The Practice Whitehawk Road

Quality Report

The Practice Whitehawk Road
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Date of inspection visit: 06 May 2015
Date of publication: 03/09/2015

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 of The Practice Whitehawk Road on 6 May 2015. Overall the practice is rated as requires improvement.

Specifically, we found the practice to require improvement in being well-led and for providing safe and effective services. It was good for providing a caring and responsive service.

The Practice Whitehawk Road provides primary medical services to people living in the Whitehawk area of Brighton and Hove. At the time of our inspection there were approximately 3980 patients registered at the practice with three part time locum GPs, one of whom was a long term locum. In addition, a lead GP from another practice within the locality that was part of The Practice Group/ Chilvers and McCrea Ltd provided additional support and supervision to the locum GPs. The lead GP from another practice within the Group also helped run a regular substance misuse clinic at the practice. The practice was also supported by a nurse and a team of reception and administrative staff.

The inspection team spoke with staff and patients and reviewed policies and procedures. The practice understood the needs of the local population and engaged effectively with other services. There was a culture of openness and transparency within the practice and staff told us they felt supported. The practice was committed to providing high quality patient care and patients told us they felt the practice was caring and responsive to their needs.

Our key findings were as follows:

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Risks to patients were assessed and well managed.

Summary of findings

- The practice had systems to keep patients safe including safeguarding procedures and means of sharing information in relation to patients who were vulnerable.
- Infection control audits and cleaning schedules were in place and the practice was seen to be clean and tidy.
- Patients' needs were assessed and care was planned and delivered following best practice guidance.
- Staff had received training appropriate to their roles, with the exception of chaperone training for administrative staff and training in the Mental Capacity Act 2005 for all staff. Any further training needs had been identified and planned.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- The practice had responded to concerns from patients about not being able to get appointments at a time that suited them and difficulties getting through to the practice by phone.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.
- The practice had the appropriate equipment, medicines and procedures to manage foreseeable patient emergencies.

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

The areas where the provider must make improvements are;

- Ensure that medicines are stored securely.
- Ensure all staff have received training in the Mental Capacity Act 2005 and that all staff acting as chaperones have received formal training.
- Ensure that plans are developed for a Patient Participation Group and that other ways are developed of gathering feedback from patients including hard to reach patients and groups.
- Ensure that there are cleaning schedules for the clinical equipment kept in the treatment rooms and accurate, up to date records that these have been cleaned in line with the schedule.

The areas where the provider should make improvements are:

- Develop plans to implement regular multidisciplinary meetings, particularly for patients on the palliative care register.

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 should make improvements. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Although risks to patients who used services were assessed, the systems and processes to address these risks were not consistently implemented well enough to ensure patients were kept safe. For example, medicines stored in the treatment room were not locked and clinical equipment was not subject to a cleaning schedule or clearly recorded as routinely cleaned.

Are services effective?

Requires improvement

The practice is rated as requires improvement for providing effective services, as there are areas where improvements should be made. Data showed patient outcomes were at or below average in some areas and above average in others for the locality. Staff referred to guidance from the National Institute for Health and Care Excellence and used it routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included promoting good health. Staff had had not always received training appropriate to their roles, specifically in relation to the Mental Capacity Act 2005 and training for administrative staff who undertook chaperone duties. There was evidence of appraisals and personal development plans for all staff although due to a high number of staffing changes this was not yet consistent over time for a number of staff. Multidisciplinary working was being developed although was generally informal as multidisciplinary meetings were not taking place.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice higher than others in some aspects of care including having confidence and trust in the last nurse they saw or spoke to. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information for patients about the services available was easy to understand and accessible. 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 generally found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day. The practice had good facilities and was well equipped to treat patients and meet their needs. 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 and other stakeholders.

Are services well-led?

Requires improvement

The practice was rated as requires improvement for being well-led. While it had a clear vision and strategy and staff were clear about the vision and their responsibilities in relation to this there had been issues with creating a stable team within the practice. There was a clear leadership structure, including locality managers and a central clinical governance team. Staff felt supported by management, however the practice relied solely on locum GPs and the input from a lead GP from another of the group's practices for one session a week. The practice manager and assistant practice manager had been in post for a few months, as had the practice nurse. This had impacted on systems within the service not being fully embedded. There were systems in place to monitor and improve quality and identify risk, however some of these had been newly implemented. For example, the practice had not consistently carried out an annual infection control audit although one had been undertaken in the two weeks preceding our visit. The practice sought feedback from staff and patients and this had been acted upon. However, the practice did not carry out their own patient survey and we did not see evidence of action to improve patient satisfaction in relation to the national GP patient survey where the practice consistently performed below the local and national average. Staff were encouraged to make suggestions for improvement and we saw evidence suggestions were acted on. There was an open culture and staff knew and understood the lines of responsibility and accountability to report incidents or concerns. Staff we spoke with felt valued and were supported through appraisals and regular meetings with managers and team meetings which they told us had recently been implemented.

Summary of findings

The six population groups and what we found

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

Older people

Requires improvement

The provider was rated as requires improvement for safe, effective and for being well-led. The concerns which led to these ratings apply to everyone using the practice, including this population group.

Patients had a named GP which allowed for continuity of care. Nationally reported data showed that outcomes for patients were variable for conditions commonly found in older people. For example their QOF score for atrial fibrillation, chronic kidney disease, heart failure and cancer were 100% which were above the average CCG and national levels. However, performance for chronic obstructive pulmonary disease (COPD) was 51% (44 points below the CCG and England average) and for diabetes mellitus it was 74% (17 points below the CCG average and 16 points below the England average). We viewed a plan for further improvements to QOF performance for 2015/16 that included additional training for clinical staff in diabetes management. Patients were able to speak with or see a GP when needed and the practice was accessible for people with mobility issues. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in dementia and end of life care. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs. There were arrangements in place to provide flu and pneumococcal immunisation to this group of patients and the practice were in the process of inviting patients aged 78 and 79 for a shingles vaccination.

People with long term conditions

Requires improvement

The provider was rated as requires improvement for safe, effective and for being well-led. The concerns which led to these ratings apply to everyone using the practice, including this population group.

The practice nurse had a lead role and was trained in chronic disease management, including asthma and COPD. We viewed plans for additional training for clinical staff in diabetes management. Patients at risk of hospital admission were identified as a priority and longer appointments and home visits were available when needed. All these patients had a named GP and a structured annual review to check that their health and medication needs were being met. For those people with the most complex

Summary of findings

needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care. For example we saw that the practice worked closely with community respiratory, heart failure and diabetes teams.

Families, children and young people

Requires improvement

The provider was rated as requires improvement for safe, effective and for being well-led. The concerns which led to these ratings apply to everyone using the practice, including this population group.

There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances would be flagged on the electronic system. Immunisation rates were relatively high (90%) for all standard childhood immunisations. Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this. Appointments were available outside of school hours and the premises were suitable for children and babies. The practice was situated next door to a children's centre which housed health visitors and community midwives and the practice had developed good day to day working relationships. We saw good examples of joint working with midwives, health visitors and school nurses. Safeguarding policies and procedures were readily available for staff and the appropriate processes to follow were clearly visible on notice boards in staff areas.

Working age people (including those recently retired and students)

Requires improvement

The provider was rated as requires improvement for safe, effective and for being well-led. The concerns which led to these ratings apply to everyone using the practice, including this population group.

The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. The practice offered a 'doctor first' model where patients wishing to speak with a GP would be called back within one to two hours and a same day appointment would be offered as appropriate. The practice also participated in a government scheme called EPIC so that patients could be offered appointments every evening until 8pm and between 9am and 2pm at weekends. The scheme was a locality scheme where patients would see a GP at another practice in the locality. 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.

Summary of findings

People whose circumstances may make them vulnerable

Requires improvement

The provider was rated as requires improvement for safe, effective and for being well-led. The concerns which led to these ratings apply to everyone using the practice, including this population group.

The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability. The practice worked closely with another member of The Practice Group/Chilvers and McCrea at their sister site that specialised in care for homeless patients. The practice had a register for patients with a learning disability and carried out annual health checks for these patients. The practice offered longer appointments for people with a learning disability. The locum GP had been trained on level one substance misuse. The practice worked with a community substance misuse nurse to run a regular clinic.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. It had told vulnerable patients about how to access various support groups and voluntary organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

People experiencing poor mental health (including people with dementia)

Requires improvement

The provider was rated as requires improvement for safe, effective and for being well-led. The concerns which led to these ratings apply to everyone using the practice, including this population group.

Patients at risk of dementia and those with dementia were flagged on the practice computer system and had an annual review. We saw that 100% of dementia reviews had been carried out. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia.

The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations. A community navigator scheme was in place where a volunteer would spend a day a week at the practice and would work with the local community and signpost patients to community and voluntary sector services. The practice had a system in place to follow up patients who had attended accident and emergency (A&E) where they may have been experiencing poor mental health. Staff had received training on how to care for people with mental health needs and dementia.

Summary of findings

What people who use the service say

Patients mostly told us they were satisfied overall with the practice. Comments cards had been left by the Care Quality Commission (CQC) before the inspection to enable patients to record their views on the practice. We received four comment cards which contained mostly positive comments about the practice. We also spoke with three patients on the day of the inspection.

We reviewed the results of the national patient survey which contained the views of 89 patients registered with the practice. The national patient survey showed patients were generally pleased with the care and treatment they received from the GPs and nurses at the practice. The survey indicated that 79% of respondents said the last GP they saw or spoke to was good at explaining tests and treatments and 89% had confidence and trust in the last nurse they saw or spoke to and 82% had confidence and trust in the last GP they saw or spoke to. However, the practice performed below the CCG and national average across all points of the GP patient survey. There was evidence of some concern from patients in terms of waiting times, with only 39% of patients saying they usually waited 15 minutes or less after their appointment time to be seen and only 27% of patients saying they felt they didn't normally have to wait too long to be seen.

We spoke with three patients on the day of the inspection and reviewed four comment cards completed by patients in the two weeks before the inspection. The patients we spoke with and the comments we received were mostly positive. Comments included those stating that the service was 'brilliant' and that staff were good and very helpful. More negative comments were focused on the waiting time for appointments and getting to speak with a doctor. The practice had recently implemented a new system for patients to speak with a doctor by phone and one of the patients stated that things had improved since the implementation of a new system where the doctor would call patients back within one to two hours if they had requested an emergency appointment.

Areas for improvement

Action the service MUST take to improve

- Ensure that medicines are stored securely.
- Ensure all staff have received training in the Mental Capacity Act 2005 and that all staff acting as chaperones have received formal training.
- Ensure that plans are developed for a Patient Participation Group and that other ways are developed of gathering feedback from patients including hard to reach patients and groups.
- Ensure that there are cleaning schedules for the clinical equipment kept in treatment rooms and accurate, up to date records that these have been cleaned in line with the schedule.

Action the service SHOULD take to improve

- Develop plans to implement regular multidisciplinary meetings, particularly for patients on the palliative care register.

The Practice Whitehawk Road

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a Care Quality Commission (CQC) Lead Inspector and included a GP specialist advisor and a practice manager specialist advisor.

Background to The Practice Whitehawk Road

The Practice Whitehawk Road offers general medical services to people living in the Whitehawk area of Brighton and Hove. It is a practice with three locum GPs, one of whom is a long term locum and the other two have been with the practice for several months. In addition a lead locality GP for The Practice Group/Chilvers and McCrea Ltd was available for support and attended the practice to run a clinic session each week. There are approximately 3890 registered patients.

The practice was run by Chilvers and McCrea Ltd. The practice was supported by central management functions from the head office, including human resources, health and safety and clinical locality leads. The practice was also supported by a long term locum GP, two additional locum GPs, a nurse, and a team of receptionists. Operational management was provided by the practice manager.

The practice runs a number of services for its patients including asthma clinics, child immunisation clinics, diabetes clinics, new patient checks, and weight management support.

Services are provided from:

The Practice Whitehawk Road

179 Whitehawk Road,

Brighton,

BN2 5FL

The practice has opted out of providing Out of Hours services to their patients. There are arrangements for patients to access care from an Out of Hours provider.

The practice population has a higher number of patients under the age of 18, compared with the England average but comparable with the clinical commissioning group (CCG) average. The practice population also has a higher number of patients claiming disability allowance compared with the England and clinical commissioning group (CCG) average, plus a higher percentage of unemployment and percentage of patients with a long standing health condition.

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 was 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

How we carried out this inspection

Before visiting the practice we reviewed a range of information we hold. We also received information from local organisations such as NHS England, Health watch and

Detailed findings

the NHS Brighton and Hove Clinical Commissioning Group (CCG). We carried out an announced visit on 6 May 2015. During our visit we spoke with a range of staff, including GPs, practice nurses, and administration staff.

We observed staff and patients interaction and talked with three patients. We reviewed policies, procedures and operational records such as risk assessments and audits. We reviewed four comment cards completed by patients, who shared their views and experiences of the service, in the two weeks prior to our visit.

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

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

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

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

Please note that when referring to information throughout this report, for example any reference to the Quality and Outcomes Framework (QOF) data, this relates to the most recent information available to the CQC at that time.

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 with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. We saw that incidents were reported on the online system via the practice intranet and all staff we spoke with had a good understanding of this process.

We reviewed safety records, incident reports and minutes of meetings where incidents were discussed for 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, incidents and accidents that had occurred during the last year and we were able to review these. Significant events were discussed at practice meetings and we saw that this included a review of actions and learning from significant events and complaints. The provider also reviewed incidents reported centrally at head office and collated these so that trends and patterns could be identified and action taken to address this. There was evidence that the practice had learned from these and that the findings were shared with relevant staff.

Staff used incident forms on the practice intranet and sent completed forms to the practice manager. They showed us the system used to manage and monitor incidents. We tracked one incident and saw records were completed in a comprehensive and timely manner. We saw evidence of immediate action taken as a result of the incident, and a risk assessment of the likelihood of recurrence.

National patient safety alerts were disseminated by the practice manager via email to practice staff. These were also received directly by the GPs. Staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for. They also told us alerts were discussed at practice meetings to ensure all staff were aware of any that were relevant to the practice and where they needed to take action.

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 all staff had received relevant role specific training on safeguarding. 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 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 and flow charts of action to be taken were visible in office and treatment areas. There was also information visible for patients in the waiting area relating to concerns about abuse and this included relevant contact numbers for people to report concerns.

The practice had appointed the practice nurse as lead in safeguarding vulnerable adults and children. They had been trained and could demonstrate that they had the necessary training to enable them to fulfil this role (level three safeguarding children training). All staff we spoke with were aware who the lead was and who to speak with in the practice if they had a safeguarding concern. We viewed the results of an internal safeguarding audit where staff had been questioned about access to information about safeguarding, indicators of abuse, and who to contact in and out of hours. The audit demonstrated 100% compliance with the practice's safeguarding policies and procedures.

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 was a chaperone policy, which was visible on the waiting room noticeboard and in consulting rooms. A chaperone is a person who can offer support to a patient who may require an intimate examination. The practice policy set out the arrangements for those patients who wished to have a member of staff present during clinical examinations or treatment. All nursing staff had been trained to be a chaperone. Some receptionists had also undertaken chaperone duties but we were told they had

not received specific training in this, although staff we spoke with appeared to understand their responsibilities when acting as chaperones. All staff undertaking these duties had received a criminal records check through the Disclosure and Barring Service. We saw there were posters on display within the waiting room which displayed information for patients.

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

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were not stored securely. The door to the treatment room was unlocked and one of two vaccination fridges was unlocked, staff told us this was because the fridge key was missing. There was a clear policy for ensuring that medicines were kept at the required temperatures and we viewed temperature logs that demonstrated regular checks were being carried out. Staff were able to tell us of an example of where there had been a problem with a medicine refrigerator. The action they had taken to ensure the safety of medicine storage included seeking advice from the manufacturer, discarding affected stock and using a temperature probe that would continuously monitor the fridge temperature at times when the practice was closed.

The practice had processes 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 stored at the practice. Controlled drugs are medicines that require extra checks and special storage arrangements because of their potential for misuse.

There were comprehensive medicines management policies in place. GPs took ownership of their own patient repeat prescription requests and patient medicines reviews and we were told they were organised by individual GPs in line with the National Prescribing Centre guidance. GPs maintained records showing how they had evaluated the medicines and documented any changes. Where changes were identified the practice liaised with the patient to describe why the change was necessary and any impact this may have. All prescriptions were reviewed and signed by a GP before they were given to the patient. Both blank prescription forms for use in printers and those for hand written prescriptions were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

Vaccines were administered by nurses using directives that had been produced in line with legal requirements and national guidance. We saw up to date copies of directives that had been signed by the lead GP from the Brighton Homeless Healthcare part of The Practice Group/Chilvers and McCrea Ltd who undertook two administrative sessions a week to support the practice. We saw evidence that nurses had received appropriate training to administer vaccines.

Cleanliness and infection control

We observed the premises to be clean and tidy. We saw there were treatment room and general cleaning schedules in place and cleaning records were kept. However, there was no cleaning schedule for equipment within the treatment rooms e.g. blood pressure monitors and nebuliser machines. Staff told us this was because clinical equipment was cleaned after each use and was the responsibility of the staff member using it. We saw that single use items such as nebuliser or oxygen masks were in use. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control. The practice had a contract with an external cleaning provider which specified the cleaning requirements and frequencies. We observed that this was checked on a regular basis and any issues that had arisen had been brought to the attention of the cleaning provider and addressed.

The practice had a lead for infection control. They had attended infection control training and attended regional infection control meetings and lead nurse meetings with colleagues within The Practice Group/Chilvers and McCrea Ltd where infection control was discussed. All staff had received induction training about infection control specific to their role and received annual updates. We saw evidence the lead had carried out infection control audits. The results had been recorded and used to monitor any improvements identified and these were discussed at meetings. We viewed meeting minutes that included a discussion about conducting a hand washing audit within the practice.

Requires improvement

Are services safe?

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use. Staff were able to describe how they would use these to comply with the practice's infection control policy. There was also a policy for needle stick injury, with signage on display to remind staff of the immediate action to be taken.

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.

We saw that the building was co-occupied with other services and that a facilities manager from the trust the building was leased from was based on site. We saw that a contract was in place between the practice and the trust and that the trust was responsible for building maintenance and some aspects of infection control, including legionella (a bacterium which can contaminate water systems in buildings) testing. The practice held copies of maintenance certificates and the practice manager was responsible for overseeing maintenance. We saw an example of a record of an infection control concern being addressed with the facilities manager as a result of an infection control audit.

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. We saw evidence of calibration of relevant equipment and pat testing that had last been completed in the past 12 months.

Records showed essential maintenance was carried out on the main systems of the practice. For example, fire safety equipment was serviced annually by an external contractor. Panic alarms were available via the computer system in all consulting and treatment rooms in case of emergency. All staff would respond if a call was raised.

Staffing and recruitment

Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records 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.

Staff told us there were suitable numbers of staff on duty and that staff rotas were managed well. The majority of practice staff worked part time which allowed for some flexibility in the way the practice was managed. Staff we spoke with told us they were flexible in the way they worked to meet the needs of patients. Staff told us there was usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to ensure patients were kept safe. The practice was reliant on locum GP cover and we saw that appropriate checks were carried out and information available for locums to ensure they operated within practice guidelines.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice manager was the lead for health and safety and a health and safety policy was produced by head office and was available via the practice intranet. A local health and safety policy was also available.

We saw that any risks were discussed at practice meetings. For example, we saw safeguarding, significant events, child protection and vulnerable adults were standard agenda items and discussed at each meeting. We also saw that examples of good practice were discussed and learning cascaded in relation to safety and responding to risk.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated

Requires improvement

Are services safe?

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 and hypoglycaemia. Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Risks identified included power failure, staff shortage and access to the building. We saw an example where the business continuity plan had been implemented effectively due to GP shortages and sickness.

The practice had carried out a fire risk assessment that included actions required to maintain fire safety. Records showed that staff were up to date with fire training.

Requires improvement

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence and from local commissioners. The staff we spoke with and the evidence we reviewed confirmed that these actions were designed to ensure that each patient received support to achieve the best health outcome for them. 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 nurse working at the practice specialised and was trained in specific chronic disease management that included diabetes, heart disease and asthma. They also carried out patient health checks. They regularly assessed patients during appointments to help them manage their conditions and to offer advice and support. Patients with learning disabilities and with poor mental health received annual health checks. Patients eligible for flu vaccinations were identified and encouraged to attend the practice to receive them. The practice monitored their performance in this area and had taken action to improve uptake for eligible patients.

There was a system in place for the effective management of patients requiring cervical smear tests. Patients were invited to book an appointment. The practice monitored performance in this area and had identified improvements to be made. We saw meeting minutes where action had been discussed in this area and saw that a plan was in place for the practice nurse and lead locality nurse to roll out a cervical smear programme to improve rates of uptake. A system was in place for dealing with abnormal results that included contacting the patient and arranging a follow-up appointment with a GP. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support. We saw that learning from educational meetings attended by individual staff was cascaded at practice meetings or through printed information available in staff areas. For example we saw that regional meetings were held at different levels within the practice locality, such as the nurses from each locality practice would meet with the regional lead nurse and share learning.

The practice used computerised tools to identify patient groups who were on registers. For example, carers, patients with learning disabilities or patients with long term conditions. We saw no evidence of discrimination when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were referred on need and that age, sex and race was not taken into account in this decision-making.

Management, monitoring and improving outcomes for people

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

The practice had a system for completing clinical audit cycles. Examples of clinical audit included an audit of high dose inhaled corticosteroids in asthma patients which included a review and successful reduction in use for two patients. The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. For example, 87% of patients with diabetes, on the register, had a record of retinal screening in the preceding 12 months compared with the CCG average of 86% and the national average of 90%. We also noted that 82% of patients with asthma, on the register, had an asthma review in the preceding 12 months compared with the CCG and national average of 75%. 67% of patients with a diagnosis of depression had been reviewed not earlier than 10 days after and not later than 35 days after the date of diagnosis compared with the CCG average of 73% and the national average of 78%. The practice met all the minimum standards for QOF in asthma/atrial fibrillation/cancer/chronic kidney disease/heart failure/hypothyroidism/palliative care.

The team was making use of clinical audit tools, clinical supervision and staff meetings to assess the performance of clinical staff. We also saw that the lead locality GP for The Practice Group/Chilvers and McCrea Ltd undertook annual consultation reviews for the GPs at the practice, reviewing a selection of consultations and identifying areas of good

Requires improvement

Are services effective?

(for example, treatment is effective)

practice and development. This was also done for the practice nurse. We saw that the review of consultations led to suggestions for improving and maintaining practice. The staff we spoke with discussed, as a group how they reflected on the outcomes being achieved and areas where this could be improved. Staff spoke positively about the culture in the practice around quality improvement. We saw that quality improvement issues were discussed and recorded at practice meetings.

There was a protocol for repeat prescribing which was in line with national guidance, and in line with national guidance, 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 were told 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 had a palliative care register but did not have regular multidisciplinary meetings to discuss the care and support needs of patients and their families. Practice staff told us that the low number of patients they had on the register had made it difficult to hold multidisciplinary meetings but that they were in discussions with a neighbouring practice that operated from the same building to hold joint meetings. The lead locum GP was lead for palliative care and staff were alerted to a patient being on the register so that if the patient contacted the surgery they could respond appropriately. There was also a system in place to ensure up to date patient information was shared with the Out of Hours service.

The practice was involved in a proactive care project to care for patients attending the practice who may require a more multi-disciplined service of care. For example, patients who were frail or most likely to be subject to unplanned hospital admissions. The proactive care project involved working within a cluster with other practices in the area and a stratification tool was being set up to identify patients. Patients were also highlighted on the practice computer system so that their care could be prioritised.

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 had outcomes that were comparable to other services in the area.

Effective staffing

Practice staffing included GPs, nursing, managerial and administrative staff. The practice was run by the provider organisation using; three locum GPs (including one long term locum and two who had been with the practice for several months). In addition a GP from one of the other practices within the group provided support and supervision to the locum GPs. Recruitment of GPs had been problematic for the surgery and we saw this reflected in some of the feedback we received from patients. The practice manager had worked with The Practice Group/ Chilvers and McCrea Ltd head office to work on recruitment and at the time of the inspection there was a stable locum GP team in place. Additional GP support was provided by a locality lead GP for The Practice Group/ Chilvers and McCrea Ltd based in Brighton. The locality lead GP would provide support as necessary and would help with a specific weekly clinic. We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as annual basic life support and safeguarding training. All GPs were up to date with their yearly continuing professional development requirements and all either had been revalidated or had a date for revalidation. (Every GP is appraised annually and every five years undertakes a fuller assessment called revalidation. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practice and remain on the performers list with NHS England).

The nurse at the practice had the necessary skills, qualifications and experience to carry out their role. They were given time to undertake their continuous professional development to enable them to keep up to date with their skill levels. Nurses had received appropriate specialist training in delivering the services provided. These included managing patients with long term conditions such as asthma or diabetes, providing immunisations for children and adults, cervical smear testing and smoking cessation advice. The practice had a vacant healthcare assistant post

they were recruiting to. In the meantime the lead locality nurse for The Practice Group/Chilvers and McCrea Ltd was supporting the practice nurse to address areas of practice where improvements were required e.g. cervical smears.

All staff undertook annual appraisals that identified learning needs from which action plans were documented although some of the staff we spoke with had not been in post for 12 months so had not yet received an appraisal. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses.

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, travel health and cervical cytology. Those with extended roles, for example seeing patients with long-term conditions such as asthma and chronic obstructive pulmonary disease (COPD) were able to demonstrate that they had appropriate training to fulfil these roles.

Working with colleagues and other services

The practice worked with other service providers to meet patient 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 policy outlining the responsibilities of all relevant staff in 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 generally worked well.

The practice was looking at ways to hold multidisciplinary meetings for patients with complex needs, particularly those with palliative care needs. We saw that discussions had been held with a neighbouring practice to hold joint meetings. The practice was co-located in a building with another practice and other healthcare services. Staff told us this meant they had key staff on site or nearby so that they could hold discussions in person more easily. However, staff acknowledged there needed to be a better system for joint working with other services.

Information sharing

The computerised patient record system was used to record all relevant details about patients on their records.

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. We found that information was being shared appropriately between other healthcare providers and the practice in relation to their patients. Electronic systems were also in place for making referrals. The practice made referrals through the Brighton and Hove Integrated Care Service (BICS). The BICS service provides a clinical review service and works to ensure patient referrals meet their needs, while providing peer review in relation to referrals. Staff reported that this system was easy to use.

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record System One to coordinate, document and manage patients' care. All staff were fully trained on the system.

Consent to care and treatment

We found that staff had some awareness of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling them. However, not all staff had attended Mental Capacity Act (2005) training. All the clinical staff we spoke to understood the key parts of the legislation and demonstrated a degree of understanding about how they would implement it in practice but this was not embedded in the practice.

Patients with a learning disability and those with dementia were recorded on a register and monitored regularly. We saw they were supported to make decisions through the use of care plans, which they were involved in agreeing. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it). When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision. All clinical staff 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).

Requires improvement

Are services effective?

(for example, treatment is effective)

There was a practice policy for documenting consent for specific interventions. Staff we spoke with demonstrated an understanding of the need to seek consent prior to carrying out a procedure, ensuring that patient's had a good understanding of what they were consenting to.

Health promotion and prevention

It was practice policy to offer a health check with the 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. The practice also offered NHS Health Checks to all its patients aged 40-75. GPs we spoke with told us that regular health checks were offered to those patients with long term conditions and those experiencing mental health concerns. We also noted that medical reviews took place at appropriate timed intervals.

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, the practice provided weight management advice, smoking cessation advice and could refer patients on for wellbeing support. There were services in place for patient's to be referred to smoking cessation clinics outside of the practice and we saw information about these on posters in the waiting area. The practice also participated in a navigator service where a volunteer navigator was available to support patients in accessing community based services that were available to them. The volunteer navigator post was vacant at the time of our inspection but we were told they would work within the local community, and spend time based at the practice.

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 dementia and we saw that 100% of them had attended a dementia review appointment in the preceding 12 months. Patients with a long term condition were offered regular health checks and we saw that additional support services were available. For example, while the practice nurse was waiting for training in smoking cessation they were able to refer patients to a local pharmacy for smoking cessation advice.

The practice's performance for cervical smear uptake was 79%, which was similar to national indicators. However, the practice had identified this as an area that was at risk due to staffing difficulties so had plans in place to run a cervical screening programme with help from one of The Practice Group/Chilvers and McCrea Ltd regional nursing leads. There was a policy to offer telephone reminders for patients who did not attend for cervical smears and the practice audited patients who do not attend. There was also a named nurse responsible for following up patients who did not attend screening.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. There was a clear policy for following up non-attenders by the named practice nurse. The practice had numerous ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice kept a register of all patients with a learning disability and invited them to yearly annual reviews. The practice also aimed to identify the smoking status and alcohol consumption of patients with a physical or mental health condition, although this was an area identified for improvement. For example, 48% of patients with schizophrenia, bipolar affective disorder and other psychoses had a record of their alcohol consumption in the preceding 12 months. We saw that this was an area the practice had targeted for improvement.

The practice offered a full range of immunisations for children, and flu vaccinations in line with current national guidance. We reviewed our data and noted that 90% of children aged below 24 months had received their mumps, measles and rubella vaccination.

Health information was made available during consultation and GPs used materials available from online services to support the advice they gave patients. There was a variety of information available for health promotion and prevention in the waiting area and the practice website referenced websites for patients looking for further information about medical conditions.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

Patients completed CQC comment cards to tell us what they thought about the practice. We received four completed cards and the majority were positive about the service experienced. Patients said they felt the practice offered a caring service and staff were kind and helpful. We also spoke with three patients individually on the day of our inspection. Two of the patients told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. One patient had concerns about appointment times and continuity of care but felt there had been some improvements since the new 'doctor first' telephone appointment system had been introduced.

We reviewed the most recent GP national survey data available for the practice on patient satisfaction. The evidence from the survey showed patients were generally satisfied with how they were treated and this was with compassion, dignity and respect. However, the practice generally performed below the CCG and national averages in terms of patient feedback. For example 71% of patients rated their overall experience of the practice as good compared with CCG and national averages of 85%. , 79% of practice respondents said the GP was good at listening to them compared with the local average of 88% and the national average of 89%. Patients who stated that the last nurse they saw or spoke to was good at listening to them was at 82% compared with the local and national average of 91%. We also noted that 82% of patients had responded that they had confidence and trust in the last GP they saw or spoke to compared with the local and national average of 95%. 89% said the same about the last nurse they saw compared with the local and national average of 97%.

The practice collected and reviewed customer comments and suggestions and complaints and collated these into a format for discussion at practice meetings. We saw that some concerns from patients included aspects of the appointment system. We saw that individual incidents and concerns were discussed and action taken as a result.

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 doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

We observed that staff were careful to follow the practice's confidentiality policy when discussing patient treatment in order that confidential information was kept private. The reception area and waiting room were separate which allowed for greater privacy for patients and we saw that patients were given the option of speaking with reception staff away from the main entrance to the surgery if they wished. We also noted that telephone calls were taken away from the reception desk so staff could not be overheard. Staff were able to give us practical ways in which they helped to ensure patient confidentiality.

There was a clearly visible notice in the patient reception area stating the practice's zero tolerance for abusive behaviour. Receptionists told us that referring to this had helped them diffuse potentially difficult situations.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded generally positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example, data from the national patient survey showed 70% of practice respondents said the GP involved them in care decisions compared with 73% of patients across the CCG and 66% nationally. Of those surveyed 79% of patients felt the GP was good at explaining treatment and results compared with 81% across the CCG and 82% nationally. The practice was working towards improving care planning for patients with long term conditions and mental health issues. For example, we saw on the day of our inspection that 86% of care plans and mental health reviews had been undertaken for patients on the register.

Patients we spoke to on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. We saw that patients with learning disabilities were offered an annual review. Patients we spoke with also told us they felt listened to and supported by staff and had sufficient time during consultations to

Good

Are services caring?

make an informed decision about the choice of treatment they wished to receive. Patient feedback on the comment cards we received was also positive and aligned with these views.

Staff told us that translation services were available for patients who did not have English as a first language.

Patient/carer support to cope emotionally with care and treatment

The survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. The results of the national GP survey showed that 74% of patients said the last GP they saw or spoke to was good at treating them with care and concern compared with 81% across the CCG and 83% nationally. Of those surveyed 82% of patients said the nurses were also good at treating them with care and concern compared with 77% across the CCG and 78% nationally. Patients we spoke with on the day of our inspection and the comment cards we received were also consistent with this survey information. For example, these highlighted that staff responded compassionately when patients needed help and provided support when required.

Notices in the patient waiting room and patient website also told patients how to access a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer. We saw information was available for carers to ensure they understood the various avenues of support available to them. Staff told us they were made aware of patients or recently bereaved families so they could manage calls sensitively and refer to the GP if needed. We were informed that the GP would contact the family and when appropriate advice on how to access support services would be given.

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 people'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 had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from patients. For example, the practice had implemented a telephone triage system and participated in an extended hours project within the locality to create greater flexibility and access for patients who had been struggling to get appointments at a time that suited them. The new system had been implemented to improve accessibility to appointments and ensure more patients could get through to the practice by telephone. We viewed an audit of telephone calls and saw that there had been a 9% improvement in calls being answered within two minutes. Patients we spoke with told us it was easier to get through to the practice by phone and that they were more easily able to get an appointment when they wanted one.

A GP triaging system was in place. Longer appointments were available for patients who needed them and those with long term conditions. GPs completed telephone consultations each day and home visits could be requested when necessary. Working age patients were able to book appointments and order repeat prescriptions on line. The practice was able to access services through EPIC (Extended Primary Integrated Care) which meant that patients could access appointments on weekends and evenings through an extended hours service with other locality practices.

Patients experiencing poor mental health were supported by the GPs and local mental health teams. A mental health lead clinician oversaw patients with a diagnosis of depression or severe mental health problems. Patients with likely dementia were offered an annual review at the practice or at home with discussion with carers following diagnosis. We saw that mental health was an area where the practice had been working to improve performance. Patients could be referred to counsellors as needed and staff were aware of the availability support from the community mental health team.

The practice had a register of patients who were house bound. The register ensured the practice was aware when these patients had medicine requests, required home flu jabs, annual reviews or care planning. The practice also supported patients who were resident in a local care home and we saw that the lead GP was involved in supporting best interest decisions for patients who did not have mental capacity.

The practice supported patients with either complex needs or who were at risk of hospital admission. The practice were involved with a local proactive care team project which included district nurses, community matron, physiotherapists, occupational therapists and pharmacists. Personalised care plans were produced and were used to support people to remain healthy and in their own homes. The practice had a palliative care register and had regular internal discussions to support patients and their families, although there had been limited success in scheduling multidisciplinary palliative care meetings. The practice was working with a neighbouring practice to arrange shared multidisciplinary meetings due to the small numbers of patients on each of their palliative care registers.

Patients with a long term condition had their health reviewed in one annual review. This provided a joined up service working with the patient as a whole rather than just their individual condition and worked with community matrons, district nurses and proactive care team to provide support. The practice provided care plans for asthma, chronic obstructive pulmonary disease (COPD), coronary heart disease, diabetes, dementia and severe mental health.

Childhood immunisation services were provided through dedicated clinics and administrative support to ensure effective follow up.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. The number of patients with a first language other than English was low. Staff knew how to access language translation services if these were required.

Good

Are services responsive to people's needs?

(for example, to feedback?)

The practice provided equality and diversity training through an on-line training programme. The practice had policies for equality and diversity and we saw that the service was planned to meet the needs of individuals.

The premises and services met the needs of people with disabilities. The patient areas within the practice were situated on the ground floor of a purpose built building. Patients had level access to the front entrance of the practice. Patients with restricted mobility could easily enter the practice and had level access to reception. The waiting area was accessible for wheelchairs and mobility scooters.

Access to the service

Appointments were available from 8am to 6pm Monday to Friday. Extended access appointments were available through an extended primary integrated care (EPIC) service where patients can see a GP in another practice during evenings and at weekends. Requests for urgent appointments were dealt with by a telephone triaging system where a doctor would call the patient to discuss the problem and arrange an appointment or provide advice as needed. Patients were asked to call the surgery in the morning for urgent appointments and home visits where possible, however practice staff told us they could still offer patients advice and appointments outside of this time if needed.

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.

Longer appointments were also available for people who needed them and those with long-term conditions. This also included appointments with a named GP or nurse. Home visits could be arranged and GPs visited a local care home.

Patients were generally satisfied with the appointments system. They confirmed that they could see a doctor on the same day if they needed to. Comments received from patients showed that patients in urgent need of treatment were able to make appointments on the same day of contacting the practice. We noted data from the national patient survey indicated that 71% of respondents said they were able to get an appointment to see or speak to someone the last time they tried compared with 88% across the CCG and 85% nationally. Of those surveyed 86% of respondents said the last appointment they got was convenient compared with 93% of patients across the CCG and 92% nationally**.** On the day of inspection we asked staff when the next available appointment would be for an emergency and a cervical screening. The appointment system showed that there was an emergency slot free for a telephone appointment that afternoon, or a face to face appointment the following morning. and that they could also offer extended hours evening appointments through the EPIC service. We noted that the next cervical screening appointment with the nurse was in two weeks.

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. There were posters in the waiting room to describe the process should a patient wish to make a complaint or provide feedback, including through a comments/suggestion box. Information was also advertised on the practice website. One of the patients we spoke with had made a complaint about the practice in the past relating to accessibility of appointments and concerns they hadn't been able to get appointments for their children when needed. However, they told us this had improved with the new appointment system and that they were always able to speak with a doctor by phone, with the doctor calling them within an hour or two of their initial call.

We looked at three complaints received in the last 12 months and found these were all discussed, reviewed and learning points noted. We saw these were handled and dealt with in a timely way. We noted that lessons learnt from individual complaints had been acted on. Staff we spoke with knew how to support patients wishing to make a complaint and told us that learning from complaints was shared with the relevant team or member of staff. The culture of the practice was that of openness and transparency when dealing with complaints and the

Good

Are services responsive to people's needs?

(for example, to feedback?)

practice tried to encourage patients to share their opinions. The practice did not have a patient participation group (PPG) involved in the practice and had not undertaken a patient survey. We were told efforts had been made to develop this using both face to face and virtual methods. The practice manager told us they were looking at a model of shared PPG with neighbouring practices who had experienced similar difficulties in setting up a PPG.

The Practice PLC reviewed complaints annually to detect themes or trends. This had helped the practice to identify changes required to how they managed their appointment and telephone systems to improve the service for patients. Lessons learnt from individual complaints had been acted on and improvements made to the quality of care as a result.

Are services well-led?

Requires improvement

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

Our findings

Vision and strategy

The practice had a clear vision to provide high standards of care, involve patients in decision making about their treatment and care, promote healthy lifestyles and ensure continuous improvement of healthcare services.

We found details of the vision and practice priorities in their statement of purpose. The practice also aimed to treat patients with dignity and respect, ensure effective governance systems, continually educate and motivate staff, and ensure the quality of service through supervision and shared learning.

We spoke with 10 members of staff and they all knew and understood the vision and values and knew what their responsibilities were in relation to these. Staff spoke positively about the practice and thought there was good team work with a good level of active support from senior staff. Staff described the culture of the practice as being supportive, positive and open to their suggestions and ideas.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the practice. Policies were generated centrally by The Practice Group/Chilvers and McCrea Ltd head office and local policies were also in place within the surgery. We looked at some of these policies and procedures and found these had been reviewed annually, were up to date and contained relevant information for staff to follow. This included recruitment, medicine management, whistleblowing, complaints, business continuity, chaperoning and infection control.

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead nurse for safeguarding and infection control. We spoke with 10 members of staff and they were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

The practice had an on-going programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. For example, audits in the preceding 12 months included cervical smears, inhaled corticosteroids and GP and nurse consultation audits.

The practice had robust arrangements for identifying, recording and managing risks. The practice manager showed us risk assessments, which addressed a wide range of potential issues, such as infection control, manual handling, fire, COSHH (control of substances hazardous to health), and violence and aggression.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed it was performing in line with national standards in some areas, for example asthma, atrial fibrillation, cancer, depression and chronic kidney disease. However, it was performing below national standards in other areas, for example dementia, mental health and chronic obstructive pulmonary disease (COPD). We viewed a plan in place and progress made by the practice to address the areas identified as falling below national and CCG levels. QOF data was discussed at monthly team meetings to maintain or improve outcomes and the practice demonstrated an improvement in their overall QOF score in the preceding 12 months. The practice held regular meeting where performance, quality and risks had been discussed. Clinical audits and significant events were regularly discussed at meetings. The practice participated in group clinical governance activities and meetings. Meetings were held which enabled staff to keep up to date with practice developments and facilitated communication between the GPs and the staff team.

Leadership, openness and transparency

We saw from minutes that team meetings had begun to be held regularly and there were regular management / clinical meetings although these were yet to be consistent over time. Staff told us there was an open culture within the practice that had been developed with changes to the practice management structure and they were happy to raise issues and felt encouraged to do so. The practice manager and clinical staff participated in group meetings with peers across The Practice Group/Chilvers and McCrea Ltd and there was support available for staff from regional leads within the group.

Are services well-led?

Requires improvement

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

We saw there were a number of human resource policies and procedures in place to support staff, including equality and diversity, complaints and whistleblowing. Staff were aware of the whistle blowing policy. They told us they knew it was their responsibility to report anything of concern and knew the management of the practice and their clinical colleagues would take their concerns seriously. Staff we spoke with knew where to find these policies on the electronic system if required.

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

The practice had gathered feedback through patient complaints and feedback but they did not routinely conduct their own patient survey and they did not have an active PPG in operation. Results from the GP patient survey showed that the practice had performed below both the local and national average in all areas. We did not see evidence that the practice had used this information to improve patient experience.

The practice had gathered feedback from staff through staff discussion, meetings and appraisals. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and supervision. We looked at staff files and saw that regular appraisals took place and included personal development plans, although a number of staff were new in post so had not had an annual appraisal at the time of our inspection. Staff told us that the practice was very supportive of training and that they had regular training either organised with the local clinical commissioning group, The Practice Group/Chilvers and McCrea Ltd or by the practice.

The practice had completed reviews of significant events and other incidents and shared with staff at meetings to ensure the practice improved outcomes for patients and staff. For example, we noted that staff had been involved in discussions about incidents concerning patients and that learning was identified and cascaded.

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 15 HSCA (RA) Regulations 2014 Premises and equipment The provider had failed to ensure that equipment was cleaned in line with current legislation and guidance. The provider had failed to operate a cleaning schedule for the cleaning of equipment and was therefore unable to monitor the levels of cleanliness. This was a breach of regulation 15 (1) (a) 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 Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider had failed to comply with the proper and safe management of medicines. Medicines were not stored securely within treatment rooms and refrigerators. This was a breach of regulation 12 (2) (g) 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 Surgical procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing The provider had failed to ensure that persons employed by the service provider in the provision of a regulated activity had received such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform.

This section is primarily information for the provider

Requirement notices

This was a breach of regulation 18 (2) (a) 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 Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider had failed to seek and act on feedback from relevant persons and other persons on the services provided in the carrying on of the regulated activity, for the purposes of continually evaluating and improving such services. This was a breach of regulation 17 (2) (e) (f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014