home visits for patients who needed regular blood samples for the monitoring of their anticoagulant (blood thinning) medicine.

Families, children and young people

Good

The practice is rated good for the care of families, children and young people.

The practice held monthly meetings with health visitors to discuss any child safeguarding issues. The practice followed up any non-attendance for routine child immunisations and for paediatric outpatient hospital appointments.

Pre-bookable, same day and emergency appointments were available outside school hours. Sick children were prioritised for same day emergency appointments.

Summary of findings

Working age people (including those recently retired and students)

Good

The practice is rated good for the care of working age patients and those recently retired. Appointments were available on Saturday mornings, early Thursday mornings and late Monday evenings for those patients who could not attend during normal working hours. Appointments were regularly monitored and emergency access altered according to demand. The practice encouraged the use of telephone call backs and the use of online ordering for prescriptions.

The practice offered well woman and well man NHS health checks and for those patients in the 40 to 70 year old age range.

There was a virtual patient participation group to capture feedback and suggestions from those patients who may find attending the patient participation group difficult due to other commitments.

People whose circumstances may make them vulnerable

Good

The practice is rated good for the care of patients whose circumstances may make them vulnerable.

One of the GP partners worked with the Isle of Wight drug and alcohol service. They were able to provide additional knowledge and advice for their colleagues to support the complex needs of patients with addictions.

The practice provided care to approximately 30 patients who were homeless and saw them as temporary residents if a medical or social need was identified.

The practice kept a record of patients who had a learning disability; these patients were known to reception staff and had priority access to the GPs. All patients with a learning disability were offered an annual health check.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated good for patients experiencing poor mental health (including dementia). The practice had a high prevalence of patients diagnosed with dementia and was actively screening at risk patient groups for signs of dementia. The practice had developed a template for their clinical system. This template contained a six item cognitive test to help with the opportunistic dementia testing of these patients.

Patients with major mental illness were invited for annual health checks during which cardiac risk factors were assessed.

Summary of findings

The practice hosted a counsellor from the primary care mental health team. This gave patients easy access to this self-referral service. The GPs and counsellor worked together to support patients with poor mental health.

GPs at the practice have experience in Mental Health Act assessments and all GPs and nurses had recently completed in house training on the Mental Capacity Act 2005.

Summary of findings

What people who use the service say

We spoke with 12 patients on the day of our inspection. We reviewed 34 comment cards which had been completed by patients in the two weeks leading up to our inspection.

We spoke with patients from a number of population groups. These included mothers and children, people of working age, people with long term conditions and people aged over 75 years of age.

Generally patients were very complimentary about the practice staff who they said were helpful, friendly and respectful. All except one of the patients we spoke with praised the practice for their ability to provide an appointment promptly. Four of the patients we spoke with had called that morning and had been given an appointment. Patients commented positively on the way GPs and nurses listened to them and the way they explained their diagnosis or medicines in a way they could understand.

The last patient survey was published by the practice in March 2014. The results from this survey showed that patients were happy with the way the staff groups at the practice communicated with them (GPs, nurses and administration staff). Results from the 2013 GP survey also showed that just over 92.9% of those patients surveyed felt that their overall experience of the practice was either good or very good.

Areas for improvement

Action the service MUST take to improve

- Ensure that procedures for the management of infection control include; an annual infection control statement and a complete audit of the premises. Also that a system is in place to monitor the cleaning of carpets and privacy curtains.

Action the service SHOULD take to improve

- Ensure staff have the opportunity to update their training in subjects such as information governance, equality and diversity and fire safety within the timescales set by the practice as mandatory.
- Ensure that regular clinical audit cycles are re-established to demonstrate change and improvements made.
- Although complaints were shared with staff groups involved there was no recorded forum for discussion to show that all complaints had been openly shared for learning.

Medina Healthcare

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a GP, a specialist advisor in practice management and a second CQC inspector.

Background to Medina Healthcare

Medina Healthcare is located at 16 West Street, Newport, Isle of Wight, PO30 1PR, which is close to the centre of Newport. Medina Healthcare is part of the Isle of Wight Clinical Commissioning Group (CCG). The practice operates from premises which are leased by the GP partners. The practice building has four consulting rooms and three treatment rooms.

Medina Healthcare has a branch at Wootton Bridge, Ryde PO33 4NW which is approximately five miles away. The new premises at Wootton Bridge were opened in November 2014. Together the two branches provide care and treatment to 9,000 patients across the two sites. Approximately 5000 patients are registered at West Street and 4000 at Wootton Bridge. All patients have access to appointments at both locations. As part of this inspection we did not visit the branch surgery at Wootton Bridge. The practice has two male and four female GP partners and a long term locum GP. The GPs in total provide the equivalent of 4.5 full time GPs. Further support is provided by a nurse practitioner, a lead nurse, three further practice nurses and two healthcare assistants. The practice is further supported by a practice manager, an assistant practice manager, reception and administrative staff. The practice has a personal medical services (PMS) contract with NHS England. (This is a locally agreed alternative to the standard General Medical Services contract. This is used when services are agreed locally with a practice which may include additional services beyond the standard contract.)

The practice is open on Monday to Friday between 08.00 and 18.30. There is late opening on a Monday until 19.00 and the practice opens at 07.20 on a Thursday morning. The practice opens on a Saturday morning to treat patients who have pre-booked appointments only.

The Care Quality Commission draws on existing national data sources and includes indicators covering a range of GP practice activity and patient experience including the Quality and Outcomes Framework and the National Patient Survey. This data showed the practice provides care and treatment to a higher than average number of patients who are over the age of 65 which includes care and treatment to people who are living in a large nursing home and two care homes.

GP's from the practice form part of an out of hours service for which the CCG are responsible. This service is accessed by patients through the 111 service.

Why we carried out this inspection

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

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations such as

Detailed findings

the local NHS England, Healthwatch and the Isle of Wight Clinical Commissioning Group, to share what they knew. We asked patients to share their views by completing comment cards for us to review.

We carried out an announced visit on 26 March 2015. During our visit we spoke with a range of staff including GPs working at the practice that day, practice nursing staff, the practice manager and reception and administrative staff. We spoke with patients who used the service. We observed how people were being cared for and reviewed some of the practice's policies and procedures. We also reviewed 34 comment cards where patients and members of the public had shared their views and experiences of the service.

We asked the practice to send us some information before the inspection took place to enable us to prioritise our areas for inspection. This information included practice policies and procedures and some audits. We also reviewed the practice website and looked at information posted on the NHS Choices website.

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

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

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

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

Requires improvement

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks in relation to patient safety. For example, reported incidents, national patient safety alerts as well as comments and complaints received from patients. Staff were aware of their responsibilities to report incidents and near misses. For example staff had worked together to put in place procedures to avoid mistakes relating to the care and treatment of patients who share the same name.

We reviewed safety records and incident reports and minutes of meetings where these reports were discussed. We reviewed the significant events that had been recorded by the practice over the last 12 months. We saw that safety incidents had been acted on promptly and action had been taken to mitigate future risks. There was evidence that significant events had been handled appropriately to protect the safety and well-being of patients.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. The records for the last 12 months were made available to us. Incidents and complaints were dealt with by the practice manager who showed us the system they used to oversee and ensure these were managed and monitored.

Significant events were discussed at each clinical meeting and also at weekly management meetings throughout the year. There was evidence that changes were made to practice as a result of incidents and those findings were disseminated to relevant staff verbally or through staff meetings. Systems within the practice had been changed to minimise future risks. For example systems had been changed to ensure that all telephoned or faxed test results were always given priority one status and passed directly to a GP. This was as a result of an incident where test results had been added to the prescription report tray which is reviewed only at set times such as later in the day. The practice had expressed that this had improved timely actions for patients.

National Patient Safety Alerts were disseminated to practice staff by the practice manager or deputy as soon as they were received by the practice. Any patient safety alert was emailed to GPs and nurses. The practice manager had recently introduced a system of saving these alerts to the practice's shared electronic file for future reference. Patient safety alerts were highlighted at the weekly partners meetings. We saw an example of how the information from a Medicines and Healthcare products Regulatory Agency alert had been acted on by the GPs. The risk of combining certain medicines had been highlighted. The practice had used an electronic search and worked with local pharmacies to identify any patients who may be at risk. These patients were contacted and their medicines reviewed.

Reliable safety systems and processes including safeguarding

The practice's electronic record system ensured risks to children and young people who were looked after or on child protection plans were clearly flagged and reviewed. All the GPs at the practice had received training in child and adult safeguarding which included level three training in child safeguarding. The lead GP in safeguarding had completed level four in child safeguarding. Staff knew how to access the practice safeguarding policy and who to speak to in the practice if they had a safeguarding concern. However some of the staff we spoke with were not clear which GP partner took the lead in safeguarding children and vulnerable adults. Staff were aware of their responsibilities to report any concerns they may have. All staff had received training in safeguarding children and vulnerable adults. Practice nurses' had all taken part in level three training in relation to safeguarding children and had also completed training in safeguarding vulnerable adults.

The GP partners met health visitors each month to discuss any child safeguarding matters. The safeguarding lead attended monthly meetings with staff from across the Isle of Wight, to discuss any concerns or issues. There was a system in place to ensure that all children who missed hospital appointments were followed up.

A chaperone policy was in place and visible on the waiting room noticeboard and in consulting rooms. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure.) Nursing staff or GPs acted as chaperones when required and some members of reception staff were also trained for the role as chaperone if a nurse or GP was not available. All staff had received checks through the disclosure and barring service.

Requires improvement

Are services safe?

Patients' individual records were written and managed in a way to help ensure safety. Records were kept on an electronic software system for primary healthcare, which collated all communications about the patient including scanned copies of communications from hospitals.

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 refrigerator failure. Staff we spoke with were clear about the action they would take should a failure of the cold chain of medicines occur.

Emergency medicines for cardiac arrest, anaphylaxis and hypoglycaemia were available; in date and ready for use should they be needed. Expired and unwanted medicines were disposed of in line with waste regulations.

Vaccines were administered by nurses using patient specific directions or patient group directions that had been produced in line with national guidance. We saw evidence that the practice nurses had received training to administer vaccines; however records showed this training had taken place more than 18 months ago. The practice had a nurse prescriber who supported the work of the GPs.

Patients were able to request repeat prescriptions in writing at the practice. The practice had a protocol for repeat prescribing which was in line with GMC guidance. This covered how changes to patients' repeat medications were managed and the system for reviewing patients' repeat medications to ensure the medication was still safe and necessary. All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescriptions were stored securely.

The practice used a software system which reconciled records of community pharmacists, the clinical commissioning group medicines management team, the practice GP and the hospital. This provided the GPs with alerts to patient safety in relation to their medicines.

Cleanliness and infection control

The practice was cleaned by a company contracted by the practice. A cleaning plan was in place and this had been reviewed in March 2015. There were cleaners' checklists in place and displayed around the practice for example in the toilet, clinical rooms and waiting room where the checklist recorded the toy cleaning schedule. The practice had a copy of a cleaning audit conducted by the contract company and we saw that these had been carried out at intervals over the last 12 months.

We observed the rooms used to consult or treat patients were visibly clean, tidy and well maintained. Work surfaces could be cleaned easily and were clutter free. Patients we spoke with told us they always found these areas of practice clean and had no concerns about infection control.

The practice had a lead for infection control who at the time of our inspection had not taken part in further training to enable them to demonstrate the knowledge and skills to lead the infection control programme, systems and policy. We were told that another nurse had attended appropriate training and could provide advice to colleagues.

An infection control policy and supporting procedures were available for staff to refer to. Personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these to comply with the practice's infection control policy. The practice used single use equipment wherever possible.

We saw there were appropriate waste disposal procedures in place in the treatment room with appropriately labelled clinical waste bins and medicines and sharps waste containers. The practice had a contract with a waste disposal company to collect and dispose of clinical and medicines waste.

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. A hand hygiene review with nurses and health care assistants had been carried out at six monthly intervals however GPs had not been part of this review.

We found there was no recorded audit of infection prevention and control procedures in place at the practice. However health care assistants completed checks of the clinical rooms at the practice. We saw that some issues had been highlighted as a result of these checks. For example the taps in one of the treatment rooms were not elbow operated and staff had to use paper towels to turn them off

to prevent recontamination of their clean hands. There had been no action taken by the practice to reduce the infection risks that had been identified during the weekly checks of the clinical rooms.

The practice consulting rooms had carpeting and fabric privacy curtains. We looked at the cleaning schedules and found that neither of these items were part of that schedule. Carpets were only cleaned when visibly stained and there was no record of the frequency of laundering the privacy curtains. There was no record and staff could not recall the last time the curtains were removed for cleaning. However privacy curtains in treatment rooms were disposable and we saw that the date they were fitted was recorded.

The practice did not have a risk assessment or policy for the management, testing and investigation of Legionella (a bacterium found in the environment which can contaminate water systems in buildings). However the practice manager was in the process of engaging a specialist company to carry out an assessment of the building and a plan for monitoring the water systems, a date for the assessment had not been set.

Equipment

Staff we spoke with did not raise any concerns about the safety, suitability or availability of equipment. They told us that all equipment was tested and maintained regularly. We saw that medical equipment had been calibrated and was functioning correctly and accurately. (Calibration is a means of testing that measuring equipment is accurate). Electrical items had been portable appliance tested (PAT tested) and were deemed safe to use. Calibration and PAT testing had last taken place in August 2014.

Staffing and recruitment

The practice staff consisted of six GP partners and a long term locum GP. These staff provided sessions equal to approximately 4.5 full time GPs. There was also a nurse practitioner, a lead nurse, three further practice nurses and two healthcare assistants.

We looked a sample of recruitment files and found that appropriate checks, including a criminal records check, such as through the Disclosure and Barring Service and satisfactory evidence of employment in previous jobs had been obtained. Nurses' registrations were checked to ensure they were current. The practice completed General Medical Council checks on GPs and locum GPs. The practice carried out their own checks of the suitability of locum GPs as well as recording the checks made by the locum agency of any locum GPs they employed through them.

The majority of administration and reception staff had worked at the practice for a number of years, the practice manager and GP partner told us they felt the stable work force provided a safe environment for their patients. The reception staff knew patients well and were able to alert GPs to any concerns they may have about individual patients.

There was a rota system in place for the different staffing groups to ensure that enough staff were on duty. There was also an arrangement in place for members of administrative staff and reception staff to cover each other's sickness or annual leave. However the practice also had a member of bank staff they could call upon if necessary to cover holiday or sickness.

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 and emergency alarms. Fire extinguishers were checked annually and the risk assessment in relation to fire had been reviewed and updated in November 2014. The practice had an up to date control of substances hazardous to health folder. The information for staff had been regularly reviewed and signed by staff to acknowledge the existence and location of this safety information.

The practice ensured that appropriate risk assessments were carried out in relation to both patients and staff. There were processes in place to identify those patients at high risk of hospital admission with an alert attached to their electronic patient record.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all staff had received annual training in cardiopulmonary resuscitation. Emergency equipment was available including access to oxygen and an automated external defibrillator (a portable electronic device that analyses life threatening irregularities of the heart including ventricular fibrillation and is able to deliver an electrical shock to attempt to restore a normal

heart rhythm). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly. Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. An anaphylaxis kit was attached to the noticeboard in every treatment and consulting room readily available should a patient suffer an allergic reaction. The practice had assessed the risks relating to the lack of security around this medicine and the potential benefit to a patient suffering an allergic reaction. However this risk assessment was not documented.

Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines checked were in date and fit for use. A practice nurse checked the emergency medicines to ensure they would be safe to use should an emergency arise.

The practice had a comprehensive business continuity plan which was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document contained relevant contact details for staff to refer to and a system of cascading information to all staff if necessary. Copies of the plan were kept off site so they could be referred to should access to the practice premises not be possible. The practice would be able to use their other practice facilities which would allow them to continue to provide patient care should they not be able to operate from their current premises.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE). For example one of the GP partners had presented hypertension guidelines to colleagues, with an emphasis on home monitoring. This provided assistance in making an accurate assessment of blood pressure in order to make a treatment decision and to monitor response to that treatment.

Patients' needs were assessed and treatment was delivered in a way which followed national standards and guidance. Patients confirmed that they received an assessment of their symptoms before GPs and nurses recommended treatment. Nursing staff at the practice were responsible for patients' chronic disease management, for example diabetes and asthma.

We found from our discussions with the GPs and nurses that they completed thorough assessments of patients' needs in line with current guidelines and these were reviewed when appropriate.

GPs and nurses remained up-to-date by attending courses in subjects relevant to their practice. We were able to see the records kept by the practice manager of all training courses and educational meetings attended by the nurses. All the GPs and nurses interviewed were aware of their professional responsibilities to maintain their professional knowledge and skills.

The practice referred patients appropriately to hospital and other community care services. Data showed the practice was in line with local referral rates for all conditions. We saw that any referrals to hospital were made without undue delay and urgent referrals were sent within 24 hours.

All new patients to the practice were offered a health assessment carried out by a healthcare assistant or practice nurse to ensure the practice was aware of their health needs. Patients who relied on long term medication were regularly assessed and their medication needs reviewed. There were systems in place to ensure that the GPs reviewed the diagnostic and blood test results of their patients. Following a recent change to the system of reviewing results we found that abnormal results not deemed by the laboratory to need immediate attention could wait for up to four days for a review if a GP was away from the practice either side of a weekend. This was discussed with the GPs at inspection who immediately reverted back to their previous buddy system were results were reviewed on the day they were received or the following day. There were arrangements for another GP to review any test results should the patient's regular GP be absent from the practice.

The GPs told us they led in specialist clinical areas such as diabetes, heart disease and asthma and the practice nurses supported this work, which allowed the practice to focus on specific conditions. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support. GPs told us this supported all staff to continually review and discuss new best practice guidelines For example one of the GPs with a diploma in diabetes worked with the local diabetic team and had carried out an analysis of literature which they had shared with colleagues with the results of the analysis published in Practical Diabetes Journal.

The practice provided specialised appointments to meet the needs of patients. These included diabetes, asthma and chronic obstructive pulmonary disease, a disease which results in breathing difficulties. These specialised appointments were carried out by the practice nurses, who had undertaken further relevant training, with support from the GPs. There were arrangements in place to ensure all patients with a long term medical condition received an annual health check.

The practice was aware of those patients at most risk of hospital admission. Care plans had been produced for each of these patients. The practice held monthly clinical meetings which were attended by other healthcare professionals such as the community matron, district nurses, a Macmillan nurse, health visitors, a midwife and physiotherapist. We saw minutes of these meetings which showed that the complex health and social care needs of specific patients were discussed, with the multidisciplinary team.

We looked at data about the practice's performance for antibiotic prescribing we found this was comparable to similar practices.

Good

Are services effective?

(for example, treatment is effective)

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

Management, monitoring and improving outcomes for people

The practice showed us a number of clinical audits that had been undertaken in previous years. These were completed audits where the practice was able to demonstrate the changes resulting since the initial audit. For example one of the GP partners had audited the prescription of the combined oral contraceptive (COC) to smokers over the age of 35 and for those with a BMI over 30. The practice had not instigated prescriptions to any patient in this at risk group but the learning from this audit was that when taking over the prescribing of COC from elsewhere the contraindications and age of the patient were to be checked before issuing further prescriptions.

There were samples of other completed audit cycles which were self-directed by the GPs and were relevant to patient care in terms of good practice and current guidance. There appeared to be a culture of audit in recent years although this had not been sustained over the past 18 months. We were told this was due to the added pressure to the partner GPs of completing the new building of their branch surgery.

We saw that the practice had, in recent years, monitored the referrals made to other services or the unplanned admission of their patients to hospital. However the audit cycle for these had not been completed. For example one had proposed a monthly audit of unscheduled admissions, which had not taken place. We did not see that recent audit cycles had been completed to demonstrate changes had taken place and improvements made. Although a recent admission avoidance audit had been completed this did not include any changes or learning outcomes it was an analysis of data only.

The practice used the information collected for the QOF and their performance against national screening programmes to monitor outcomes for patients. For example, 84% of patients diagnosed with dementia had received a face to face review of their care. The total QOF points for this practice for 2013/2014 were 90.7% which was below the average for the Isle of Wight Clinical Commissioning Group. The practice met the minimum standards for QOF in diabetes, asthma and chronic obstructive pulmonary disease (lung disease).

The practice used the appraisal system and staff meetings to assess the performance of clinical staff. The staff we spoke with told us how they discussed their practice, the outcomes achieved and areas where they could be improved. Staff spoke positively about the culture in the practice around quality improvement.

There was a protocol for repeat prescribing which was in line with national guidance. In line with this, staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also checked that all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used. The evidence we saw confirmed that the GPs had oversight and a good understanding of best treatment for each patient's needs.

The practice had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss the care and support needs of patients and their families.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff had received training in safeguarding children and vulnerable adults and cardiopulmonary resuscitation. However the practice had identified a number of courses which they defined as mandatory and should be repeated annually. Records showed that a number of staff were overdue updates in some subjects such as information governance, equality and diversity and fire safety.

We noted a good skill mix among the doctors with some having additional diplomas or special interests in areas such as diabetes and drug abuse. All GPs told us they were up to date with their yearly continuing professional development requirements and all either have been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

Good

Are services effective?

(for example, treatment is effective)

All the staff we spoke with in both nursing and administrative roles told us they were well supported by the GP partners, the practice manager and their assistant. There was an annual appraisal system in place for staff. Staff told us they had taken part in an annual appraisal and had been able to use the protected time to discuss any concerns they may have, around patient care or practice management, and their own personal development. They also told us that the practice was very supportive of training. One member of staff told us that staff received protected time to undertake learning and development and that management were very supportive. The staff member said they had requested specific training for her their own development and that this training was being sourced. Staff told us that training was carried out in conjunction with other practices on the Isle of Wight. This included mandatory training and training for staff who led in roles such as diabetes management.

Practice nurses performed defined duties and were able to demonstrate that they were trained to fulfil these duties. For example the administration of vaccines and diabetes care. We saw that those with extended roles for example the nurse prescriber had appropriate training to fulfil these roles.

Working with colleagues and other services

The practice worked with others to improve the service and care of their patients. There were arrangements in place for other health professionals to meet regularly with the GPs to discuss the needs of their patients.

Antenatal and postnatal care was provided by community midwives and health visitors who were based at a nearby children's centre. The GPs provided postnatal care at the practice and had links with the midwives and health visitors for the shared care of their patients. The practice held monthly multidisciplinary meetings to discuss the health and social needs of patients, including those at the end of life. These were attended by health care professionals as appropriate. The practice had regular communication with the health visiting team, especially in relation to any safeguarding issues.

There were systems in place to ensure that the GPs reviewed communication from other health care providers, for their patients. 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 reviewed their procedure to ensure that all relevant staff passed on, read and acted on any issues arising from communications with other care providers on the day they were received. Administration staff collated information in a variety of formats from the out of hours provider or from other organisations. All information was collated and passed to the patient's GP or another GP in their absence. Immediate action was taken if required; including for those patients whose GP was not available that day.

Regular meetings with regard to the management of patients with long term conditions were attended by staff who worked in collaboration with the local diabetes centre.

The practice hosted a psychological wellbeing practitioner from the primary care mental health team who ran a weekly clinic from the premises. Patients could refer themselves for this service with advice from their GP. The practitioner told us there was good two way communication with the practice for the benefit of patients. They had been made to feel welcome by the practice and invited to clinical and staff meetings when appropriate.

Information sharing

Patient information was stored securely on the practice's electronic record system. All staff were fully trained on the system, and commented positively about the system's safety and ease of use. The software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference. Patient records could be accessed by appropriate staff in order to plan and deliver patient care. We saw that information was transferred to patient records promptly following out of hours or hospital care. The practice retained historic paper patient records which were stored securely and used if necessary to review medical histories.

Electronic systems were also in place for making referrals, and the practice made approximately 20% of their referrals last year through the Choose and Book system. (Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital). Staff reported that this system was easy to use.

The practice ensured that the out of hours and ambulance service were aware of any relevant information relating to their patients. For example care plans that were in place for

Good

Are services effective?

(for example, treatment is effective)

patients with complex medical needs were shared with the out of hours and ambulance services. These services were also made aware of any patient whose end of life was being managed at their home.

Consent to care and treatment

The GPs and nurses we spoke with understood the key parts of the legislation in relation to the Mental Capacity Act 2005 (MCA) and were able to describe how they would implement it in their practice. For some specific scenarios where capacity to make decisions was an issue for a patient, the practice staff were clear how patients should be supported to make their own decisions and how these should be documented in the medical notes.

Although staff were able to describe the principles of the MCA when assessing whether a patient was able to give informed consent, there was no record of specific formal training on this subject. However the practice had produced guidance for staff which included 'Adult Safeguarding-Salient Points' and 'Mental Capacity Act Brief Advice'.

There was a practice policy for documenting consent for specific interventions. For example, for some family planning procedures and minor surgical procedures. In other cases verbal consent was documented in the electronic patient notes with a record of relevant discussions. Staff followed written guidance from local commissioners on making best interests decisions for cervical screening. GPs and nurses understood that patients could withdraw their consent at any time.

Patients said that they felt involved in decisions about their care and treatment. They said they were given time to consider options available and were never rushed. One parent told us that the GPs had involved their child in conversations and spoke with them and explained things in an age appropriate way.

Health promotion and prevention

All new patients to the practice were offered a new patient health check with the practice nurse or healthcare assistant to ensure the practice was aware of their health needs. The GP was informed of any health concerns identified and these were followed-up. GPs and nurses used their contact with patients to help maintain or improve mental and physical health and wellbeing, for example, by offering smoking cessation advice and weight management and monitoring. Nurses and healthcare assistants were able to refer patients for exercise and diet programmes with local and national organisations. The practice offered well woman and well man health checks and promoted appropriate health screening. The practice had the results of bowel screening for 1164 of their patients carried out during the last 12 months. They had performed cervical smear tests for 619 patients, which meant that 75% of those women in the 25 to 65 year old age range had been tested within the last five years. Systems were in place to identify at risk groups such as those that required specialist health screening or patients who had chronic disease. These groups were offered further support in line with their needs.

The practice had a range of health promotion leaflets in their waiting rooms and other areas. Noticeboards were used to signpost patients to relevant support organisations, community schemes and counselling services such as cognitive behaviour therapy. The practice brochure and information about the practice was available for new patients. They had also produced their own leaflets on minor illness and self-treatment of common illness. This was backed up with further information available for patients on illness, family health and long term conditions on the practice website

Practice nurses had specialist training and skills, for example in the treatment of lung disease, diabetes and travel vaccinations. This enabled nurses to advise patients about the management of their own health in these specialist areas.

The practice had a good knowledge of all their patients with a learning disability. Patients with a learning disability were offered a physical health check; the practice had carried out these checks for approximately 80% of these patients either in their own home or at the practice. Additionally the practice staff knew those patients in vulnerable circumstances such as the homeless. Practice staff were aware of the physical barriers to healthcare experienced by these groups of patients.

The practice offered a full range of immunisations for children and data showed that the practice had vaccinated a high percentage of eligible children. The practice offered flu vaccinations in line with current national guidance and had vaccinated over 75% of those aged 65 and older.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

During our inspection we spoke with 12 patients and reviewed 34 comment cards. The majority of patients were complementary about the care that they received from all the practice staff, however two of the comments cards made reference to some staff being abrupt or rude. We spoke with patients of varying ages. They all said that they had been dealt with courteously by all staff. We observed staff interacting with patients and we saw that patients were treated with dignity and respect.

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the NHS England GP patient survey, NHS Choices and the practice's latest satisfaction survey conducted in between November 2013 and February 2014 and the results of the Friends and Family test. The evidence from all these sources showed patients happy with the way they were treated and described the staff as polite, courteous and helpful. The NHS GP patient survey showed that 92.9% of those who responded rated their overall experience of the practice as either good or excellent. The majority of patients told us that the GP or nurse they saw listened to them and gave them enough time during their consultation, they did not feel rushed. The Friends and Family test results for February 2015 showed that 78% of patients who had commented would be likely or extremely likely to recommend the practice.

Staff told us how they respected patients' confidentiality and privacy. Some telephone calls were made and answered by staff who were not sitting at the reception desk. This helped keep patient information private and ensured that confidential information could not be overheard. There were signs at the reception desk to inform patients that a room was available should they have anything they wished to discuss in private and that there were facilities for breastfeeding for those that wished to use them. However during our observations we heard a member of reception staff discussing directions for a patient to provide a urine sample for testing.

Reception staff had taken part in information governance training in March 2013 and a date for refresher training in March 2014 had not taken place. Those we asked were able to demonstrate how they ensured patients' privacy and confidentiality was maintained.

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.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example, data from the national patient survey showed 90% of practice respondents said the GP involved them in care decisions and 92% felt the GP was good at explaining treatment and results. Both these results were broadly in line with the average for other practices in the Isle of Wight clinical commissioning group area.

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

Staff told us that translation services were available for patients who did not have English as a first language. The practice had staff available to communicate in three languages other than English.

Patient/carer support to cope emotionally with care and treatment

The practice ensured that the out of hours service was aware of any information regarding patients' end of life needs and ensured they received specific patient notes. This included individualised information about patients' complex health, social care or end of life needs. The practice supported their patients with end of life care in their own home if it was the patients wish to die at home rather than in hospital.

Good

Are services caring?

The patients we spoke with on the day of our inspection and the comment cards we received highlighted that staff responded compassionately when they needed help and provided support when required.

Indicators were on patients' records to show whether the patient was a carer or was cared for by another person. This system allowed GPs to provide further information of their responsibilities or the support they required. GPs were aware of the support organisations available for carers and ensured they understood the various avenues of support available to them. The practice website gave carers information about the support available to them and those they cared for. Notices in the patient waiting room told people how to access a number of support groups and organisations.

Staff told us that if families had suffered bereavement, the practice sent a letter of condolence to the family. This was signed by the GP who had been most recently involved in the patients care. This offered families a consultation at a flexible time and location to meet the family's needs where GPs were able to provide advice on how to find a support service.

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 patients' 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.

All patients over 75 had a named GP in line with current recommendations. Whenever possible patients were offered the GP of their choice.

The practice was aware of the practice population in respect of age, culture, and number of patients with long term conditions. The practice had responded to the needs of the practice population.

The practice worked collaboratively with The Isle of Wight Clinical Commissioning Group (CCG) and other practices to discuss local needs and service improvements that needed to be prioritised.

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 practice had purchased staff identification notice boards for the practice and had provided chairs with arms for the waiting room and each consulting room.

The NHS England Area Team and the CCG told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised.

Tackling inequity and promoting equality

The practice had suitable arrangements in place to protect patients' confidentiality. Staff we spoke with were aware of Gillick competence when asked about treating teenage patients. (Gillick competence is a term used in law to determine whether a patient aged under 16 is able to consent to their medical treatment, without the need for parental permission or knowledge).

The practice premises were accessible to patients who were wheelchair users or required walking aids. There were a number of consulting rooms on the ground floor but only one with level access from outside. For those patients who could not negotiate steps arrangements were made for their GP to use this room for their consultation. The reception desk was at a high level which could represent a barrier to patients who used wheelchairs.

Baby changing and disabled toilet facilities were available and accessible to all patients.

Staff had access to a language line if needed for patients whose first language was not English and needed an interpreter.

Access to the service

For patients of working age or for patients who could not attend during normal working hours the practice had extended hours opening until 7.00 pm every Monday and from 7.15 am on Thursdays. Patients could also be seen at the branch surgery at Wootton Bridge on Saturday mornings but for pre booked appointments only. Nurse appointments were available each day until 6.30pm. During our inspection we spoke with 12 patients and reviewed 34 comment cards, most commented positively on the availability of appointments, how quickly their telephone calls were answered and waiting times once they were at the practice. However some patients found that it was sometimes difficult to get an appointment with the GP of choice at a time to suit them. Those we spoke with were happy that if they needed an urgent appointment they would be seen the same day.

The practice did not close at lunchtime and was open from 8 am Monday, Tuesday, Wednesday and Friday with appointments available from 8.15 am and was open from 7 am on Thursdays. Routine appointments could be booked on line or by telephone. Patients were able to access same day appointments if medically necessary but those we spoke with understood that if they wanted to see a specific GP there may be a wait of a number of days.

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits and how to book appointments through the website. There were also arrangements 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

Good

Are services responsive to people's needs?

(for example, to feedback?)

should ring depending on the circumstances. Information on the out of hours service was provided to patients. This service was provided by Island Health Line and accessed through the 111 service.

Longer appointments were also available for people who needed them and those with long-term conditions. This also included appointments with a named GP or nurse. Home visits were made to those patients who needed them.

Patients were generally 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. Comments received from patients showed that patients in urgent need of treatment had often been able to make appointments on the same day of contacting the practice. For example, three of the patients we spoke with told us they had contacted the practice that morning and had been given their appointment. One parent of a young child had called the practice and their child had been given an appointment immediately. They were pleased that their sick child had been prioritised for an urgent appointment.

The practice had a nurse practitioner who was available to see patients for minor illness. There was a practice leaflet available for patients which outlined the illnesses that could be dealt with by the nurse practitioner, this also provided guidance for reception staff when allocating appointments. GPs provided telephone consultations these were booked by the reception team and the GP would call the patient at the end of their surgery.

Listening and learning from concerns and complaints

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

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

We looked at the five complaints received in the last 12 months and found that these had been dealt with appropriately and in a timely manner. The responses from the practice had included appropriate explanations and apologies where necessary.

The practice reviewed complaints to look for themes or trends. Although no themes or trends had been identified lessons learned from individual complaints had been acted on. For example following one complaint the practice had met with the local CCG to create a local protocol for mental health referrals, to be shared with all the Island's GPs.

Although complaints were shared with staff groups involved there was no recorded forum for discussion to show that all complaints had been openly shared for learning.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a vision statement, which was to deliver high quality, patient focused healthcare through a dedicated team of skilled, helpful professionals. The practice vision statement was displayed in the reception area.

GPs and staff told us there was an open culture and they all worked as a team. Each person we asked felt valued as part of their team and the wider practice. Decisions were made democratically and patient care was delivered consistently by GPs or shared if this benefitted patients.

We spoke with five GPs, two practice nurses, a healthcare assistant, the practice manager and their deputy and a number of reception and administration staff. They all knew and understood the practice values and knew what their responsibilities were in relation to these.

All staff felt able to make suggestions to improve outcomes for patients and would be happy to speak to any GP or the practice management team if they felt a process or system could be improved. GPs and nursing staff used clinical meetings, information from external meetings, personal research and advice from other healthcare professionals to share and discuss information to improve effective patient care.

The practice worked with other practices and the Isle of Wight clinical commissioning group towards providing improved services for their patients.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity.

There was a leadership structure with named members of staff in lead roles. We spoke with members of staff and they were all clear about their own roles and responsibilities. Staff that we spoke with told us they felt valued, well supported and knew who to go to in the practice with any concerns.

However procedures for managing infection control failed to meet the standards set out in the code of practice on the prevention and control of infections and related guidance. Staff had not completed a full audit of infection control procedures but had made a number of checks of the premises and had identified shortfalls which we were told had been escalated to the GP partners. At the time of our inspection these had not been addressed by the partners who were also unaware that a complete audit had not been completed.

The practice used the Quality and Outcomes Framework (QOF) to measure their performance and to monitor the effectiveness of some aspects of the practice. The QOF data for this practice showed it had achieved 93% of their target. Administration staff told us they had regular discussions with the GP partners to ensure they were constantly aware of the practice performance.

The practice manager told us that they met with other practice managers from the Island each month. This gave the practice the opportunity to measure their service against others and work collaboratively to identify best practice.

Clinical audits had been undertaken by the practice GPs. We saw evidence of completed audit cycles but these were from previous years. Although the practice had analysed performance in certain areas, they acknowledged that clinical audit cycles had not always been completed due to recent pressures of opening the new branch.

The practice manager and GP partners used the information from incidents and significant events to minimise risk by identifying trends and themes that may affect care and service quality. However the systems in place did not ensure that staff training was appropriately monitored and shortfalls acted upon, for example in relation to training updates.

We spoke with GPs who told us they had protocols in place for the management and review of pathology results. There was a system in place to review test results when a GP was absent through illness, leave or because of a non-working day. This system had been agreed at a partnership management meeting. The practice made further changes to their protocol and ensured this was cascaded to other practice staff. This system was revised to ensure there was no delay in the diversion of pathology results and they could be reviewed the day they were received.

GPs told us that they had made their arrangements for their revalidation. They held their own records. The practice did not keep a record of the dates of GPs revalidation.

Are services well-led?

Good

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

Leadership, openness and transparency

The practice had clear leadership from the GP partners who had lead roles in areas of clinical practice, for example; dementia, diabetes and mental health. Some lead roles were shared with practice nurses. Practice nurses supported the lead GPs in managing chronic disease and there was a lead nurse for infection control.

The practice held monthly clinical meetings and weekly management meetings. The practice manager took minutes of these meetings and we were told these were distributed to any GP or nurse who was not able to attend. Information was cascaded as necessary to other staff groups who told us they felt well informed and that communication within the practice was good. Vision and strategy meetings were held by the GP partners every three months however these did not include the practice manager. Reception and administration staff had weekly team meetings.

The practice manager was responsible for the day to day running of the service and assessing, monitoring and developing non-clinical staff whose roles were in reception or administration.All the staff we spoke with told us they felt very well supported by the GP partners and the practice manager.

All staff confirmed there was an open culture and felt able to go to any senior staff member with any problems, concerns or ideas. All staff were clear about their roles and responsibilities and that they were provided with opportunities for development and training, appraisals were carried out annually. Although we found there were some gaps in the training of staff in certain areas. Staff informed us that communication within teams and across the service was good with information shared appropriately and that they felt valued.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example the recruitment policy, data protection and health and safety, which were in place to support staff.

Seeking and acting in feedback from patients and staff

The practice had gathered feedback from patients and through the family and friends survey. The results of the survey were publicised by the reception desk. The survey indicated that in January 52 patients had responded to the survey and that all of these patients had indicated that they were either very likely or likely to recommend the practice to their family and friends. The practice website recorded the results for February which showed that 27 completed forms showed that 23 were likely or very likely to recommend the practice.

The practice had gathered feedback from staff through discussion. Staff told us that they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. One member of staff told us that as staff were located across two sites they did not meet regularly as a whole team. This had been identified as a concern and we were told that the practice had addressed this by implementing team meetings on a weekly basis during lunchtime. There was no protected time for all staff from both sites to hold a meeting during working hours.

Staff told us the practice supported them to maintain their clinical professional development through training and mentoring. We spoke to staff who told us they received appraisals annually Staff told us that the practice was very supportive of training. One GP told us they had attended specific training in diabetes management which was provided on the island. This training was also attended by nursing staff who undertook diabetes management as part of their role.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Systems in place for managing infection control did not include procedures to monitor the cleaning of carpets and privacy curtains. An infection control audit had not been carried out, although shortfalls in relation to infection control had been identified these had not been acted on. An annual infection control statement had not been produced. The practice had not assessed the risks relating to Legionella. How the regulation was not being met: The provider had not assessed the risk of, and preventing, detecting and controlling the spread of, infections, including those that are health care associated. This was a breach of Regulation 12 (2)(h) of the Health and Social Care Act 2008 (Regulated Activities Regulations 2014 which corresponds to Regulation 12 (1) (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010,