Dr S Johal & Partner

Quality Report

Oakland Medical Centre, 32 Parkway, Hillingdon,
Tel: 01895 237411
Website: www.oaklandmedical.co.uk

Date of inspection visit: 7 April 2015
Date of publication: 02/07/2015

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?	Requires improvement
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 carried out an announced comprehensive inspection at 9:00 am on 7 April 2015. Overall the practice is rated as requires improvement.

Specifically, we found the practice to be good for providing caring and responsive services and requires improvement for providing safe and effective services and for being well led. We rated the practice as requires improvement for the care provided to older people and people with long term conditions and requires improvement for the care provided to, families, children and young people, working age people (including those recently retired and students), people living in vulnerable circumstances and people experiencing poor mental health (including people with dementia).

Our key findings were as follows:

- Data showed patient outcomes were at or above average for the locality.
- Staff understood their responsibilities to raise safety concerns, and to report incidents.
- Patients said they were treated with compassion, dignity and respect.
- Patients said they found it reasonably easy to make an appointment.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- Information about how to complain was available and evidence showed that the practice responded quickly to issues raised.
- The practice sought feedback from patients and had acted on it.

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

Importantly, the provider must:

- Ensure all staff have up to date training in child protection and safeguarding vulnerable adults.
- Ensure leads are appointed for child protection and safeguarding vulnerable adults and staff are aware of who to report to with specific concerns.

Summary of findings

- Ensure clinical staff are up to date with the key principles of the Mental Capacity Act 2005 and how they are implemented in the practice.
- Carry out criminal record checks or a risk assessment on non-clinical staff who act as chaperones.
- Ensure all staff receive infection prevention and control training on induction and at regular intervals thereafter.
- Ensure a lead is appointed for infection prevention and control, and staff are aware of who to report to with specific concerns.

In addition the provider should:

- Ensure the business continuity plan is reviewed annually.
- Formalise induction training for new members of staff.
- Share the practice's vision with all staff and develop a strategy to deliver it.
- Ensure all practice policies and procedures are updated annually.
- Ensure the patient leaflet is updated.
- Develop a clear leadership structure with named members of staff in lead roles.
- Provide training for all staff in equality and diversity to raise awareness of equality and diversity issues within the practice.
- Ensure written, annual appraisals are undertaken for all staff to assess performance and identify training and development needs.
- Introduce regular staff meetings and ensure all meetings are minuted with actions.
- Introduce a system to disseminate new clinical guidelines and medicine updates within the practice.
- Ensure all staff receive basic life support training on an annual basis in line with UK Resuscitation Council guidelines.
- Provide staff with training in fire safety.

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 safety concerns, and to report incidents. Lessons learned were communicated with the appropriate staff to support improvement. Safeguarding procedures were in place however they were not robust. We found some staff had not received up to date training in child protection and no staff had received training in safeguarding vulnerable adults. Staff were not aware of who to report to within the practice with safeguarding concerns and criminal record checks had not been sought for non-clinical staff who acted as chaperones. Staff had not received training in infection prevention and control and there was no designated lead responsible for infection control within the practice. We also found that basic life support training was not completed annually by staff in line with the UK Resuscitation Council guidelines.

Are services effective?

Requires improvement

The practice is rated as requires improvement for providing effective services. Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from National Institute for Health and Care Excellence (NICE) and used it routinely. Patient's needs were assessed and care was planned and delivered in line with current legislation. However, we found staff were not up to date with the key principles of the Mental Capacity Act 2005. Staff had received training, however not all mandatory training was up to date. There was some evidence of appraisals for staff but they had not been undertaken consistently. Staff worked with multidisciplinary teams to provide care for patients with complex needs.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice higher than other practices in the locality 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 and respect, and maintained confidentiality.

Summary of findings

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 England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients said they found it reasonably easy to make an appointment, however not always with their preferred GP. They said 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. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised.

Are services well-led?

Requires improvement

The practice is rated as requires improvement for being well-led. The practice had a vision, however there was no strategy to deliver it and the vision was not shared with all staff. There was no clear leadership structure, not all staff felt supported by management and at times they weren't sure who to approach with issues. The practice had a number of policies and procedures to govern activity, but some of these were overdue a review. The practice proactively sought feedback from patients and had an active patient participation group (PPG). We were told that all staff had received inductions. However these were not documented and not all staff had received regular performance reviews. Staff meetings were infrequent.

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 practice is rated as requires improvement for the care of older people.

The practice had a higher than National average number of older patients. The percentage over 75 years was 9.4% and over 85 years was 2.7% (National average 7.6% and 2.2% respectively). This population group were encouraged to attend five yearly NHS health checks to assess their risk of cardiovascular disease with the aim of identifying and modifying any risk factors. The practice had recently purchased a blood pressure machine to allow patients to opportunistically measure their blood pressure.

Longer appointments were available for older patients and multidisciplinary meetings were held monthly to plan care for older patients.

The provider was rated as good for caring and responsive overall and this includes for this population group. The provider was rated as requires improvement for safety, effectiveness and for well-led. The concerns which led to these ratings apply to everyone using the practice, including this population group.

People with long term conditions

Requires improvement

The practice is rated as requires improvement for the care of people with long-term conditions.

The percentage of patients at the practice with a long standing health condition or with health related problems in daily life were 48.4% and 41.2%. These were lower than the England averages of 54% and 48.8%. The practice kept a register of all patients with long-term conditions such as diabetes, coronary heart disease, heart failure, asthma and chronic obstructive pulmonary disorder (COPD). There was a dedicated diabetic nurse who had completed the Warwick course (a nationally recognised course of study) on more in-depth management of type 2 diabetes including initiating insulin. The nurse pro-actively reviewed patients with diabetes and ran a dedicated diabetic clinic affording longer 30 minute consultations to provide a holistic approach to their management.

The practice conducted annual reviews of all patients with cardiovascular disease with the aim to reduce modifiable risk factors such as smoking, cholesterol, blood pressure, weight and lifestyle. The health care assistant ran a dedicated smoking cessation clinic and patients with long-term conditions who smoked were encouraged to attend the clinic.

Summary of findings

The care of patients with chronic diseases and significant co-morbidities (one or more additional diseases) were discussed on a monthly basis at in-house multidisciplinary meetings involving other health care professionals.

The provider was rated as good for caring and responsive overall and this includes for this population group. The provider was rated as requires improvement for safety, effectiveness and for well-led. The concerns which led to these ratings apply to everyone using the practice, including this population group.

Families, children and young people

Requires improvement

The practice is rated as requires improvement for the care of families, children and young people.

The practice had a lower number of children aged 0 to 4 years compared to the National average (5.5% compared to 6%) and a higher number of children aged 5 to 14 years compared to the National average (11.4% compared to 11.8%). The practice's childhood immunisation uptake was higher than the local CCG average. The practice provided child health surveillance including the six-week developmental check.

The practice provided family planning guidance and over the last year had started to provide intrauterine contraceptive and implant services to patients. The practice actively promoted these services both on the practice website and with notices in the patient waiting room. A GP had advanced training in specialised contraception service which included the fitting of intrauterine contraceptive devices (IUCDs).

The provider was rated as good for caring and responsive overall and this includes for this population group. The provider was rated as requires improvement for safety, effectiveness and for well-led. The concerns which led to these ratings apply to everyone using the practice, including this population group.

Working age people (including those recently retired and students)

Requires improvement

The practice is rated as requires improvement for the care of working age people (including recently retired and students).

The percentage of patients in paid work or full time education was 68.5% which was higher than the national average of 60.2%. The practice provided an extended hour's service on Mondays, Tuesdays and Thursdays, offering both routine and urgent appointments with the GPs and nurses to help improve access for patients. Appointments and repeat prescriptions could be accessed online for those of working age. Telephone consultations were also available for those who could not attend the practice during working hours.

Summary of findings

The provider was rated as good for caring and responsive overall and this includes for this population group. The provider was rated as requires improvement for safety, effectiveness and for well-led. The concerns which led to these ratings apply to everyone using the practice, including this population group.

People whose circumstances may make them vulnerable

Requires improvement

The practice is rated as requires improvement for the care of people whose circumstances may make them vulnerable.

The practice kept a register of patients with learning disabilities and conducted annual physical health checks for these patients providing them and their carers with a tailored care plan.

The practice had a "primary care navigator" attached to the practice two days a week who encouraged the practice to use social care networks and support groups to help manage vulnerable patients. The primary care navigator, as well as meeting patients at the practice, conducted home visits to patients and their families.

The practice had access to online and telephone translation services for those patients who first language was not English including British Sign Language.

The provider was rated as good for caring and responsive overall and this includes for this population group. The provider was rated as requires improvement for safety, effectiveness and for well-led. The concerns which led to these ratings apply to everyone using the practice, including this population group.

People experiencing poor mental health (including people with dementia)

Requires improvement

The practice is rated as requires improvement for the care of people experiencing poor mental health (including people with dementia).

The primary care navigator provided support for patients with dementia and cognitive impairment through the use of local resources such as admiral nurses (specialist dementia nurses who give practical and emotional support to people living with dementia, their family and carers), respite care, carer's support services and befriending schemes.

The practice had an onsite counsellor from the Improved Access to Psychological Therapies (an NHS programme providing services across England offering interventions approved by the National Institute of Health and Clinical Excellence (NICE) for treating people with depression and anxiety disorders). The practice also liaised with local mental health link workers to support patients experiencing poor mental health.

Summary of findings

Data from QOF indicated the practice exceeded both CCG and National averages for the 10 indicators for mental health.

The provider was rated as good for caring and responsive overall and this includes for this population group. The provider was rated as requires improvement for safety, effectiveness and for well-led. The concerns which led to these ratings apply to everyone using the practice, including this population group.

Summary of findings

What people who use the service say

We spoke with six patients during our inspection including two members of the Patient Participation Group (PPG). We reviewed one CQC comment card which had been completed by a patient prior to our inspection, data from the 2014 National GP Patient Survey, and the practice patient participation survey conducted in 2013/14. Data from the National Patient Survey showed that 82% of respondents would recommend the practice to someone new in the area, which was above the local Clinical commissioning Group (CCG) average of 70%. Patients also rated the practice higher than others in the locality for several aspects of care, including their experience of making an appointment and being able to see their preferred GP. This aligned with the PPG survey where the majority of respondents rated the overall service provided as 'excellent' or 'very good'.

Some feedback was less positive. For example data from the national patient survey showed that only 34% of patients said they had to wait 15 minutes or less after their appointment time to be seen which was considerably lower than the local CCG average of 65%. This was also confirmed by patients we spoke with on the day of our inspection.

Areas for improvement

Action the service MUST take to improve

- Ensure all staff have up to date training in child protection and safeguarding vulnerable adults.
- Ensure leads are appointed for child protection and safeguarding vulnerable adults and that staff are aware of who to report to with specific concerns.
- Ensure clinical staff are up to date with the key principles of the Mental Capacity Act 2005 and how they are implemented in the practice.
- Carry out criminal record checks on non-clinical staff who act as chaperones.
- Ensure all staff receive infection prevention and control training on induction and at regular intervals thereafter.
- Ensure a lead is appointed for infection prevention and control and staff are aware of who to report to with specific concerns.

Action the service SHOULD take to improve

- Ensure the business continuity plan is reviewed annually.
- Formalise induction training for new members of staff.
- Share the practice's vision with all staff and develop a strategy to deliver it.
- Ensure all practice policies and procedures are updated annually.
- Ensure the patient leaflet is updated.
- Develop a clear leadership structure with named members of staff in lead roles.
- Provide training for all staff in equality and diversity to raise awareness of equality and diversity issues within the practice.
- Ensure written, annual appraisals are undertaken for all staff to assess performance and identify training and development needs.
- Introduce regular staff meetings and ensure all meetings are minuted with actions.
- Introduce a system to disseminate new clinical guidelines and medicine updates within the practice.
- Ensure all staff receive basic life support training on an annual basis in line with the UK Resuscitation Council guidelines.
- Provide staff with training in fire safety.

Dr S Johal & Partner

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector and included a GP who was granted the same authority to enter registered persons' premises as the CQC inspector.

Background to Dr S Johal & Partner

Dr S Johal and Partner (also known as Oakland Medical Centre) is situated at 32 Parkway, Hillingdon, Middlesex, UB10 9JX. The practice provides primary medical services through a General Medical Services (GMS) contract to approximately 6600 patients living within the local area (GMS is one of the three contracting routes that have been made available to enable commissioning of primary medical services). The practice is part of the NHS Hillingdon Clinical Commissioning Group (CCG) which is made up of 48 GP practices. The practice population is culturally diverse and has a much higher middle-aged and elderly patient population across both genders whilst also having lower than average numbers for the younger age groups and children compared to local and national averages. Life expectancy is 84 years for males and 80 years for females which is higher than the National average, and the local area is the third least deprived in the Hillingdon CCG (people living in more deprived areas tend to have greater need for health services).

The practice team consists of two male GP partners, two female salaried GP, four locum GPs, two nurses, locum advanced nurse practitioner, health care assistant, practice manager and a team of reception/administration staff.

The practice offer a wide range of clinics and services including diabetes management, family planning, minor surgery, antenatal and maternity care. Services provided by the nurses and/or healthcare assistant include blood pressure clinics, long-term condition checks, cervical smears, child immunisations, travel vaccinations, family planning, ear syringing and dressings. The practice has links with counselling services, mental health workers and specialist cancer nurses. The practice is also a local hub for the community ophthalmology service (a branch of medicine that deals with the anatomy, physiology and diseases of the eye).

The service is registered with the Care Quality Commission to provide the regulated activities of diagnostic and screening procedures, treatment of disease, disorder and injury, surgical procedures, family planning and maternity and midwifery services.

The practice's opening hours are 8:50 am to 6:30 pm weekdays and closed at weekends. Appointments are available 8:50 am to 12:15 pm and 2:15 pm to 6:00 pm on weekdays with extended hours on Mondays 6:30 pm to 8:00 pm and Tuesdays and Thursdays 6:30 pm to 7:00 pm. The practice has opted out of providing out-of-hours services to their own patients which is provided by Harmoni, a local out-of-hours service. Appointments can be booked online, by telephone or in person and prescriptions ordered online.

Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health

and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014. This provider had not been inspected before and that was why we included them.

How we carried out this inspection

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

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

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

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

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 7 April 2015. During our visit we spoke with a range of staff including two GPs, a nurse, health care assistant, four reception/administration staff and spoke with six patients who used the service two of whom were members of the Patient Participation Group (PPG). We also reviewed one Care Quality Commission (CQC) comment card completed by a patient prior to our inspection. We observed how people were being cared for and talked with carers and/or family members and reviewed the personal care or treatment records of patients.

Requires improvement

Are services safe?

Our findings

Safe track record

The practice used some information to identify risks and improve patient safety. For example, reported incidents 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. For example one incident we reviewed involved misplaced patient notes. The incident had been reported and the patient's notes located the following day. The practice took action to ensure staff were more careful when handling patient's notes.

We reviewed safety records, incident reports and significant event analysis summaries where these were discussed for the last 12 months. This showed the practice had managed these over this period of time and so could show evidence of a safe track record.

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 12 months and we were able to review these. There was evidence from significant event analysis summaries that the practice had learned from these and that the findings were shared with relevant staff.

We were shown the system used to manage and monitor incidents. Incidents were logged on incident forms located on the practice computer system. We tracked two incidents and saw records were completed in a comprehensive and timely manner. We saw evidence of action taken as a result. For example, one incident involved an error with the allocation of appointments resulting in a shortage of GPs to cover. The extra appointments had not been put onto the computer system by the practice manager because they were off work and reception staff did not know how to do this in their absence. The GPs took action to ensure reception staff received training so it would not happen again. We saw evidence that learning was shared with all the relevant staff. We also noted that NHS national patient safety alerts were disseminated via email by the practice manager to practice staff and acted on.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults however safeguarding training had not been updated consistently. We looked at training records which showed that all staff had received relevant role specific training in safeguarding. Clinical staff were trained to Level 3 and non-clinical staff to Level 1 in child protection. Although staff had received training in child protection not all staff had attended regular update courses. For example, we found one clinical staff member had not received an update since 2010 and another since 2011. We also found one non-clinical staff member had not been updated since 2007. There was no evidence that staff had received training in safeguarding vulnerable adults.

Staff we spoke with had a basic understanding of how to recognise signs of abuse in older people, 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. Contact details were easily accessible.

The practice did not have appointed dedicated GPs as leads in safeguarding vulnerable adults and children. Staff were not clear on who the responsible person was in the practice if they had safeguarding concerns. They said that they would speak to whoever was available at the time.

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 subject to child protection plans.

There were chaperone notices displayed on the consulting room doors offering patients the choice of a chaperone if circumstance required. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). All nursing staff, including health care assistants, had been trained to be a chaperone. Reception staff would act as a chaperone if nursing staff were not available. Receptionists had also undertaken training and understood their responsibilities when acting as chaperones, including

where to stand to be able to observe the examination. However, we found that the practice had not completed criminal record checks via the Disclosure and Barring Service (DBS) for non-clinical staff acting as chaperones.

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 included the action to take in the event of a potential failure. The practice staff followed the policy. We found that all vaccines were stored within the correct temperature range.

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. There were no Controlled Drugs on the premises.

The nurses administered vaccines using directions that had been produced in line with legal requirements and national guidance. We saw examples of Patient Group Directions (PGDs) and evidence that nurses had received appropriate training to administer vaccines. We also saw examples of Patient specific Directions (PSDs) for the healthcare assistant to administer vaccines and that they were appropriately trained (PGDs and PSDs are written instructions from a GP for non-prescribing health care professionals to legally administer medicines).

All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

Cleanliness and infection control

We observed the premises to be clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

The practice did not have a lead for infection control who took overall responsibility for infection control within the practice. There was no evidence that staff had received induction training about infection control specific to their role, and no evidence of regular update training in infection control for any staff.

We saw evidence that an infection control audit had been carried out, however it was not dated. The practice nurse told us the audit had been completed in 2014. We found that any improvements identified for action were completed. For example, the audit highlighted that hand wash posters were not displayed next to sinks for patients and staff to reference. During our inspection we found that this had been actioned.

An infection control policy was available for staff to refer to on the shared drive of the practice computer system which enabled them to plan and implement measures to control infection. For example, the policy included guidance on the use of personal protective equipment such as disposable gloves, aprons and coverings. There was also a policy for needle stick injury and staff knew the procedure to follow in the event of an injury.

Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms.

The practice had a policy for the management, testing and investigation of legionella (a bacterium that can grow in contaminated water and can be potentially fatal).We saw records that confirmed the practice was carrying out regular checks in line with this policy 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 displayed stickers indicating the last testing date which was within the last year. We saw evidence of calibration of relevant equipment; for example weighing scales, spirometers, blood pressure measuring devices and the fridge thermometer.

Staffing and recruitment

Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to

employment for all staff including locums. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal record checks through the Disclosure and Barring Service (DBS). The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. However, we found criminal record checks had not been completed for non-clinical staff acting as chaperones.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. There was also an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual leave. Staff told us there were usually enough staff to maintain the 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 annual and monthly checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment.

The practice also had a health and safety policy. Health and safety information was displayed for staff to see and there was an identified health and safety representative.

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, however this had not been updated since March 2013 which was not in accordance with the UK Resuscitation Council guidelines which recommend annual updates. 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.

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 (severe allergic reaction) and hypoglycaemia (low blood sugar). Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained contact details. For example, the company to call in the event that the heating system failed. However, we noted that although the business continuity plan was detailed, it had not been reviewed since 2011. Therefore the practice could not be assured that all the contact details were up to date.

The practice had carried out a fire risk assessment that included actions required to maintain fire safety. Records showed that staff had practised regular fire drills and information on the use of fire extinguishers was displayed for staff to reference.

Requires improvement

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nurses we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. However, there was no system in place to disseminate new guidelines within the practice, although 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 GP partners shared responsibility for 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. The practice had a dedicated nurse for the management of diabetes and a second nurse specialising in asthma and chronic obstructive pulmonary disorder (COPD) checks.

A GP partner showed us data from the local CCG of the practice's performance for antibiotic prescribing, which was comparable to other practices in the locality. The practice followed current guidelines on antibiotic prescribing and received updates from the CCG medicine management team. However, there was no system in place to disseminate updates within the practice therefore it was unclear how these were actioned by the GPs.

The practice used computerised tools to identify patients with complex needs who had multidisciplinary care plans documented in their case notes. The practice had care plans in place for 2% of at risk patients as recommended by the unplanned admissions enhanced service (enhanced services require an enhanced level of service provision above what is normally required under the core GP contract).

The GPs we spoke with used national standards for referrals including urgent two week wait referrals for suspected cancer. Data showed that the practice's referral rates to secondary care were high when compared to the local CCG average. The GPs told us they we aware of this and they had recently introduced an in house peer review system to bring referral rates in line with other local practices. However, at the time of our inspection it was too early to assess the impact of this on referral rates. Outpatient attendances were also high compared to the local CCG average.

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 two clinical audits that had been undertaken in the last 12 months. Both of these were completed audit cycles where the practice was able to demonstrate the changes resulting since the initial audit.

The first audit was carried out to monitor the prescribing of omega-3 supplements. The objective of the audit was to assess that omega-3 prescribing met British National Formulary (BNF) and NICE guidance. Eleven patients on omega-3 supplements were identified and assessed and actions agreed to ensure guidance was being followed. A re-audit carried out in the following year highlighted that omega-3 supplements were no longer recommended by NICE guidance. As a result the patients on omega-3 supplements were invited in for a medication review and their medication changed. The second audit we reviewed was carried out to monitor the effectiveness of a medicine used to treat diabetes and ensure prescribing requirements were being met.

The practice had achieved 95% in their Quality and Outcomes Framework (QOF) performance in 2013/14 which was 3.6% above the local CCG average and 1.4% above the National average (QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). The practice scored above the local CCG/National averages for a number of disease areas including asthma, chronic obstructive pulmonary disorder (COPD), hypertension and rheumatoid arthritis. However, the practice had scored 6.2% below the local CCG average and 9.2% below the National average for diabetes. A GP partner told us that the poor performance in diabetes was likely due to patient's reluctance to begin insulin therapy. However we found the practice had no clear strategy in place to improve performance.

Requires improvement

Are services effective?

(for example, treatment is effective)

The practice kept a register of all patients with chronic diseases such as diabetes, coronary heart disease, heart failure, asthma and COPD and had completed annual reviews for them. The nurse told us that patients with diabetes were pro-actively called in to the practice for annual reviews or reviewed at other times according to their needs. The nurse also provided dedicated diabetic clinics to provide a holistic approach to the management of their condition.

There was a protocol for repeat prescribing which was in line with national guidance. Staff regularly checked that patients receiving repeat prescriptions had been reviewed by a 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 IT system flagged up relevant medicines alerts when the GP was prescribing medicines. We saw evidence to confirm that, after receiving an alert, the GPs had reviewed the use of the medicine in question and, where they continued to prescribe it, outlined the reason why they decided this was necessary. The evidence we saw confirmed that the GPs had oversight and a good understanding of best treatment for each patient's needs.

The practice also participated in local benchmarking run by the CCG. This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area. This benchmarking data showed the practice was comparable to other services in the area for antibiotic prescribing although referral rates and outpatient attendances were high.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that not all staff were up to date with attending mandatory courses. For example, annual basic life support and safeguarding children required updating. We also found no evidence of formal training in safeguarding vulnerable adults, infection control or fire safety.

We noted a good skill mix among the doctors with GPs having special interests in diabetes, cardiology and women's health. One GP had advanced training in specialised contraception service which included the fitting of intrauterine contraceptive devices (IUCDs). 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 and remain on the performers list with NHS England).

We were told that annual appraisals had not been undertaken for staff for some time and a new appraisal system had been recently introduced. On the day of our inspection we found appraisals had not been undertaken for all staff. For example, the practice nurse had received an appraisal one week prior to our inspection, however the health care assistant (HCA) had not received an appraisal for the last three years. We also found that annual appraisals were not undertaken for all non-clinical staff.

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. The practice also had a dedicated diabetic nurse who had undertaken the Warwick course on more in-depth management of type 2 diabetics including initiating insulin.

Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and manage those of patients with complex needs. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. The practice had procedures in place to ensure that all relevant staff met their responsibilities for passing on, reading and acting on any issues arising from communications with other care providers on the day they were received. The GP who saw these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well. There were no instances identified within the last year of any results or discharge summaries that were not followed up appropriately.

The practice held multidisciplinary team meetings monthly to discuss the needs of complex patients, for example those with end of life care needs or children on the at risk register. These meetings were attended by district nurses, social workers, palliative care nurses and the primary care navigator.

Requires improvement

Are services effective?

(for example, treatment is effective)

Information sharing

The practice had systems in place 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 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 has also signed up to the electronic Summary Care Record (Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours). Information for patients in relation to Summary Care Records was available on the practice website including a form for patients to complete if they wished to opt out.

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record to coordinate, document and manage patients' care. All staff were fully trained on the system, and commented positively about the system's safety and ease of use. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004. However, not all clinical staff we spoke with were up to date with the key parts of the legislation and how they implemented it in their practice. For example the GPs we interviewed were not up to date with the decision making process for acting in the best interests of patients who lacked capacity.

All clinical staff demonstrated a clear understanding of Gillick competencies (these are used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions).

There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures such as inserting intrauterine contraceptive devices (IUCDs), a patient's written consent was documented in the electronic patient notes with a record of the relevant risks, benefits and complications of the procedure. Written consent was also sought for minor surgical procedures.

Health promotion and prevention

The practice had met with the Public Health team from the local authority and the CCG to discuss the implications and share information about the needs of the practice population identified by the Joint Strategic Needs Assessment (JSNA). The JSNA pulls together information about the health and social care needs of the local area. This information was used to help focus health promotion activity.

It was practice policy to offer a health check with the health care assistant / practice nurse to all new patients registering with the practice. The GP was informed of all health concerns detected and these were followed up in a timely way. We noted a culture among the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering smoking cessation advice to smokers.

Patients aged 40 to 75 years were encouraged to attend a five yearly, NHS health check to assess their risk of cardiovascular disease with the aim of identifying and modifying any risk factors. This was undertaken by the health care assistant and practice nurse as well as the GPs. The practice had also recently purchased a blood pressure machine available in the waiting room to allow patients to opportunistically measure their blood pressure. We were told this had been widely utilised and patients were encouraged to use this machine, record their readings and bring them to reception where they were scanned into patient notes. Practice data we reviewed showed that 41% of patients in this age group had taken up the offer of a health check in the previous year.

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. The practice had 15 patients on the register and all had received an annual physical health check in the last 12 months. The practice had also identified the smoking status of patients over the age of 16 and actively offered health care assistant (HCA) smoking cessation clinics to these patients. Data showed that all smokers identified for support including those smokers with long-term conditions

Requires improvement

Are services effective?

(for example, treatment is effective)

had received advice in the previous 12 months. However, the practice had not monitored the number of patients who had successfully managed to stop smoking after receiving support. The practice had achieved 95.3% of QOF points in the previous 12 months for smoking which was 1.9% above the local CCG average and 1.6% above the National average.

The practice's performance for cervical smear uptake was 78% in the previous 12 months. The practice had also achieved 98% of QOF points in the last 12 months for cervical screening. This was 7% above the local CCG average and 0.5% above the National average. The practice had achieved 100% of QOF points for obesity management which was 2.1% above the local CCG average and in line with the National average.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance for all childhood immunisations was above average for the CCG, for example 100% of children aged 24 months had received a 5 in 1 vaccination (polio, whooping cough, diphtheria, tetanus and Haemophilus influenzae type b) compared to the CCG average of 96% and 100% of children aged 5 years had received a Meningoccocal C vaccination compared to the CCG average of 93%.

Last year's performance for flu vaccination uptake was 78% for over 65s and 28% for under 65s.

The practice had achieved 100% of QOF points for child health surveillance in the previous 12 months which was 2.1% above the local CCG average and 1.2% above the National average.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey 2014 and a survey of 70 patients undertaken by the practice's patient participation group (PPG) in February 2014. The evidence from both these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. Data from the national patient survey showed that 82% of patients would recommend the practice to someone new in the area which was above the local CCG average of 70%. The national patient survey showed that 84% of patients described their experience of making an appointment as good and 70% of patients with a preferred GP usually get to see or speak to that GP. Both these results were well above the local CCG averages of 69% and 57% respectively. These results also aligned with the practice's PPG survey where 86% of patients rated their overall experience of the practice as 'excellent' or 'very good' and 97% of patients rated their overall experience as 'good' or 'very good'.

We received one completed CQC comment card to tell us what patients thought about the practice. The comment card we reviewed was not positive about the service experienced. Feedback highlighted that the patient was not always listened to by their GP. This feedback aligned with the national patient survey where 79% of patients said the last GP they saw or spoke to was good at listening to them which was below the local CCG average of 84%.

Patients we spoke with on the day of our inspection were generally satisfied with the practice however some patients told us that they often had to wait 20 minutes or more after their appointment time to be seen by the GP. This was reflected in the results of the national patient survey where only 34% of patients usually waited 15 minutes or less to be seen which was considerably lower than the local CCG average of 65%. Waiting times were also highlighted as an area for improvement in the practice's PPG survey. However it was not clear from the survey action plan how this was to be addressed.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Disposable curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation / 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. The practice had a separate room adjacent to the reception desk for patients to use if they wanted to speak with staff in private. Patient's paper medical records were kept secure in locked cabinet behind the reception area.

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

There was information in the patient leaflet stating the practice participated in the NHS "Zero Tolerance Campaign". Staff told that they did not tolerate abusive behaviour from patients and they would follow the practice's zero tolerance policy in these instances. We saw evidence from minutes that challenging patients had been discussed in the most recent practice meeting.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed a mixed response to questions about patient's involvement in planning and making decisions about their care and treatment. For example, data from the national patient survey showed 71% of practice respondents said the GP involved them in care decisions (which was below the local CCG average of 84%). The results from the practice's own satisfaction survey showed that only 67% of patients rated the GPs as 'very good' at involving them in decisions about their care. In contrast, patients we spoke with on the day of our inspection were more positive about these aspects of care. They said health issues were discussed with them and they felt involved in decision making about the care and treatment they received.

Good

Are services caring?

Staff told us that translation services were available for patients who did not have English as a first language including British Sign Language. We saw notices in the reception areas informing patents that interpreting services were available.

Patient/carer support to cope emotionally with care and treatment

The survey information we reviewed did not assess emotional support provided by the practice to patients. However, patients we spoke with said they had received help to access support services to help them manage their treatment and care when it had been needed. They said staff responded compassionately when they needed help and provided support when required.

Notices in the patient waiting room told patients how to access a number of support groups and organisations for example those organisations that offered support for patients with Alzheimer's disease. The practice's computer system alerted GPs if a patient was also a carer. We were shown the written information available for carers to ensure they understood the various avenues of support available to them, information for carers was also available on the practice website.

Staff told us that if families had suffered bereavement, their usual GP contacted them. Patients we spoke with who had had a bereavement confirmed they had received this type of support and said they had found it helpful. The practice liaised with specialist cancer nurses to support people through terminal illness and cancer and also had links with a local counselling service which patients were referred to in times of need.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

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

The practice engaged regularly with the NHS England Area Team and Clinical Commissioning Group (CCG) to discuss local needs and service improvements that needed to be prioritised. The practice had co-founded the "Wellcare Health Network", which comprised eight local practices with a combined population of over 51,000 patients. The practice had collaborated with other practices in the network on a number of initiatives such as providing out of hours Saturday morning surgeries during winter (when demand was high) to all patients in the network. We were told that other initiatives were being proposed including the recruitment of chronic obstructive pulmonary disorder (COPD) nurses to monitor and optimise the care of COPD patients both at the practice and in their homes, the recruitment of two community matrons to help manage patients in care homes and a further two primary care navigators to help reduce unplanned admissions.

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, as a result of feedback the practice had made available a room for patients waiting for a flu vaccination, more seats in the waiting room, a blood pressure machine and redecorating the practice.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example, the practice offered longer minute appointments for patients with a learning disability, those with long term conditions and older patients.

Patients whose first language was not English were encouraged to attend their appointments with a relative who spoke English and the practice had access to online telephone translation services for those patients who were not accompanied by a relative. Fact sheets were also available on the practice website in 21 different languages explaining the role of UK health services, the National Health Service (NHS), to newly-arrived individuals seeking asylum.

The practice offered temporary registration for up to three months for patients who fell ill when away from home, which allowed them to be on the patient list whilst remaining a patient of their permanent GP. A registration form was available on the practice website for this purpose.

We found the practice had not provided staff with any training to understand equality and diversity issues.

The premises and services had been adapted to meet the needs of patient with disabilities. The main entrance to the practice provided for full disabled access and there were lifts for disabled patients to access all floors. Toilet facilities had been adapted to accommodate wheelchair users and a low-level reception counter was in place. There was also a hearing loop for those patients who were hard of hearing. The waiting areas were spacious and could easily accommodate wheelchairs and mobility scooters. There was a children's play area in the waiting room and baby changing facilities were available.

Access to the service

The practice's opening hours were 8:50 am to 6:30 pm weekdays and closed at weekends. Appointments were available 8:50 am to 12:15 pm and 2:15 pm to 6:00 pm on weekdays with extended hours on Mondays 6:30 pm to 8:00 pm and Tuesdays and Thursdays 6:30 pm to 7:00 pm.

Information was available to patients about appointments in the patient leaflet and the practice website. This included how to arrange urgent appointments and home visits. Children were always treated as urgent and given appointments on the same day. Appointments could be made by telephone, in person or online. Telephone consultations were offered daily to those who needed one. 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 the out-of-hours service was provided to patients. Longer 15 minute appointments were also available for patients who needed them and 30 minute appointments for those with long-term conditions.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Patients we spoke with on the day of our inspection told us it was often difficult to get an appointment. However, this did not align with the national patient survey 2014 where 84% of patients described their overall experience of making an appointment as 'good'.

Patients said when they had been in urgent need of treatment they could usually make an appointment for the same day.

The practice's extended opening hours on Mondays, Tuesdays and Thursdays were particularly useful to patients with work commitments.

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. There was a designated responsible person who handled all complaints in the practice.

We saw that information was available to help patients understand the complaints system in the practice leaflet. 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 four complaints received in the last 12 months and found these were satisfactorily handled and dealt with in a timely way.

Minutes of team meetings showed that complaints were discussed to ensure all staff were able to learn and contribute to determining any improvement action that might be required. Lessons learnt from individual complaints had been acted on. For example, one complaint we reviewed was from a patient who said her child had been adversely affected by a news channel on the television in the patient waiting room. The complaint was discussed amongst staff and the Patient Participation Group (PPG) where it was decided to create a children's play area at a distance from the television screen.

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 GP partners had a vision to provide 'excellent patient care in a welcoming and accessible environment' and to provide community services across a range of disciplines. The practice was one of the two local hubs for the community ophthalmology service (a branch of medicine that deals with the anatomy, physiology and diseases of the eye) providing secondary care ophthalmology services to patients. The partners vision was to further develop the community services, with a view to also provide community musculoskeletal services. Although there was a vision for the practice there was no strategy in place to deliver it and the vision had not been shared with other staff.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the shared drive on any computer within the practice. We looked at five of these policies and procedures and found that although they were available for staff to reference, not all of them were up to date. For example, the practice's business continuity plan used in the event of a major disruption to the service had not been reviewed since 2011. We also found that information on the practice leaflet was in need of updating.

There was no evidence of a clear leadership structure with named members of staff in lead roles and members of staff we spoke to were not clear on who to speak to with specific concerns. There was no clear lead for infection control, safeguarding children or safeguarding vulnerable adults.

Staff told us that communication was sometimes a problem with the management. This was confirmed by meeting minutes we reviewed where staff had raised in a meeting their dissatisfaction that they were not informed about the introduction of a CCTV system in the practice until after it had been installed.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed it was performing above local CCG and national averages for both clinical and public health indicators in the previous year.

The practice provided us with examples of clinical audits which it used to monitor quality and systems to identify where action should be taken. However, clinical audit was limited to those relating to prescribing and there was no ongoing programme of clinical audit in place to systematically improve the quality of care for patients.

The practice had arrangements for identifying, recording and managing risks. We saw examples of risk assessments and audits that had been carried out and where risks had been identified control measures were in place to minimise them. For example, the latest infection control audit highlighted that hand wash posters were not displayed next to sinks for patients and staff to reference and this had been rectified.

Leadership, openness and transparency

We were provided with minutes from two partners meetings held in 2014 and one practice meeting for all staff held in March 2015. There was no evidence that practice meetings took place on a regular basis and there was no evidence from partners meetings of discussions around performance, quality and risks.

Staff we spoke with told us that prior to March 2015 there had been no practice meetings for over three years. Staff told us the culture in the practice was not as open as it could be. Staff felt they would benefit from regular team meetings. Clinical meetings were held weekly on an informal basis.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example the sickness policy which were in place to support staff. These policies were available on the shared drive of the computer system and staff we spoke with knew where to find these policies if required access to them.

Seeking and acting on feedback from patients, public and staff

The practice had gathered feedback from patients through patient surveys and complaints received. We looked at the results of the annual patient survey and 21% of patients said that it was not easy to speak to a doctor or nurse on the telephone. To improve this the practice had introduced slots at the end of a GPs surgery for telephone consultations.

The practice had a patient participation group (PPG) which comprised of seven patients. The PPG included representatives from various population groups; including older people and those of working age. The PPG had carried out annual surveys and met every quarter. The

Are services well-led?

Requires improvement

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

practice manager showed us the analysis of the last patient survey, which was considered in conjunction with the PPG. We saw the results of the survey and actions agreed. For example, improving patients' awareness of the online appointment system was highlighted as an area for action and this had been implemented. The results were available on the practice website. The practice also encouraged patients to join the PPG through a link on the practice website.

There was little evidence to show the practice gathered feedback from staff. Staff told us they did not get much opportunity to feedback and discuss any concerns or issues with colleagues and management as meetings were seldom held and the GPs were very busy. Not all staff felt involved and engaged in the practice to improve outcomes for both staff and patients.

The practice had a whistleblowing policy which was available on the shared drive of any computer within the practice. Staff were aware of the policy and understood the whistleblowing procedures.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and development. We looked at staff files and saw that regular appraisals did not take place consistently. Induction training was in place for new staff members, however it had not been documented.

The practice had completed reviews of significant events and other incidents and shared with staff.

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 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment Service users were not protected from abuse and improper treatment because not all staff had up to date training in child protection. Staff had not received training in safeguarding vulnerable adults. Staff were unclear on who to report to with safeguarding concerns within the practice. Criminal record checks had not been undertaken on non-clinical staff acting as chaperones and not all staff were up to date with the key principles of the Mental Capacity Act 2005. Regulation 13

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 Service users were not protected from unsafe care and treatment because staff had not received training in infection prevention and control and staff were unclear on who to report to with infection control issues within the practice. Regulation 12 (2) (c)