Pavilion Surgery

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Pavilion Surgery on 27 May 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing well-led, caring, effective and responsive services. It was also good for providing services for the care of all the population groups. It required improvement for providing safe services.

Our key findings across all the areas we inspected 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 with the exception of those relating to legionella re-inspection and ensuring all clinical staff had received DBS checks prior to commencing in post.
- The process of risk assessment was focused on the identification and monitoring of risk, however a documentation did not clearly record control measures or summaries of action taken.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and 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.
- Information about services and how to complain was available and easy to understand.
- Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day.

Summary of findings

- 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.

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

Importantly the provider must;

- Ensure that a legionella inspection is carried out.
- Ensure that all clinical staff have received a DBS check prior to them commencing in post.

In addition the provider should;

- Ensure that meeting minutes include details of which staff were present and a summary of discussions held to include actions to be taken and by whom.
- Support the PPG to gather and review patient feedback on the practice and ensure this is recorded so that the practice demonstrates on-going learning from patient feedback and involvement.
- Ensure that identified health and safety risks are recorded in a way that details the actions to be taken to eliminate or reduce the risk of harm.

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 their responsibilities to raise concerns, and to report incidents and near misses and reviews and investigations were carried out and communicated to support improvement. Although risks to patients who used services were assessed, the systems and processes to address these risks were not implemented well enough to ensure patients were kept safe. For example, risk assessments did not always include details of how the risk could be effectively managed, clinical staff had not all received criminal records checks via the Disclosure and Barring Service prior to commencing in post and a legionella inspection had not been carried out.

Are services effective?

Good 

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from 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 assessing capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. There was evidence of appraisals and personal development plans for all staff. Staff worked with multidisciplinary teams.

Are services caring?

Good 

The practice is rated as good for providing caring services. Data showed that patients rated the practice higher than others for several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information 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.

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 Brighton and Hove Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients said they found it easy to make

Summary of findings

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?

Good

The practice is rated as good for being well-led. It had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group (PPG) was active, although the goals and remit of the PPG in terms of seeking feedback from patients needed to be clarified. Staff had received inductions, regular performance reviews and attended staff meetings and events.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. 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.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. 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 needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. 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. Immunisation rates were relatively high 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. We saw good examples of joint working with midwives, health visitors and school nurses.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered

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to ensure these were accessible, flexible and offered continuity of care. 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.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability. It had carried out annual health checks for people with a learning disability. It offered longer appointments for people with a learning disability. 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)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). People experiencing poor mental health had received an annual physical health check. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. It carried out advance care planning for patients with dementia. The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations. It 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 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 40 completed comment cards. 30 comment cards were positive, stating that the care they received had been good, they had been treated with dignity and compassion, and staff were polite and helpful. 10 comment cards included some expression of concern about the practice. A particular theme for six patients was a difficulty in getting an appointment in a timely way. We spoke with seven patients on the day of our visit, all of whom were complementary about the service and positive about their experience.

We reviewed the results of the national patient survey which contained the views of 103 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 93% had confidence and trust in the last GP they saw or spoke to and 93% said the last nurse they saw or spoke to was good at giving them enough time.

We spoke with seven patients on the day of the inspection. The patients we spoke with were positive about the service they received. We were told there was good quality and continuity of care and that staff were caring and respectful.

Areas for improvement

Action the service MUST take to improve

- Ensure that a legionella inspection is carried out.
- Ensure that all clinical staff have received a criminal record check via DBS check prior to them commencing in post.

Action the service SHOULD take to improve

- Ensure that meeting minutes include details of which staff were present and a summary of discussions held to include actions to be taken and by whom.
- Support the Patient Participation Group to gather and review patient feedback on the practice and ensure this is recorded so that the practice demonstrates on-going learning from patient feedback and involvement.
- Ensure that identified health and safety risks are recorded in a way that details the actions to be taken to eliminate or reduce the risk of harm.

Pavilion Surgery

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 Pavilion Surgery

Pavilion Surgery offers general GP services to patients in central Brighton. There are approximately 8965 registered patients.

The practice was run by Dr Gilhooly and four other partners. The practice was supported by a practice manager, two salaried GPs, practice nurses, a healthcare assistant and a team of administrative and reception staff.

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

Services are provided from:

Pavilion Surgery

2-3 Old Steine

Brighton

Sussex

BN1 1EJ

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 than national average percentage of patients in paid work or full-time education at 72% compared with 60%. The practice has a higher than national average deprivation score.

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.

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

How we carried out this inspection

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

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

Detailed findings

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

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

Before visiting we reviewed a range of information we hold about the practice and asked other organisations such as NHS England and Brighton and Hove Clinical Commissioning Group and Health watch to share what they knew. We asked the provider to send us information about their practice and to tell us about the things they did well. We reviewed the information for patients on the practice website and carried out an announced visit on 27 May 2015.

We talked with all the staff employed in the practice who were working on the day of our inspection. This included four GPs, one healthcare assistant, one practice nurse, four administrative staff, the office manager and assistant practice manager. We spoke with seven patients visiting the practice during our inspection.

Requires improvement

Are services safe?

Our findings

Safe track record

The practice prioritised safety and 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. For example we viewed an incident where blood results had been incorrectly read and we saw that this had been reported and action taken to address the impact on the patient and to ensure learning.

We reviewed safety records, incident reports and minutes of meetings where these were discussed for the last year. This showed the practice had managed these consistently over time and so could show evidence of a safe track record over the long term.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. We reviewed records of 12 significant events that had occurred during the last year and saw this system was followed appropriately. Significant events was a standing item on the practice meeting agenda and we saw this documented as a heading on meeting minutes. However, details of discussions were not recorded so we could not gauge the content of discussions. Staff confirmed that these discussions included a review of actions from past significant events and complaints. There was evidence that the practice had learned from these and that the findings were shared with relevant staff. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

Staff used incident forms on the practice intranet and sent completed forms to the practice manager. She showed us the system used to manage and monitor incidents. We tracked 12 incidents and saw records were completed in a comprehensive and timely manner. We saw evidence of action taken as a result and that the learning had been shared, for example we saw that an incident relating to a delay in one patient's urgent referral for investigations had been discussed and changes to the way the practice followed these up had been identified. Where patients had been affected by something that had gone wrong they were given an apology and informed of the actions taken to prevent the same thing happening again.

National patient safety alerts were disseminated by the practice manager to practice staff. 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 the practice meeting 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 we viewed flow charts that detailed the process to follow including contact details.

The practice had appointed dedicated GPs as leads in safeguarding vulnerable adults and children. They had been trained in both adult and child safeguarding and could demonstrate they had the necessary competency and training to enable them to fulfil these roles. All staff we spoke with were aware who these leads were and who to speak with in the practice if they had a safeguarding concern.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments. For example children subject to child protection plans were flagged on the electronic system. There was active engagement in local safeguarding procedures and effective working with other relevant organisations including health visitors and the local authority.

Requires improvement

Are services safe?

There was a chaperone policy, which was visible on the waiting room noticeboard and in consulting rooms and on the practice web site. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). All nursing staff, including health care assistants, had been trained to be a chaperone. Not all staff undertaking chaperone duties had received Disclosure and Barring Service (DBS) checks, or a risk assessment. For example two new clinical staff had started in post without a completed criminal record check via DBS or sight of a criminal record check via DBS from a previous employer. We were told the checks were being processed and we viewed the paperwork for this. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).

GPs were appropriately using the required codes on their electronic case management system to ensure risks to children and young people who were looked after or on child protection plans were clearly flagged and reviewed. The lead safeguarding GP was aware of vulnerable children and adults and records demonstrated good liaison with partner agencies such as the police and social services. Staff were proactive in monitoring if children or vulnerable adults attended accident and emergency or missed appointments frequently. These were brought to the GPs attention, who then worked with other health and social care professionals.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. Records showed room temperature and fridge temperature checks were carried out which ensured medication was stored at the appropriate temperature.

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

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

There was a lead GP for medicines who disseminated information to other GPs and staff in relation to prescribing data. There was a system in place for the management of high risk medicines such as warfarin, methotrexate and other disease modifying drugs, which included regular monitoring in accordance with national guidance. Appropriate action was taken based on the results. We viewed audits of high dose inhaled corticosteroid prescribing and saw that this had led to the successful reduction in prescribing for sixteen patients.

The nurses used Patient Group Directions (PGDs) to administer vaccines and other medicines that had been produced in line with legal requirements and national guidance. We saw sets of PGDs that had been updated in the preceding 12 months.

We saw a positive culture in the practice for reporting and learning from medicines incidents and errors. Incidents were logged efficiently and then reviewed promptly. This helped make sure appropriate actions were taken to minimise the chance of similar errors occurring again.

Cleanliness and infection control

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

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 and 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 and staff knew the procedure to follow in the event of an injury. We saw information about action to be taken in the event of a needle stick injury on the wall in the treatment rooms.

The practice had a lead for infection control who had undertaken further training to enable them to provide

advice on the practice infection control policy and carry out staff training. All staff received induction training about infection control specific to their role and received annual updates. We saw evidence that the lead had carried out audits for each of the last three years and that any improvements identified for action were completed on time. For example we saw that toys in the waiting area had been replaced with a cleanable bead toy and that a cleaning schedule for clinical equipment had been implemented. We viewed records that demonstrated the cleaning schedule was completed. We viewed minutes of meetings with the contracted cleaning company, where issues relating to infection control and general cleanliness were addressed.

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

The practice did not have a policy for the management, testing and investigation of legionella (a bacterium which can contaminate water systems in buildings).The practice had not undertaken a risk assessment for legionella to identify the level of risk to enable them to make a decision about on-going formal legionella testing.

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 in the preceding 12 months. A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example weighing scales, spirometers, blood pressure measuring devices and the fridge thermometer. However, we found one blood pressure monitor that had not been included in a programme of routine testing and calibration. This was taken out of operation when brought to the practice manager's attention.

Staffing and recruitment

The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. 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 the appropriate criminal records checks via the Disclosure and Barring Service (These checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable). However, we saw that two clinical staff who were new into post had not received criminal records checks via the DBS prior to commencing in post. We saw that the documentation was being processed at the time of our visit but this meant that clinical staff had been working in the practice without the practice being assured they had a criminal record check via DBS in place.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure that enough staff were on duty.

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. We saw arrangements were in place to recruit to additional nursing hours and the practice manager showed us records to demonstrate that actual staffing levels and skill mix met planned staffing requirements.

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 regular checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy. Health and safety information was displayed for staff to see and there was an identified health and safety representative.

The practice identified risks and included these on a risk log. A member of the administrative staff undertook a daily health and safety check and took action as necessary to address the risks identified. However, risks were not rated and mitigating actions were not recorded in a comprehensive risk assessment. The practice had risk assessment forms using a red, amber, green (RAG) rating system, however these were not in use at the time of our inspection although we saw that they had been used historically.

Requires improvement

Are services safe?

We saw that staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies. For example staff gave examples of how they responded to patients experiencing a mental health crisis, including supporting them to access emergency care and treatment. Staff told us they had good access to rapid access and crisis management teams.

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 in cardiac emergencies). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly. We checked that the pads for the automated external defibrillator were within their expiry date.

Emergency medicines were easily accessible to staff 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. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to. For example, contact details of the electricity company to contact if the electricity system failed. The plan was last reviewed in 2015.

The practice had carried out a fire risk assessment in 2015 that included actions required to maintain fire safety. Records showed that staff were up to date with fire training and that they practised regular fire drills.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We saw that guidance from local commissioners was readily accessible in all the clinical and consulting rooms.

We discussed with the practice manager, GP and nurse how NICE guidance was received into the practice. They told us this was downloaded from the website and disseminated to staff. We were told this was then discussed and implications for the practice's performance and patients were identified and required actions agreed. Staff we spoke with all demonstrated a good level of understanding and knowledge of NICE guidance and local guidelines.

Staff described how they carried out comprehensive assessments which covered all health needs and was in line with these national and local guidelines. They explained how care was planned to meet identified needs and how patients were reviewed at required intervals to ensure their treatment remained effective. For example, patients with diabetes were having regular health checks and were being referred to other services when required. Feedback from patients confirmed they were referred to other services or hospital when required.

The GPs told us they lead in specialist clinical areas such as diabetes, heart disease and asthma and the practice nurses supported this work, which allowed the practice to focus on specific conditions. Nurses and healthcare assistants confirmed they ran specific clinics to focus on supporting patients with long term conditions, for example asthma, COPD and diabetes. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support. GPs told us this supported all staff to review and discuss new best practice guidelines.

The practice used computerised tools to identify patients who were at high risk of admission to hospital. These patients were reviewed regularly to ensure multidisciplinary care plans were documented in their records and that their needs were being met to assist in reducing the need for them to go into hospital. We saw that after patients were discharged from hospital they were followed up to ensure that all their needs were continuing to be met.

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

Management, monitoring and improving outcomes for people

Information about people's care and treatment, and their outcomes, was routinely collected and monitored and this information used to improve care. 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 information staff collected was then collated by the practice manager and deputy practice manager to support the practice to carry out clinical audits.

The practice showed us eight clinical audits that had been undertaken in the last year. Following each clinical audit, changes to treatment or care were made where needed and we were told the audit would be repeated to ensure outcomes for patients had improved. For example, we viewed an audit of long term iron supplement prescribing where the practice was able to demonstrate the changes resulting since the initial audit which included the discontinuation of iron supplements in fifteen patients and a reduction to maintenance for a further four. Other examples included audits to confirm that the GPs who undertook minor surgical procedures were doing so in line with their registration and National Institute for Health and Care Excellence guidance.

The GPs told us clinical 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 voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). For example, we saw an audit regarding the prescribing of high risk medicines in frail elderly patients. Following the audit, the GPs carried out

Good

Are services effective?

(for example, treatment is effective)

medication reviews for patients who were prescribed these medicines and altered their prescribing practice to ensure it aligned with national guidelines. GPs maintained records showing how they had evaluated the service and documented the success of any changes and shared this with all prescribers in the practice.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. This practice was not an outlier for any QOF (or other national) clinical targets, It achieved 90.4% of the total QOF target in 2014, which was marginally lower than both the CCG and the national average of 92% and 93.5%. Overall, the practice performance was mixed in comparison with the CCG and national averages with a strong performance in some areas but lower in others. Specific examples to demonstrate this included:

- Performance for diabetes related indicators was worse than the national average, 8.5 points below.
- The percentage of patients with hypertension having regular blood pressure tests was worse than the national average, 27.7 points below.
- Performance for epilepsy was better than the national average, 1.6 points above.
- The dementia diagnosis rate was 6.6 points above the national average.
- Performance for osteoporosis was 16.6 points above the national average.

The practice was aware of all the areas where performance was not in line with national or CCG figures and we saw action plans setting out how these were being addressed. For example, diabetes was an area identified for improvement. The practice had recently recruited a nurse who was trained in diabetic care and had implemented a plan for all patients with diabetes to receive a review by the nurse of one of two GPs in the next three months.

The team was making use of clinical audit tools, and staff meetings to assess the performance of clinical staff. The staff we spoke with discussed how, as a group, they reflected on the outcomes being achieved and areas where this could be improved. Staff spoke positively about the culture in the practice around audit and quality improvement.

The practice's prescribing rates were also similar to national figures. There was a protocol for repeat prescribing which followed national guidance. This required staff to regularly check patients receiving repeat prescriptions had been reviewed by the GP. They also checked all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines. We saw evidence 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 practice had made use of the gold standards framework for end of life care. It had a palliative care register and had regular multidisciplinary meetings to discuss the care and support needs of patients and their families.

The practice also kept a register of patients identified as being at high risk of admission to hospital and of those in various vulnerable groups, for example those with learning disabilities, mental health problems and substance misuse problems. Structured annual reviews were also undertaken for people with long term conditions e.g. diabetes, COPD and asthma.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that the majority of staff were up to date with attending relevant mandatory courses such as annual basic life support and infection control and mental capacity awareness. The practice manager told us this was an area they had worked on to improve as there had been some problems with attendance due to staffing shortages. All GPs were up to date with their yearly continuing professional development requirements and all either have been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

All staff undertook annual appraisals that identified learning needs from which action plans were documented. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses, for example. As the practice was a training

Good

Are services effective?

(for example, treatment is effective)

practice, doctors who were training to be qualified as GPs were offered extended appointments and had access to a senior GP throughout the day for support. We received positive feedback from the trainees we spoke with.

Practice nurses and health care assistants had job descriptions outlining their roles and responsibilities and provided evidence that they were trained appropriately to fulfil these duties. For example, on administration of vaccines, cervical cytology, care for patients with HIV. Those with extended roles for example those seeing patients with long-term conditions such as asthma and COPD were also able to demonstrate that they had appropriate training to fulfil these roles.

Working with colleagues and other services

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

Emergency hospital admission rates for the practice were relatively low at 1.1% compared to the national average of 1.3%. The practice was commissioned for the unplanned admissions 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).

The practice held internal team meetings every week where patients with complex needs would be discussed. In addition the practice was also working within a locality cluster on a proactive care project to proactively support patients with complex needs. The practice was also involved with the palliative care locally commissioned service and attended bi-monthly multi-disciplinary meetings. These meetings were attended by district nurses, social workers, palliative care nurses and decisions about care planning were documented in a shared care record. Staff felt this system worked well. Care plans were in place for patients with complex needs and shared with other health and social care workers as appropriate.

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. We saw evidence there was a system for sharing appropriate information for patients with complex needs with the ambulance and out-of-hours services.

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. We saw evidence that audits had been carried out to assess the completeness of these records and that action had been taken to address any shortcomings identified.

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. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it.

Patients with a learning disability and those with dementia 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) and had a section stating the patient's preferences for treatment and decisions. When interviewed, staff demonstrated an understanding of how a patient's best interests were taken into account if a patient did not have capacity to make a decision, however they were unable to give examples of when a best interest decision meeting had been held. All clinical staff demonstrated a clear understanding of the

Good

Are services effective?

(for example, treatment is effective)

Gillick competency test. (These are used to help assess whether a child under the age of 16 has the maturity to make their own decisions and to understand the implications of those decisions).

There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures, a patient's verbal consent was documented in the electronic patient notes with a record of the discussion about the relevant risks, benefits and possible complications of the procedure. In addition, the practice obtained written consent for significant minor procedures and all staff were clear about when to obtain written consent. We were shown an example of a consent form for patients having their ears syringed at the practice.

The practice had not needed to use restraint in the last three years, but staff were aware of the distinction between lawful and unlawful restraint.

Health promotion and prevention

It was practice policy to offer a health check to all new patients registering with the practice. The GP was informed of all health concerns detected and these were followed up in a timely way. We noted a culture among the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering smoking cessation advice to smokers. The practice also offered NHS Health Checks to all its patients aged 40 to 75 years.

The practice had many ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice had identified the smoking status of 79.7% of patients over the age of 16 and actively offered nurse-led smoking cessation clinics to 88.8% of these patients. Similar mechanisms of identifying 'at risk' groups were used for patients who were obese and those receiving end of life care. These groups were offered further support in line with their needs.

The practice's performance for the cervical screening programme was 77%, which was below the national average of 81%. There was a policy to offer telephone reminders for patients who did not attend for their cervical screening test. A practice nurse had responsibility for following up patients who did not attend. The practice also encouraged its patients to attend national screening programmes for bowel cancer and breast cancer screening.

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 was above average for the majority of immunisations where comparative data was available. For example:

- Flu vaccination rates for the over 65s were 63%, and at risk groups 41%. These were below national averages.
- Childhood immunisation rates for the vaccinations given to under twos were at 90% and for five year olds at 70%.

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 January 2015 and results of the 'I Want Great Care' friends and family test the practice had signed up to. The practice had set up a patient participation group (PPG) in September 2014 but they had not undertaken their own patient satisfaction survey. (A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care).

The evidence from all these sources showed patients were generally satisfied with how they were treated and that this was with compassion, dignity and respect. However, survey data showed that 76% of patients describe their overall experience of good compared to the CCG and national average of 85% and 68% would recommend the surgery compared to the CCG and national average of 78%. The practice was generally on a par with local and national practices for its satisfaction scores on consultations with doctors and nurses. For example:

- 82% said the GP was good at listening to them compared to the CCG average of 88% and national average of 89%.
- 93% said the GP gave them enough time compared to the CCG average of 92% and national average of 92%.
- 93% said they had confidence and trust in the last GP they saw compared to the CCG average of 95% and national average of 95%
- 90% of patients said the last nurse they saw or spoke to was good at treating them with care and concern compared to the CCG average of 91% and the national average of 90%.
- 98% of patients said they had confidence and trust in the last nurse they saw or spoke to compared with the CCG average of 97% and the national average of 97%.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 40 completed cards and the majority were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. 10 comments were less positive and there was a common theme relating to difficulties getting appointments (6). We also spoke with seven patients on the day of our inspection. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

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

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. The practice switchboard was located away from the reception desk which helped keep patient information private. We were told that staff would offer patients an opportunity to hold confidential discussions away from other patients if they wished to, enabling confidentiality to be maintained. Additionally, 84% said they found the receptionists at the practice helpful compared to the CCG average of 88% and national average of 87%.

Staff told us that if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected, they would raise these with the practice manager. The practice manager told us she would investigate these and any learning identified would be shared with staff. We were shown an example of a report on a recent incident that showed appropriate actions had been taken.

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.

We observed staff treating patients whose circumstances may make them vulnerable with dignity and respect, for example those patients with a learning disability. Staff, including reception and administrative staff had attended training on equality and diversity and disability awareness.

Care planning and involvement in decisions about care and treatment

Good

Are services caring?

The patient survey information we reviewed showed the majority of patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas, although slightly below the CCG and national average. For example:

- 79% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 86% and national average of 86%.
- 72% said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 81% and national average of 82%.
- 83% of patients said the last nurse they saw or spoke to was good at explaining tests and treatments compared to the CCG and national average of 90%
- 78% of patients said the last nurse they saw or spoke to was good at involving them in decisions about their care compared to the CCG average of 84% and the national average of 85%.

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

Staff told us that translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patents this service was available and we observed one patient who had a translator arranged by the practice to be present during a consultation.

We viewed examples of older people and people with long term conditions being involved in discussions about their care plans. We saw evidence of patients on the palliative care register being involved in decisions about DNACPR (do not attempt cardiopulmonary resuscitation) and their preferred place of care.

Patient/carer support to cope emotionally with care and treatment

The patient survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. For example:

- 81% said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 84% and national average of 85%.
- 90% said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 91% and national average of 90%.

The 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 they 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 were shown the written information available for carers to ensure they understood the various avenues of support available to them.

Staff told us that if families had suffered bereavement, their usual GP contacted them. This call was either followed by a patient consultation to meet the family's needs and/or by giving them advice on how to find a support service.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to 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 increased the number of emergency appointments available and had made changes to the way information was communicated as a result of feedback.

GPs had their own patient lists which enabled good continuity of care. 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 had early morning and evening surgeries for GP and nurse appointments.

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. We saw that the practice had a system of assessing mental capacity and deprivation of liberty safeguards on admission to nursing homes and we viewed one example of this. Patients could be referred to 'time to talk' counsellors as needed and staff were aware of the availability of crisis assessments at the local urgent treatment centre.

The practice had a housebound register. 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 at several care homes. The practice organised a review for each patient on first moving into a local care home and subsequent annual reviews. Named doctors were involved in the day to day provision of care. Staff from two homes the practice supported told us the service they received was good. One staff member told us that GPs would visit patients in the home when asked.

The practice supported patients with either complex needs or who were at risk of hospital admission. The practice worked closely with the local proactive care team which included district nurses, community matron, physiotherapists, occupations therapists and pharmacists. Personalised care plans were produced and were used to support people to remain healthy and in their own homes. Patients with palliative care needs were supported using a multidisciplinary approach. They had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss patient and their families care and support needs.

Patients with long term conditions 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. For example, longer appointment times were available for patients with learning disabilities. The majority of the practice population were English speaking patients but access to online and telephone translation services were available if they were needed. Staff were also able to access face to face translation services for patients and we saw this in operation at the time of our visit. Staff were aware of when a patient may require an advocate to support them and there was information on advocacy services available for patients. A hearing loop was available for patients who were deaf.

The premises and services had been designed to meet the needs of people with disabilities. The practice was accessible to patients with mobility difficulties as facilities were all on one level, with lift access to a second level. The consulting rooms were also accessible for patients with mobility difficulties and there were access enabled toilets

Good

Are services responsive to people's needs?

(for example, to feedback?)

and baby changing facilities. There was a large waiting area with plenty of space for wheelchairs and prams. This made movement around the practice easier and helped to maintain patients' independence.

Staff told us that they did not have any patients who were of "no fixed abode" as there was a dedicated local service for this but would see someone if they came to the practice asking to be seen and would register the patient so they could access services. There was a system for flagging vulnerability in individual patient records.

There were male and female GPs in the practice; therefore patients could choose to see a male or female doctor.

The practice provided equality and diversity training through e-learning. Staff we spoke with confirmed that they had completed the equality and diversity training in the last 12 months and that equality and diversity was regularly discussed.

Access to the service

The surgery was open from 8am to 6.30pm Monday to Friday. There were also extended access appointments available on a Monday evening from 6.30pm until 8pm and on a Monday and Thursday morning from 7.20am until 8am.

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 older patients, those experiencing poor mental health, patients with learning disabilities and those with long-term conditions. This also included appointments with a named GP or nurse. Home visits were made to local care homes, by a named GP and to those patients who needed one.

The patient survey information we reviewed showed patients responded positively to questions about access to appointments and generally rated the practice well in these areas. For example:

- 67% were satisfied with the practice's opening hours compared to the CCG average of 74% and national average of 76%.
- 72% described their experience of making an appointment as good compared to the CCG average of 77% and national average of 74%.
- 68% said they usually waited 15 minutes or less after their appointment time compared to the CCG average of 65% and national average of 65%.
- 77% said they could get through easily to the surgery by phone compared to the CCG average of 77% and national average of 74%.

Patients we spoke with were satisfied with the appointments system and said it was easy to use. They confirmed that they could see a doctor on the same day if they felt their need was urgent although this might not be their GP of choice. They also said they could see another doctor if there was a wait to see the GP of their choice. Routine appointments were available for booking four weeks in advance. Comments received from patients also showed that patients in urgent need of treatment had often been able to make appointments on the same day of contacting the practice. For example, one patient we spoke with had attended the practice to try and access an appointment that day. They had been able to see a doctor.

Older people and people with long-term conditions had access to longer appointment and home visits were available where needed. Working age people had access to early morning and evening appointments through the extended access service. Online booking system available and easy to use and the practice used text message reminders for appointments.

Listening and learning from concerns and complaints

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

We saw that information was available to help patients understand the complaints system such as posters displayed in the waiting areas. Patients we spoke with were aware of the process to follow if they wished to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice.

Good

Are services responsive to people's needs?

(for example, to feedback?)

We looked at two complaints received in the last 12 months and found that these were satisfactorily handled, with openness and transparency with dealing with the complaint. The practice reviewed complaints annually to detect themes or trends. We saw that six complaints had been received in the last 12 months and that no themes had been identified. However, complaints along with significant events were discussed at practice meetings and lessons learned from individual complaints had been acted on and improvements made to the quality of care as a result.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. We found details of the vision and practice values were part of the practice's statement of purpose and strategy. We saw evidence the strategy and business plan were regularly reviewed by the practice and also saw the practice values were clearly displayed in the waiting areas and in the staff room. The practice vision and values included to improve the health, well-being and lives of patients and to work in partnership with patients and staff to provide the best primary care services possible.

We spoke with 12 members of staff and they all knew and understood the vision and values and knew what their responsibilities were in relation to these and had been involved in developing them.

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. We looked at 10 of these policies and procedures and most staff had completed a cover sheet to confirm that they had read the policy and when. All 10 policies and procedures we looked at had been reviewed annually and were up to date.

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead nurse for infection control and the senior partner was the lead for safeguarding. We spoke with 12 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 GP and practice manager took an active leadership role for overseeing that the systems in place to monitor the quality of the service were consistently being used and were effective. The included using the Quality and Outcomes Framework to measure its performance (QOF is a voluntary incentive scheme which financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). The QOF data for this practice showed it was performing in line with national standards. We saw that QOF data was regularly discussed at team meetings and action plans were produced to maintain or improve outcomes.

The practice also 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 we viewed an audit of urinary tract infection diagnosis and prescribing against relevant guidelines. This audit highlighted areas where improvements could be made and the results were discussed at a practice meeting and action agreed to address practice. Evidence from other data from sources, including incidents and complaints was used to identify areas where improvements could be made. Additionally, there were processes in place to review patient satisfaction and that action had been taken, when appropriate, in response to feedback from patients or staff. The practice regularly submitted governance and performance data to the CCG.

The practice identified, recorded and monitored risks. In some areas it had carried out risk assessments where risks had been identified and action plans had been produced and implemented, for example within infection control. The practice monitored general risks on a daily basis to identify any areas that needed addressing, however this was not always carried out using a comprehensive risk management approach.

The practice held weekly staff meetings where governance issues were discussed. We looked at minutes from these meetings and saw that a summary of the meetings included headings around performance, quality and risks. However, the meeting minutes were not always detailed in terms of the discussions held or the staff members present so it was difficult to see that discussions included the identification of learning or actions taken.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example recruitment, training and performance review policies which were in place to support staff. We were shown the electronic staff handbook that was available to all staff, which included sections on equality and harassment and bullying at work. Staff we spoke with knew where to find these policies if required. The practice had a whistleblowing policy which was also available to all staff in the staff handbook and electronically on any computer within the practice.

Are services well-led?

Good

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

Leadership, openness and transparency

The partners in the practice were visible in the practice and staff told us that they were approachable and always took the time to listen to all members of staff. All staff were involved in discussions about how to run the practice and how to develop the practice: the partners encouraged all members of staff to identify opportunities to improve the service delivered by the practice.

We saw from minutes that team meetings were held every week as part of a generic practice meeting. We were also told that regular nursing meetings were due to start up again following recent changes to the nursing establishment in the practice. Staff told us that there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and confident in doing so and felt supported if they did. Staff said they felt respected, valued and supported, particularly by the partners in the practice.

Seeking and acting on feedback from patients, public and staff

The practice encouraged and valued feedback from patients. It had gathered feedback from patients, surveys and complaints received. It had a recently formed PPG which included representatives from various population groups. We were told that the PPG met every quarter and discussed issues that were relevant at the time. The PPG was in development and the practice sought feedback from members although the PPG had not begun to carry out patient surveys at the time of our visit. We spoke with one member of the PPG and they told us they felt engaged with the practice. (A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care).

We saw that the practice reviewed the results of the friends and family test survey as they came through, and they intended to undertaken a review at the 12 month point. The practice manager told us they reviewed the results of the national patient survey data and took account of this when developing the service.

Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. 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 clinical professional development through training and mentoring. We looked at staff files and saw that regular appraisals took place which included a personal development plan. Staff told us that the practice was very supportive of training and that they had staff away days where guest speakers and trainers attended. For example, at a recent training session an external speaker had attended to share information about a multi-agency-risk-assessment-conference and raise awareness about domestic abuse.

The practice had completed reviews of significant events and other incidents and shared with staff at meetings and away days to ensure the practice improved outcomes for patients.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: We found that the registered provider did not ensure that effective systems were in place to assess the risk of, and to prevent, detect and control the spread of infections due to not assessing the risk from legionella bacteria. This was in breach of regulation 12(2)(h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Surgical procedures Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed How the regulation was not being met: The provider had failed to assess whether an applicant was of good character and had not confirmed information about the candidate before being employed as set out on Schedule 3 of the Health & Social Care Act 2008 namely by not having completed a criminal record check through the Disclosure and Barring Service (DBS). This was in breach of Regulation 19(1)(a)(3)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.