Mrs Suhasini Nirgude

Quality Report

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

Ratings

Overall rating for this service	Requires improvement
Are services safe?	Requires improvement
Are services effective?	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

Mrs Suhasini Nirgude manages the primary healthcare services delivered from Abbey Medical Centre in Reading, Berkshire. The medical centre is located in a listed building, built during the Victorian era. The building was refurbished to provide a GP surgery in 1985. Approximately 2,250 patients are registered at the practice. We carried out an announced comprehensive inspection of the practice on 14 January 2015. This was the first inspection of the practice since registration with the CQC.

Overall we have rated the practice as requiring improvement. There was evidence of delivery of services from a caring team of GPs and staff. Patients did not find it difficult to obtain appointments. However, some processes and procedures relating to recruitment of staff, infection control and quality monitoring must be improved.

Our key findings were as follows:

- The significant majority of the comments on comment cards and patients we spoke with during inspection referred to the GPs and staff being caring.
- Staff were well motivated and were supported by appraisal and a proactive registered manager.
- The practice appointment system was flexible and we saw that appointments were available on the day of inspection and on the next day. Patients were generally pleased with access to appointments.
- New patients were offered health checks when they registered. This enabled GPs to identify future treatment needs and ensure that health screening checks were completed. For example, scheduling annual health checks for new patients with a diagnosis of diabetes.

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

Importantly, the provider must:

- Undertake and record all employment checks required by legislation.

Summary of findings

- Maintain accurate records relating to health and safety and risk assessments that are up to date and fit for purpose and retain management records that are easily accessible.
- Ensure treatments carried out are accurately recorded in patient records. For example, those relating to the treatment of patients diagnosed with heart failure and depression.
- Enhance and improve quality monitoring of processes and procedures in use at the practice. Policies and procedures employed to support delivery of care and treatment must be kept under review and audited.
- Introduce cleaning schedules and monitoring of cleaning standards.Ensure cleaning equipment is appropriately segregated for use in clinical and non-clinical areas and that it is properly prepared for use the next day. Provide training for the lead for infection control, carry out a legionella risk assessment and act upon the findings.
- Expand the programme of clinical audits and introduce an audit programme to identify, plan and monitor improvements to clinical care.

In addition the provider should:

- Commission testing of portable electrical appliances and follow Health and Safety Executive (HSE) guidance relating to frequency of future similar tests.

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 and improvements must be made. Staff were clear about their responsibilities for reporting incidents. The practice reviewed when things went wrong and lessons learned were communicated to improve safety. The procedures for recruitment of staff must be improved. Information relating to staff required by legislation was not kept on file. The standards of general cleanliness were not specified and cleaning standards were not monitored. The member of staff responsible for infection control had not received appropriate training and a legionella risk assessment had not been carried out. Some equipment checks for example, the safety of portable appliances had not been carried out.

Are services effective?

Requires improvement

The practice is rated as requires improvement for providing effective services. Data showed most patient outcomes were at or above average for the locality. Where they were below the local average the practice was taking action to improve. Staff referred to relevant clinical guidance from NICE and other sources. The guidance was used routinely. People's needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and training needs were identified and planned. The practice undertook appraisals for all staff and development needs identified were met or planned. Staff worked with multidisciplinary teams. Clinical audits were limited and there was no audit programme to identify, plan and monitor improvements to clinical care.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed improving patients satisfaction for the service being caring. Patients we spoke with and those who completed CQC comment cards 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.

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

Summary of findings

Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients said they found it easy to make an appointment with their preferred GP and they were able to access urgent and telephone appointments.

The practice had appropriate facilities and was equipped to treat patients and meet most of their needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. Learning from complaints was shared with staff.

Are services well-led?

Requires improvement

The practice is rated as requires improvement for being well-led. The core philosophy of delivering the best quality care in a timely manner was evident and was demonstrated by staff we spoke with. Staff felt supported by management and there was an open culture within the practice. The practice had a number of policies and procedures to govern activity, but some of these were overdue a review. Systems to review quality were not operated consistently. Records relevant to the management of the service were either not kept or were not up-to-date. The practice sought feedback from patients and made efforts to establish a patient participation group (PPG). All staff had received inductions and regular performance reviews and attended staff meetings.

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 provision of safe services, provision of effective services and for being well led and this affects all population groups. Very few patients over the age of 75 were registered at the practice. National data showed that outcomes for these patients were good for conditions commonly found in this group. The practice offered proactive, personalised care to meet the needs of this group and one GP was the named doctor for all. However, patients in this group were able to choose which GP they saw. End of life care arrangements were in place and there was evidence of GPs working with other health care and voluntary sector colleagues to support the care of patients in this group with complex health needs. We spoke with some patients in this group and they told us the GPs were kind and caring.

People with long term conditions

Requires improvement

The practice is rated as requires improvement for provision of safe services, provision of effective services and for being well led and this affects all population groups. There were processes in place to make referrals for patients whose health deteriorated suddenly. Longer appointments and home visits were available when needed. Patients in this group were recalled for a structured annual review to check that their health and medication needs were being met. For those people with the most complex needs, the GPs worked with relevant health and care professionals to deliver packages of care.

Families, children and young people

Requires improvement

The practice is rated as requires improvement for provision of safe services, provision of effective services and for being well led and this affects all population groups. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example children on the at risk register were identified and the GPs worked with health visitors to support them. Immunisation rates were in line with the CCG average for all standard childhood immunisations. Appointments were available outside of school hours and the premises were suitable for children and babies. Mothers and new babies were called for review and these reviews were carried out.

Working age people (including those recently retired and students)

Requires improvement

The practice is rated as requires improvement for provision of safe services, provision of effective services and for being well led and

Summary of findings

this affects all population groups. The needs of the working age population, those recently retired and students had been identified. Most services required by this group were offered at the practice. When these were not, arrangements were in place for patients to be seen elsewhere. For example, women wishing to be fitted with a contraceptive coil were referred to the nearby walk in centre. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group. Evening appointments were available one day a week and telephone appointments were offered for patients who found it difficult to attend the practice during the working day.

People whose circumstances may make them vulnerable

Requires improvement

The practice is rated as requires improvement for provision of safe services, provision of effective services and for being well led and this affects all population groups. The practice held registers of patients with a learning disability and those who were carers. It had carried out 90% of annual health checks for people with a learning disability. The needs of patients whose first language was not English had been recognised and interpretation services were available for this group. Information relating to support for carers was available both from the GPs and in the form of leaflets and carers could request a telephone consultation if they were unable to leave the person they cared for to attend the practice.

People experiencing poor mental health (including people with dementia)

Requires improvement

The practice is rated as requires improvement for provision of safe services, provision of effective services and for being well led and this affects all population groups. The practice worked with multi-disciplinary teams in the case management of people experiencing poor mental health. However, data showed the practice was not delivering the national quality standards expected for patients diagnosed with depression.

The practice offered patients experiencing poor mental health advice about how to access various support groups and voluntary organisations. It had a system in place to identify patients with long term mental health problems which enabled staff to offer appropriate support when the patient attended for an appointment.

Summary of findings

What people who use the service say

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey and a recent 'friends and family' survey of 52 patients undertaken by the practice. The results of this survey had been summarised the week before our inspection and showed that 50 of the 52 respondents said they were either likely or very likely to recommend the practice to others. The evidence from all these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the national patient survey showed the practice received positive feedback for treating patients with care and concern. The practice satisfaction scores on consultations showed 83% of practice respondents said GPs were good at listening to them and 87% said the nurse was good or very good at treating them with care and concern. The survey also showed 80% said the last GP they saw and 83% said the last nurse they saw was good at giving them enough time. These results were similar to the CCG average.

Patients completed CQC comment cards to provide us with feedback on the practice. We received 44 completed cards and the significant majority were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were helpful and caring. They said staff treated them with dignity and respect. We also spoke with ten patients on the day of our inspection. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

Patients were satisfied with the appointments system. They confirmed that they could either see or speak with a GP on the same day if they needed. They also told us they were able to book appointments in advance to see the GP of their choice. Comments received from patients showed that patients in urgent need of treatment had usually been able to make appointments on the same day of contacting the practice.

Areas for improvement

Action the service MUST take to improve

- Undertake and record all employment checks required by legislation.
- Maintain accurate records relating to health and safety and risk assessments that are up to date and fit for purpose and retain management records that are easily accessible.
- Ensure treatments carried out are accurately recorded in patient records. For example, those relating to the treatment of patients diagnosed with heart failure and depression.
- Enhance and improve quality monitoring of processes and procedures in use at the practice. Policies and procedures employed to support delivery of care and treatment must be kept under review and audited.
- Introduce cleaning schedules and monitoring of cleaning standards. Ensure cleaning equipment is appropriately segregated for use in clinical and non-clinical areas and that it is properly prepared for use the next day. Provide training for the lead for infection control, carry out a legionella risk assessment and act upon the findings.
- Expand the programme of clinical audits and introduce an audit programme to identify, plan and monitor improvements to clinical care.

Action the service SHOULD take to improve

- Commission testing of portable electrical appliances and follow Health and Safety Executive (HSE) guidance relating to frequency of future similar tests.

Mrs Suhasini Nirgude

Detailed findings

Our inspection team

Our inspection team was led by:

This inspection was undertaken by two inspectors. A CQC Lead Inspector and a GP advisor.

Background to Mrs Suhasini Nirgude

Mrs Suhasini Nirgude is the registered manager and nominated individual responsible for managing the primary healthcare services at Abbey Medical Centre. Approximately 2,250 patients are registered with the practice. Two GPs, one male and one female work at the practice and they share the clinical sessions during the week to provide medical cover every day. A part time practice nurse is employed at the practice and the practice manager is supported by a small team of administration and reception staff.

The practice offers a range of services to the local population. There are a larger number of younger patients registered with the practice compared to other practices in the area. Income deprivation data shows the practice population has higher levels of income deprivation than other parts of the town.

Services to patients are provided via a personal medical services (PMS) contract. (PMS contracts are negotiated between the practice and the local team of NHS England).

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

Services are provided from one location at Abbey Medical Centre, 41 Russell Street, Reading, Berkshire, RG1 7XD.

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

Why we carried out this inspection

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

We carried out a comprehensive inspection of this service on 14 January 2015 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 practice is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, and to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

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

Detailed findings

How we carried out this inspection

Before visiting Mrs Suhasini Nirgude at Abbey Medical Centre we reviewed a range of information we hold. We also received information from local organisations such as NHS England, Healthwatch and the South Reading Commissioning Group (CCG). We carried out an announced inspection visit on 14 January 2015. During our inspection we spoke with a range of staff, including a GP, the practice nurse, the practice manager and reception staff.

We observed the interactions with patients at the reception, how phone calls from patients were received and looked at the environment in which patients received care and treatment. We did not observe patients' consultations and treatments. We reviewed five records relating to management of clinical conditions and others relevant to the management of the service were reviewed.

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)

The Abbey Medical Centre has a larger percentage of patients aged between 25 and 44 registered than many of the other practices in the local area. The percentage of very young children aged up to four was also greater than most practices in the CCG. The percentage of patients registered over the age of 50 was much lower than the national average. Income deprivation data showed the practice served patients from a wide ranging income background.

Requires improvement

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke to were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. For example some flu vaccines which should have been subject to temperature control had been left out of the fridge at overnight and had to be destroyed to ensure they were not used. The incident had been discussed with the practice team and an end of day double check introduced to ensure vaccines were appropriately stored in the medicines fridge.

We reviewed safety records and the minutes of the meetings where significant events were discussed for 2014. This showed the practice had managed these consistently over the last year.

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 year and we reviewed these. Significant events were an item on the practice meetings as they arose. The manager and GPs reviewed them annually because very few arose. There was evidence that the practice had learned from these. For example, GPs scrutinised skin lesions more closely to ensure patients with possible skin cancers were referred to hospital as quickly as possible. Staff told us they would not hesitate to report a possible significant event to the manager who completed a significant event report form which was then discussed with the GPs.

Where patients had been affected by something that had gone wrong, in line with practice policy, they were given an apology and informed of the actions taken to prevent reoccurrence where possible.

National patient safety alerts were dealt with by the practice manager and they kept a computer record confirming that either action had been taken or the alert was not relevant to the practice. GPs were aware of their responsibility to respond to alerts relating to medicines and were able to tell us what action they took.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed that staff had received relevant role specific training on safeguarding. Staff had attended relevant training organised by the CCG. We asked members of medical, nursing and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities, knew how to share information and where to locate the contact details of the relevant agencies in working hours and out of normal hours.

The practice had a GP lead in safeguarding vulnerable adults and children. They had been trained and could demonstrate they had the necessary training to enable them to fulfil this role. All staff we spoke to were aware who the lead GP was and told us they would speak to that GP if they had a safeguarding concern. If the GP was not in the practice they told us they would inform the practice manager of their concern. We saw that this process followed the practice safeguarding policy.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of children subject to child a protection plan or a child on the looked after register.

There was a chaperone policy, which was visible on the waiting room noticeboard and in consulting rooms. The nurse and two other members of staff, one of whom was the practice manager, had been trained to be a chaperone

Medicines management

We checked medicines stored in the medicine refrigerator. There was a clear policy for ensuring that medicines were kept at the required temperatures and we saw that the procedures contained in the policy had been followed in September 2014 to transfer medicines from the treatment room fridge to the backup fridge in the waiting area near the treatment room. This had resulted in medicines being held in a fridge which did not lock and was located in a public area. Medicines in this fridge were not held securely and could have been removed by unauthorised persons. The registered manager told us they would move the fridge

into the treatment room, which was locked when not in use, immediately after clinics were completed. We were sent photographic evidence, the day after inspection, to confirm this action had been taken.

Processes were in place to check medicines were within their expiry date and suitable for use. We checked a sample of ten medicines held in the fridge and all were within their expiry dates. We also checked the medicines held in GPs bags, in consulting rooms and held for medical emergencies all were within their expiry date. Expired and unwanted medicines were disposed of in line with waste regulations.

We reviewed the data available to the practice regarding their performance against recognised prescribing best practice. This showed the practice achieved 96% of local prescribing targets. Other prescribing data showed the practice to be better than the local average in achieving the targets for prescribing of antibacterial and hypnotic medicines. The GPs were supported by visits from the CCG medicines management advisor and we saw evidence of how this supported the practice to prescribe appropriately

The nurse administered vaccines using directions that had been produced in line with legal requirements and national guidance. The up to date copy of these directions was sent to us immediately following the inspection as it could not be located on the day.

There was a system in place for the management of high risk medicines, which included regular monitoring in line with national guidance. Appropriate action was taken based on the results. For example, monitoring of blood thinning 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. Prescriptions awaiting collection were securely locked in a cupboard at the end of the day.

Cleanliness and infection control

We found the practice clean, tidy and free from clutter. Monitoring of cleaning standards did not follow a set process because the cleaning tasks required, and the frequency at which they should be undertaken, was not specified. The practice was not following a process which ensured the practice was appropriately cleaned. There was a deep cleaning schedule in place. This included deep cleaning of carpets, curtains and upholstery. The majority of chairs in the practice were covered in non-permeable wipe clean fabric. However, the few chairs which were covered in soft fabric were only deep cleaned once a year. This did not meet the best practice of deep cleaning soft furnishings twice a year. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control. Staff we spoke with told us they had no concerns regarding the standards of general cleanliness.

Cleaning equipment was stored safely in rooms not accessed by patients and others. Separation of cleaning materials and equipment had not been fully achieved to ensure cleaning equipment used in clinical areas was not used in non-clinical areas. Equipment was not being cleaned and dried appropriately after use. There was therefore a risk of cross infection from cleaning equipment because it was not appropriately segregated or prepared appropriately for use.

The practice had a lead for infection control. This member of staff had not undertaken further training to enable them to provide advice on the practice infection control policy or to carry out future audits of infection control processes. We saw the practice had invited the CCG lead for infection control to carry out a detailed infection control audit in November 2014. We reviewed the results of this audit and found it identified a number of actions the practice needed to take to reduce risk and improve management of infection control processes. There was evidence the practice was taking action to address the issues identified. For example, separate pedal bins had been purchased and were in use for general waste and automated soap dispensers had been installed. There was a plan to complete the outstanding actions and for the CCG control of infection lead to return in spring 2015 to carry out a follow up audit.

We saw that the worktop in the treatment room was not sealed to the tiled 'splashback' and dirt could gather in the gap between wall and worktop. The practice manager was made aware of our findings and confirmed arrangements for a repair had been made.

The practice had a contract in place for the disposal of clinical waste. Clinical waste was appropriately segregated from general waste and placed in suitable receptacles. For

example, foot operated bins and sharps boxes were in place in the practice. The main bin holding waste for collection by the contractors was locked and held away from the practice building.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement control of infection measures. For example, personal protective equipment (PPE) including disposable gloves, aprons and coverings were available for staff to use. Staff told us there was always sufficient PPE available. Staff who received specimens from patients had been trained in the safest way to take receipt.

There were policies and procedures to deal with spillages of bodily fluids. A spill kit was kept in the treatment room to deal with any spillage of this nature.

Hand hygiene techniques signage was 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 not completed a risk assessment relating to legionella (a germ found in the environment which can contaminate water systems in buildings) and other waterborne bacteria. Consequently there were no control measures in place to reduce the risks associated with waterborne bacteria.

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 medical equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. For example, evidence of calibration of relevant equipment including weighing scales and the blood pressure machines.

However, portable electrical equipment had not been tested at appropriate intervals in accordance with guidance from the Health and Safety Executive (HSE). We also found urine test sticks and some syringe needles that had exceeded their use by dates. Both had expiry dates of December 2014 and the practice was unaware of this. They were removed from use and replacements were ordered.

Staffing and recruitment

The practice did not retain appropriate records to evidence recruitment checks had been undertaken prior to employment. The only relevant documentation held for two members of staff were criminal records checks undertaken by the disclosure and barring service (DBS). The manager had not obtained a CV or application form, references or proof of identity for these members of staff. One of these members of staff worked part time hours at the practice. This member of staff worked the remainder of the week at a nearby practice. The practice manager was aware that personnel records were held at the second practice but had not obtained copies of these records. There was evidence that the second member of staff was a qualified GP not working in that capacity at the time of inspection. We looked at the files of three other members of staff. In all three information such as references and photographic proof of identity were missing. The manager showed us pre-employment checklists for these staff. They showed that references had been received, passports had been checked and all other required documentation reviewed. The supporting evidence had not been kept to comply with legislation.

We were unable to review records for the salaried GPs and the manager did not have a system in place to check GPs registration with the General Medical Council (GMC). The manager told us they had seen evidence confirming that the GPs and nurse had completed their course of immunisations for hepatitis B. However, this had not been retained. We saw that this important immunisation was offered to reception and administration staff and that some staff had taken up this offer.

We saw there was a rota system in place for staff to ensure that enough staff were on duty. There was also an arrangement in place for members of staff to cover each other's annual leave. Locum GPs and nurses were employed to cover holidays to ensure medical and nursing services were maintained.

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 manager undertook some checks to manage and monitor risks to patients, staff and visitors to the practice. For example, the practice manager checked the condition of the building and we saw that repair to damaged walls had been completed and the treatment room redecorated. Other safety checks were undertaken. For example one of the GPs checked the emergency

equipment and the phlebotomist checked medicines were within expiry date. Contracts were in place for essential safety checks. For example, annual testing and servicing of fire equipment and alarm systems. However, a full fire risk assessment had not been completed and equipment had not been checked to see whether it needed an electrical test.

The practice also had a health and safety policy and some supporting risk assessments. For example manual handling. There was evidence that some identified risks were communicated with staff who were then tasked with taking action to reduce risk. For example, the practice manager had shared the recent findings from an infection control audit with the member of staff who led on control of infection. We saw this member of staff was taking action to address the issues arising from the audit.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). When we asked members of staff, they all knew the location of this equipment. A GP told us they undertook a visual check of the equipment regularly. The checks had not been recorded. However, we found the defibrillator was in working order and the oxygen cylinder functional and both had been subject to an annual service by contractors. We were told these items of emergency equipment had never had to be used.

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. Processes were 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 and heating system failure. The document also contained relevant contact details for staff to refer to. For example, details of a heating company to contact if the heating system failed.

The practice had not carried out a full fire risk assessment that included actions required to maintain fire safety and fire drills had not taken place. Not all risks associated with prevention and reduction of spread of fire had therefore been assessed. However, there was a brief record of a visit from the local fire service which had been undertaken eight years earlier and the actions arising from recommendations of the fire officer had been taken. For example, fire doors were appropriately labelled and fire extinguishers had been relocated.

Requires improvement

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs 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 a variety of sources including the National Institute for Health and Care Excellence and from local commissioners. We found from our discussions with the GPs that thorough assessments of patients' needs in line with relevant guidelines were undertaken, and these were reviewed when appropriate.

The GPs were responsible for ensuring best practice in reviewing patients with long term or complex conditions such as diabetes, heart disease and asthma. The practice nurse and phlebotomist supported this work, which allowed the practice to focus on specific conditions. The GPs had a system in place that enabled them to contact each other for advice on specific treatments and to support continuity of care for the patient.

We reviewed data that showed the practice's performance for prescribing of antibacterial medicines, which was better than similar practices. The practice used computerised tools to identify patients with complex needs who had multidisciplinary care plans documented in their case notes.

National data showed that the practice was in line with referral rates to secondary and other community care services for all conditions. GPs followed national standards for the referral of patients with suspected cancer and we saw there was a system in place to ensure these patients were seen within two weeks of referral.

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

Management, monitoring and improving outcomes for people

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, and managing child protection alerts and medicines management.

The practice showed us four audits that had been undertaken in the last year. One of these audits was on the benefits of using 24 hour blood pressure monitoring to diagnose high blood pressure. The audit had been repeated but the results had not been collated at the time of inspection. We were unable to evidence whether changes made since the first audit had a positive benefit to patient care. The GPs told us audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). QOF is a national performance measurement tool. The number of audits completed was limited and there was no overall programme of audit to identify, plan and monitor improvements to clinical care.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. The practice met all the minimum standards for QOF in management of diabetes and asthma. This practice was an outlier for the treatment of patients with heart failure and depression. The GPs were aware of this and had reviewed their treatment of these patients. This showed that appropriate care had been delivered for these patients but the recording of the treatment had not registered on the patient's records. Discussion with one of the GPs showed that they were seeking advice from GPs in other practices to resolve this recording and disease coding issue. GPs we spoke with recognised that they could expand and enhance the range of audit undertaken.

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 IT system flagged up relevant medicines alerts when the GP was prescribing medicines. We saw that the practice achieved 96% of the local prescribing targets. Support from the CCG prescribing advisors included providing the GPs with records of patients who required a review of specific medicines they were taking. The advisors then checked that action had been taken when they next visited.

The practice had achieved and implemented the gold standards framework for end of life care. It had a palliative care register and had regular meetings with district nurses

Requires improvement

Are services effective?

(for example, treatment is effective)

to discuss the care and support needs of patients and their families. There were very few patients receiving end of life care and contact with palliative care nurses was made on an individual basis when the patient was first diagnosed or when changes in their care needs were identified.

Effective staffing

The practice staff comprised 2 GPs, a part time practice nurse, phlebotomist, practice manager and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as annual basic life support. Both the GPs were up to date with their yearly continuing professional development requirements. One had been revalidated and the second GP was in their first five year cycle working towards 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 (GMC) can the GP continue to practise and remain on the performers list with NHS England).

The number of GP clinics held was similar to other practices with a similar number of patients registered. However, the number of practice nurse hours available at the practice was lower than would be expected for the number of patients registered. We noted that some duties usually undertaken by practice nurses were completed by the GPs. For example, reviews of patients diagnosed with asthma. The phlebotomist had also been trained to carry out some tasks carried out by nurses in other practices. This included spirometry (a test to monitor the severity of lung conditions). Patients we spoke with and the comments we reviewed on CQC comment cards did not identify any problems with the availability of practice nurses and we saw that alternative arrangements were in place to deal with most tasks usually carried out by practice nurses.

Staff undertook annual appraisals that identified learning needs. For example, a member of staff identified they required additional training to improve their competency in dealing with repeat prescriptions. They told us the practice manager provided additional training immediately following the identification of this need.

The practice nurse was expected to perform defined duties and was able to demonstrate they were trained to fulfil these duties. For example, administration of vaccines and cervical cytology. The nurse also undertook the annual reviews of patients diagnosed with diabetes. These reviews were co-ordinated to coincide with these patients receiving their annual eye screening from the visiting eye screening service. This meant the patient was only required to attend once to receive their full review.

Working with colleagues and other services

The practice worked with other service providers to meet patient needs and manage complex cases. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. The practice had a system in place to ensure staff passed on all clinical information to both the GPs which enabled prompt access to information for the GPs. The GPs were responsible for 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. Staff we spoke with understood their roles and felt the system in place worked well.

The practice was commissioned for the new enhanced service and had a process in place to follow up patients discharged from hospital. (Enhanced services require an enhanced level of service provision above what is normally required under the core GP contract). We saw that the policy for actioning hospital communications was working well in this respect.

The GPs held a regular meeting with a visiting consultant specialising in diabetic care. This enabled detailed discussion of the patients with the most complex diabetic conditions and those patients who were having difficulty with their treatment. The GPs valued the advice from the consultant and we were told the input of the expert helped improve care for this group of patients.

The practice held team meetings with district nurses and the community matron every six weeks to discuss the needs of patients with complex medical conditions, for example those with end of life care needs. There were very few patients receiving end of life care and decisions regarding their care requiring input from palliative care nurses were communicated on an individual basis. Decisions about care planning were documented in patient's records to which the district nurses had access. The system worked appropriately for a practice of this size.

Requires improvement

Are services effective?

(for example, treatment is effective)

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. Electronic systems were also in place for making referrals and the practice made the majority of referrals last year through the Choose and Book system. (The Choose and Book system enables patients to choose which hospital they will be seen in and to book their own outpatient appointments in discussion with their chosen hospital). Staff reported that this system was easy to use and that when referrals were not made using this system fax and e-mails were employed to ensure referrals were completed in a timely manner.

The practice shared information for patients receiving end of life care with the local out of hours provider by a system of special patient notes. This ensured these patients received appropriate care when their needs changed.

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

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. We discussed this in detail with one of the GPs. They understood the key parts of the legislation and described how they implemented it in their practice. Patients with a learning disability were supported to make decisions through the use of care plans, which they were involved in agreeing. The GP we spoke with was able to give examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision.

GPs demonstrated a clear understanding of Gillick competencies. (These help clinicians to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment).

The practice did not carry out surgical procedures or fit contraceptive coils. The requirement for written consent was therefore limited. However, we were told if a patient declined consent for an annual review of their medical condition or for an annual health check their decision would be recorded in their medical records.

Health promotion and prevention

The practice was active in offering a health check for all new patients. We heard that around 70% of new patients attended for this check. Any health issues found during this check could be followed up by the GPs quickly.

A wide range of health promotion material was available in the form of advice leaflets. These were displayed prominently in the waiting room. The GPs and nurse had access to health promotion material in their consulting and treatment rooms. The GPs referred patients to local smoking cessation clinics.

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 childhood immunisations met the national targets and there was a system in place to follow up those that did not attend. The practice's performance for cervical smear uptake was just below the national target and was affected by the high turnover of patients. Sometimes patient records were delayed in reaching the practice and new patients could not recall when they last had a cervical smear. Data showed the practice performed better than most in the CCG for completing flu immunisations for patients with long term conditions. The practice took part in the national screening campaigns for chlamydia, mammography and bowel cancer.

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. We noted that only 20% of the patients who were sent the national survey responded resulting in a very small sample of patient views. The national patient survey response to the question about GPs treating patients with care and concern showed 69% of the 33 patients who responded rated this good or very good which was lower than the local average. This did not reflect the views we received from both comment cards and patients we spoke with during inspection which were very positive. The practice results were average or better than average for satisfaction scores on consultations with doctors and nurses with 83% of practice respondents saying the GP was good at listening to them and 80% saying the GP gave them enough time. The views of patients we spoke with were positive in regard to these questions.

We also reviewed the results of a survey undertaken by the practice in early 2014 and a recently completed 'friends and family' survey completed by 52 patients. The evidence from these sources showed that recently the views of patients had improved in relation to being treated with compassion, dignity and respect. The friends and family survey undertaken by the practice showed that 50 out of 52 patients who responded were either extremely likely or very likely to recommend the practice. We looked at all 52 of the responses and saw that when patients took the opportunity to add a comment to their answer this usually related to the caring attitude of the GPs.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 44 completed cards and the majority were positive about the service experienced. Patients said they felt the practice offered an excellent or very good service and staff were efficient and helpful. Over 50% of the respondents described how caring the GPs and staff were. The ten patients we spoke with during the inspection gave us similar feedback. The patients we spoke with and many of the comments on the comment cards told us staff treated patients with dignity and respect. Only four of the comments on the comment cards were less positive but there were no common themes to these.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that both consultation and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. Incoming telephone calls to the practice were taken at the reception desk. The waiting room was separated from the reception by a corridor and discussions at reception could not be overheard from the waiting room. We observed that reception staff dealt with one patient at a time and asked other patients who arrived at the desk to either wait in the waiting room or in the corridor when a discussion was taking place with the first patient. A similar procedure was followed when the receptionist was talking to a patient on the phone. These procedures enabled confidentiality to be maintained.

We observed how staff interacted with patients and saw that these interactions were friendly, caring and professional. The registered manager demonstrated a strong commitment to training and coaching their staff in delivering a caring and person centred service. We saw the manager working at the reception when the receptionist was away from the desk and leading by example in the way they treated patients with respect and empathy.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded relatively positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice similarly to others in the CCG in these areas. For example, data from the national patient survey showed 23 out of 31 patients who responded said the GP involved them in care decisions and 26 out of 33 patients felt the GP was good at explaining treatment and results. Both these results were slightly lower than the local average but came from a very small number of respondents.

Patients we spoke to on the day of our inspection told us that health issues were discussed with them and they felt

Good

Are services caring?

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. We saw that the practice advised patients they could book double appointments if they felt they needed to discuss complex matters or more than one health condition. Patient feedback on the comment cards we received was positive in relation to involvement in decisions about care. There was evidence that the practice was involved in care planning for patients with diabetes. Patients we spoke with who had this medical condition told us they felt involved in planning their care and understood the treatments they were receiving.

There was evidence that patients who required care plans to assist them in avoiding admission to hospital were involved in developing their plan. The discussion with the GP to formulate the plan could either take place at the practice or by telephone. This enabled some patients to contribute to the formulation of their care plans without the worry of having to get to the practice.

Patient/carer support to cope emotionally with care and treatment

The responses on comment cards we reviewed told us that staff offered compassionate support to patients when needed. There were examples given on the comment cards we received of patients receiving support in both understanding and learning to manage long term medical conditions and being given support when they were diagnosed with cancer. We heard that patients could be accompanied by a relative during a consultation if they wished and that chaperones were available to support patients during examinations and treatment. We saw parents accompanying children to their consultation. Patients we spoke with were positive about the compassionate support they received from the GPs.

There were leaflets in the waiting room and information on the patient website offering advice to patients on how to access a number of support groups and organisations. The practice held a register of patients who were also carers. When carers could not attend the practice the GPs offered telephone consultations and would visit the patient at home if their medical condition warranted this.

There were patients registered with the practice who had a learning disability. We saw that these patients were given the choice of whether to be seen for their care and treatment either at the practice or in their own home. Those that found it difficult or challenging to attend the practice were therefore able to receive support in an environment which they found more comfortable.

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 needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered. For example, the practice encouraged new patients to attend for a health check because the practice continued to register a large number of patients each year.

The South Reading Clinical Commissioning Group (CCG) told us that the practice engaged regularly with them. The registered manager and a GP regularly attended CCG meetings to meet with other practices to discuss local needs and service improvements that needed to be prioritised. We saw minutes of meetings where local initiatives had been shared with the staff team. For example, the initiative to carry out care planning with patients identified as at risk of admission to hospital. There was data to show that the practice had developed care plans for 3% of this group of patients which exceeded the local target of 2%.

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 made efforts to advise patients of the availability of disabled access to the building because some patients had commented that they were unaware this access was available.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. Registers of patients with a learning disability and those with carer responsibilities were held. Due to its location the practice had a large number of patients registered who lived in rented accommodation. This resulted in a transient patient population and data showed a turnover of 16% of the registered patients in the last year. The practice supported these new patients by offering them a health check.

The practice had access to both telephone and visiting translation services and one GP and members of the practice staff who spoke two different languages. Staff told us how they accessed translation services and how useful it had been to have interpreters visit the practice to support patients whose first language was not English.

The premises and services were accessible to meet the needs of patients with disabilities. One of the consulting rooms was on the ground floor and access to the practice for patients with mobility difficulties was available near this consulting room. A separate waiting area was available for these patients to ensure they did not have to manage any steps. Staff greeted patients who used the disabled entrance and booked them in for their appointments. When a patient who found it difficult to manage stairs attended for an appointment the GPs and nurse used the ground floor consulting room which enabled the patient to see the GP of their choice an access nurse treatments.

Accessible toilet facilities were available for patients attending the practice. A baby changing facility was available.

Access to the service

The practice was open from 8am to 6.30pm every weekday. Appointments were available from 9am to 5.20pm on weekdays and the GPs were able to add additional appointments for patients who needed to be seen after the last scheduled appointment. Appointments with the practice nurse were available on a Wednesday afternoon between 2pm and 6.30pm. Reception staff were available throughout the day and if a patient rang, or visited the practice, during lunch time the GP was called and given the patient's details to carry out a call back. The practice had extended opening hours on Monday evenings between 6.30pm and 7.45pm. These appointments were particularly useful to patients with work commitments.

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 should ring depending on the circumstances. Information on the out-of-hours service was provided to patients.

Patients were generally satisfied with the appointments system. They confirmed that they could see a doctor on the

Good

Are services responsive to people's needs?

(for example, to feedback?)

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. Longer appointments were also available for people who needed them and those with long-term conditions. This also included appointments with the patient's preferred GP.

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 registered manager handled all complaints in the practice.

We saw that information was available to help patients understand the complaints system. The procedure was displayed on a notice board, referred to on the patient website and included in the patient information leaflet. Some patients we spoke with were aware of the process to follow if they wished to make a complaint and none had ever needed to make a complaint about the practice.

The practice received very few complaints. The only complaint received in the last year was dealt with in accordance with the practice procedure and was responded to promptly. The practice reviewed formal complaints. Lessons learned from individual complaints had been acted on. Staff we spoke with, and the registered manager, told us that any concerns or issues raised by patients attending the practice were dealt with immediately. The resolution of these concerns was not recorded. When we discussed this with the registered manager they told us they would keep a summary of such concerns in the future to enable them to identify any themes or trends.

Are services well-led?

Requires improvement

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

Our findings

Vision and strategy

The practice charter underpinned the delivery of services to patients. The charter included sections on treating patients with respect and ensuring confidentiality. It also set out criteria for ensuring patients were offered appointments appropriate to their needs and how the GPs would deliver the best care possible. The discussions we had with GPs, the manager and staff showed us that the practice team constantly strove to deliver services in line with the stated aims of their patient charter.

Our observations and the feedback we received from patients showed us that patients were treated with respect, courtesy and in a professional manner. Staff made significant effort to ensure patient confidentiality was maintained and to offer appropriate support for patients who may find difficulty accessing services. For example, interpreter services were offered and patients who may experience difficulty entering or leaving the practice premises were assisted by staff.

Governance arrangements

The practice had some policies and procedures in place to govern activity and these were available to staff in a range of files held in the manager's office. Staff we spoke with knew where to access files. We looked at five of the policies and procedures and found that they had not been reviewed to ensure they were up to date.

We spoke with four of the five staff on duty during our inspection and they were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and would go to the practice manager with any concerns.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed it was mostly performing in line with national standards. We saw that QOF data was regularly discussed by the GPs and the practice manager at team meetings. The practice manager co-ordinated action to improve outcomes. It was clear from our discussions with the GPs and staff that there was a heavy reliance on the practice manager who took responsibility for the significant majority of governance matters. When the manager took planned leave they produced a detailed briefing for staff on where to find information and on what tasks needed completing in their absence. However, there was no contingency plan to cover the duties of the manager if they were absent for any length of time due to an emergency. Staff might not have access to important information or know what was required to maintain the service in the manager's absence.

Some records we requested could not be located on the day of inspection. For example, the copy of the direction enabling the nurse to carry out flu vaccinations and a copy of a DBS check. These were forwarded to us within 48 hours of the inspection. Records relating to the management of the service and recruitment of staff were not held in a tidy and well-ordered manner. The practice manager kept some records in electronic format and some in manual files. It took some time before some of the records we requested were found as the manager was not certain which format they were in. The practice manager did not have any administrative support to maintain records. There was a risk that important matters relating to management of safe systems could be missed because records were not easily accessed or maintained in a tidy manner. For example, the practice manager was not aware that testing of portable electrical equipment had not been undertaken because they were not aware it was due.

The practice had a limited programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. For example prescribing audits were undertaken to ensure patients received appropriate medicines at the right dose. A programme of clinical audits to identify, plan and monitor improvements to clinical care was not in place.

The practice must improve arrangements for identifying, recording and managing risks. For example, the practice did not have an up to date fire risk assessment in place. There were no arrangements for practice staff to complete control of infection audits and a legionella risk assessment had not been undertaken. We found that testing of portable electrical appliances had not been undertaken. Appropriate systems were not in place, or support available to the manager, to ensure risks were monitored and managed.

Leadership, openness and transparency

We reviewed six sets of minutes of team meetings that had been held in the previous year. We saw that team meetings were held every six to eight weeks. Staff told us that there was an open culture within the practice and they had the

Are services well-led?

Requires improvement

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

opportunity and were happy to raise issues at team meetings. We were also told that staff had easy access to both the GPs and the manager because it was a small practice. They told us they did not wait for team meetings to be held to offer ideas and suggestions or raise concerns with the practice manager.

The practice manager was responsible for human resource policies and procedures. Most of these were contained within the staff handbook. The procedures included management of sickness the disciplinary procedures which were in place to support staff. We did not find evidence of these procedures being subject to review to ensure they remained current and fit for purpose. Staff told us they knew where to access the staff handbook and we saw that this also equal opportunities and harassment at work.

Our discussion with one of the GPs showed us they were active in seeking peer support from other GPs outside the practice. They took an active role in a young GPs group and in an online peer review group. They also told us of their work on reviewing referral rates with other practices within the CCG.

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

The practice had gathered feedback from patients through a patient survey conducted in early 2014, from a 'friends and family' survey that had recently been completed, and complaints received. The practice was aware of the results of the national patient survey and we saw that the manager responded to patient comments posted on the NHS choices website. Both the manager and staff told us how they had focussed on delivering compassionate care that was personal to the individual patient. Their efforts appeared to be reflected in the results of the friends and family survey results which showed 96% of patients were likely or very likely to recommend the practice to others. The national survey results from 2013, which were from a smaller sample of patients, showed only 69% of patients would recommend the practice to others.

The practice had made efforts to form a patient participation group (PPG) and we spoke with two members of this group which had become dormant during the last eight months. We saw posters inviting patients to join the group and the patient website contained a similar invitation. Both members of the dormant PPG told us the practice was very open to listening and acting upon patient feedback. This was demonstrated by the practice promoting the availability of access to the service for patients with a disability in response to the comments received from the PPG.

The practice gathered feedback from staff both informally from day to day discussions with the practice manager and through the team meetings that were held every six to eight weeks. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with the GPs and practice manager. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their professional development through training. We looked at the appraisals file and saw that regular appraisals took place which identified training and development needs. Staff told us that the practice was very supportive of training and that they participated in the CCG learning days that were held on at least seven occasions each year. We heard that various topics were covered at these events including safeguarding training.

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 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider failed toimplement systems and processes to ensure— 1.Care and treatmentwas provided in a safe way for service users by means of- 2(h) assessing 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 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed The registered person must ensure – 1. Persons employed for the purposes of carrying on a regulated activity must- a. be of good character. Regulation 19 (1)(a) This was a breach of regulation 21 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

Diagnostic and screening procedures

Family planning services

Maternity and midwifery services

Treatment of disease, disorder or injury

Regulation 17 HSCA (RA) Regulations 2014 Good governance

The registered person did not ensure such systems or processes were in place to enable the registered person, in particular, to—

2a. assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services);

b. assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity.

d. maintain securely such other records as are necessary to be kept in relation to-

(i) the management of the regulated activity

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