Almondsbury Surgery

Quality Report

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Date of inspection visit: 15 April 2015
Date of publication: 23/07/2015

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Almondsbury Surgery on 15 April 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing safe, effective, caring and responsive services. It was also good for providing services for all the population groups. They required improvement for providing well led 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.
- Patients' needs were assessed and care was planned and delivered following best practice guidance.
- Staff had not always received training appropriate to their roles. 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 there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.
- Governance arrangements needed further attention including ensuring policies and procedures reflect current guidance and legislation, mandatory training was provided for all staff and ensuring regular clinical audit cycles were completed.

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

Summary of findings

Importantly the provider must

- Ensure its governance systems and audits remain effective including regular clinical audit cycles and ensuring all policies and procedures were regularly updated and reflected current legislation and guidance including the infection control policy to ensure it met with 'The Health and Social Care Act 2008 Code of Practice on the prevention and control of infections and related guidance'.

The provider should

- Review its patient's complaints information to ensure it included information on how a patient could refer their concerns or complaints to other agencies.
- Ensure staff were trained at appropriate intervals for subject areas such as safeguarding vulnerable adults, infection control and fire safety.

Professor Steve Field (CBE FRCP FFPH FRCGP)
Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services.

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. Risks to patients were assessed and well managed. There were enough staff to keep patients safe.

Are services effective?

Good

The practice is rated as good for providing effective services.

National data from the Quality Outcomes Framework showed patient outcomes were mainly average or above average for the locality and nationally. 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 some appraisals and personal development plans for staff. However, some were overdue and were planned in to complete by the practice manager. Staff worked with multidisciplinary teams.

Are services caring?

Good

The practice is rated as good for providing caring services.

National GP patient survey data showed 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 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.

The practice reviewed the needs of its local population and engaged with the NHS England Area Team and local Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients said they found it easy to make an appointment with a named GP and there was continuity of care, with urgent appointments available the same day. The practice had good

Summary of findings

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 is rated as requires improvement for being well-led.

The practice had a clear vision and strategy and staff understood 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, but some of these were overdue a review and did not reflect current guidance and legislation. The practice lacked clinical audits and no audit cycles had been completed to show improvements to patient care. The practice proactively sought feedback from patients and acted upon it to improve practice. All staff had received inductions but not all staff had received regular performance reviews.

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 patients.

Quality and outcome framework data showed that outcomes for patients were good for conditions commonly found in older patients. The practice offered proactive, personalised care to meet the needs of the older patients in its population and had a range of enhanced services, for example, in facilitating the timely diagnosis and support for patients with dementia. They were responsive to the needs of older patients, and offered home visits and rapid access appointments for those with enhanced needs including those residing in nursing and residential homes.

People with long term conditions

Good

The practice is rated as good for the care of patients 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 patients 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 patients.

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 patients were treated in an age-appropriate way and were recognised as individuals. 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 patients (including those recently retired and students).

Summary of findings

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 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 patients 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. They had carried out annual health checks for patients with a learning disability. The practice had seven patients registered with a learning disability and six of these had received an annual check-up. They offered longer appointments for patients with a learning disability.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable patients. They 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 patients experiencing poor mental health (including patients with dementia).

We saw 96% of patients experiencing poor mental health had received an annual physical health check. The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those with dementia. They carried out advance care planning for patients with dementia.

The practice had told patients experiencing poor mental health how to access various support groups and voluntary organisations. They had a system in place to follow up patients who had attended accident and emergency (A&E) when they may have been experiencing poor mental health.

Summary of findings

What people who use the service say

From reviewing a number of sources we found patient satisfaction with patient experience and the service provided was generally very high. The sources we reviewed were that seven patients were spoken with on the day of the inspection, 14 comment cards were received from patients visiting the practice, a review of the NHS choices website, a review of the 'I want great care' website, the national GP patient survey and speaking with senior staff at two nursing and residential homes who had a number of residents who were patients at the practice.

During our inspection we spoke with seven patients who were very complimentary about the practice. Patients commented how easy it was to access the practice for appointments particularly through the open surgery in the morning, we heard comments on how GPs listened to patients, that they were knowledgeable about treatments and also how helpful the staff were.

We received 14 comment cards and a letter from a patient, which had been completed by patients for us to view prior to the inspection. Thirteen out of the 14 comment cards mentioned were highly satisfied with all the staff at the practice providing exceptional care.

We reviewed NHS Choices (a forum for patients to publicly provide their views about the practice and where the practice can respond to these views). We saw there had been four patient comments made about the practice in the last year. Two out of four comments were positive about the service provided and the other two raised concerns about the receptionist's attitude and GPs being unhelpful. The practice had responded to these comments on the website and where necessary encouraged the patient to contact them to discuss further. The practice also encouraged patients to post their views on to another website called 'I want great care'. We saw 14 patients had commented on this website from December 2014 until we inspected the practice. All comments were positive about the care and treatment provided at Almondsbury Surgery including satisfaction with the morning open surgery and the ease of getting appointments.

We reviewed the national GP patient survey for the periods of January to March and July to September 2014. This is a national survey sent to patients by an independent company on behalf of NHS England. We saw 110 patients had completed the surveys from the 258 sent. In summary and in comparison to the South Gloucestershire Clinical Commissioning Group (CCG) and national average patients were highly satisfied with having confidence and trust in their GP and the overall experience of the service provided. Patients were least satisfied with the nurse treating them with care and concern and seeing their preferred GP. The survey results showed patients were highly satisfied with the appointments system in all areas.

- 98.7% of patients surveyed said their overall experience of the practice was good in comparison to 84.1% CCG average and 85.2% national average.
- 100% of patients saying they trusted and had the confidence in the last GP they spoke with in comparison to 93% CCG average and 92.2% national average.
- 82.3% had confidence in the last nurse they saw in comparison to 88.3% CCG average and 85.5% national average.
- 42.9% of patients were able to see their preferred GP in comparison to 46% CCG average and 53.5% national average.
- 96% of patients said they were able to get through on the phone easily in comparison to 66.2% CCG average and 71.8% national average.
- 91.9% of patients said their experience of making an appointment was good in comparison to 70.7% CCG average and 73.8% national average.
- 70.1% of patients said they do not normally have to wait too long to be seen in comparison to 53.6% CCG average and 57.8% national average.
- 97.5% of patients surveyed said they would recommend the practice in comparison to 77.4% CCG average and 78% national average.

Summary of findings

Areas for improvement

Action the service MUST take to improve

- Ensure its governance systems and audits remain effective including regular clinical audit cycles and ensuring all policies and procedures were regularly updated and reflected current legislation and guidance including the infection control policy to ensure it met with 'The Health and Social Care Act 2008 Code of Practice on the prevention and control of infections and related guidance'.

Action the service SHOULD take to improve

- Review its patient's complaints information to ensure it included information on how a patient could refer their concerns or complaints to other agencies.
- Ensure staff were trained at appropriate intervals for subject areas such as safeguarding vulnerable adults, infection control and fire safety.

Almondsbury Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector and a GP specialist advisor.

Background to Almondsbury Surgery

We inspected the location of Almondsbury Surgery, Sundays Hill, Almondsbury, Bristol, BS32 4DS, where all registered regulated activities were carried out.

The practice serves approximately 4800 patients and sees patients who live in Almondsbury and the surrounding areas of South Gloucestershire. The national general practice profile shows the practice has a higher than average in England population of patients aged between the ages of five to 14 years old. They are below the national average for 15 to 34 years. The practice is above average for being one of the least deprived areas in this practice catchment area.

The practice provides additional services from the practice premises holding clinics for treating patients with Deep Vein Thrombosis and dietician clinics.

There was one GP partner and three salaried GPs; one male and three female. Each week all the GPs work the equivalent to approximately three full time GPs.

There were five female members of the nursing team which consisted of one practice nurse, one health care assistant and three part-time phlebotomists.

The practice is open from 8:30am Monday to Friday, the practice closed between 12:30pm and 2pm. On a Monday they were open until 7pm, Tuesday 7:30pm, Wednesday 6pm, Thursday 7pm and Friday until 5:30pm. Appointments were available from 9am to 11am every morning and varying times between 2:50pm to 5:50pm daily. Extended hours appointments are offered at the following times from 6:30pm to 7:30pm on Tuesdays. Arrangements were in place for patients to contact other services when the practice was not open.

The practice had a Personal Medical Services contract with NHS England (a locally agreed contract negotiated between NHS England and the practice). The practice was contracted for a number of enhanced services including extended hours access, facilitating timely diagnosis and support for patients with dementia, learning disabilities and remote care monitoring. The practice referred their patients to Brisdoc for out-of-hours services to deal with urgent needs when the practice was closed.

The practice had patients registered in one nursing home for people living with dementia and a residential home for older people.

Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Detailed findings

Please note that when referring to information throughout the report, for example any reference to the National GP Survey, this relates to the most recent information available to the CQC at the 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 patient's needs?
- Is it well-led?

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

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

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. Prior to our inspection we had spoken with the South Gloucestershire Clinical Commissioning Group, NHS England local area team and local area Healthwatch. We carried out an announced visit on the 15 April 2015. During our visit we spoke with nine staff including three GP's, the practice manager, one practice nurse, one health care assistant, two receptionists and one administration staff.

We spoke with 11 patients and reviewed 14 comment cards where patients shared their views and experiences of the service prior to our inspection.

Prior to the inspection we also spoke with two senior staff members from the nursing home and residential home where there were residents who were registered at Almondsbury Surgery to gain their experience of the service provided.

Good

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, a vulnerable patient had left the practice without being seen, this was followed up by the GP to check the patient was safe and reviewed their process for this patient to mitigate the risk of it from happening again.

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 three significant events that had occurred during the last year and saw this system was followed appropriately. Significant events were discussed as and when they occurred with appropriate members of the staffing team. This worked well for this practice due to the practice having a small staff team. 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. We saw the practice fed back to other authorities when necessary to highlight any learning that would be appropriate to them.

The practice had a system to manage and monitor incidents. Staff accessed incident forms on the practice intranet and sent completed forms to the practice manager.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We saw training records which showed that all staff had received relevant role specific training on safeguarding. All GPs had received level three training in child protection, nursing staff level two and non-clinical staff level one. We were informed GPs had completed two days training in domestic violence and other staff had completed one day training.

However, staff had not received any specific training for safeguarding vulnerable adults. The practice manager was reviewing their training supplier and told us staff would be trained as soon as possible. Staff had access to a detailed policy on vulnerable adults which described how to recognise abuse and what action to take. Staff spoken with knew how to recognise signs of abuse in older patients, 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 within the safeguarding policies.

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. There was active engagement in local safeguarding procedures and effective working with other relevant organisations including health visitors and the local authority.

The practice used chaperones to act as a safeguard and witness for a patient and health care professionals during a medical examination or procedure. All nursing staff, including health care assistants, had been trained to be a chaperone. Receptionists had also undertaken training and understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination. Reception staff acted as a chaperone if nursing staff were not available. All staff undertaking chaperone duties had received Disclosure and Barring Service (DBS) checks. (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).

Medicines management

Good

Are services safe?

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.

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.

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 had been reviewed in the last year. The practice nurse was qualified as an independent prescriber and they received regular supervision and support in their role as well as updates in the specific clinical areas of expertise for which they prescribed.

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, protocols were in place to provide guidance on the procedure for cleaning up spillages of blood and bodily fluids, treatment room cleaning and equipment cleaning protocols. We saw personal protective equipment was available in treatment rooms including disposable gloves. Disposable curtains and coverings for couches were available for staff to use. The infection control policy and procedures were limited in detail and did not include information such as needle stick injuries or what personal protective equipment should be worn, what training staff should receive and how often, and what should happen in the event of an outbreak of infection.

Staff had not received regular training in infection control. However there was a plan in place to ensure staff received training. The practice manager informed us they had had problems with the training supplier and this was why training had been delayed.

We saw an infection control audit had been completed in April 2015 and areas for improvement had been highlighted. The practice had recently replaced the waiting room seating to aid cleaning efficiency.

The practice had carried out a risk assessment in January 2014 for the management, testing and investigation of legionella (a bacterium which can contaminate water systems in buildings). We saw records that confirmed the practice was carrying out regular checks in line with this risk assessment to reduce the risk of infection to staff and patients.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. We saw evidence of calibration of relevant equipment; for example weighing scales, spirometers and blood pressure measuring devices.

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 checks through 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).

Good

Are services safe?

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 there were enough staff on duty. There was also an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual leave.

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. 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 annual and monthly checks of the building, the environment, staffing and equipment. Health and safety information was displayed for staff to see and there was an identified health and safety representative.

We saw a fire risk assessment had been completed in December 2014. We saw completed fire logs and fire extinguishers had been regularly checked by an external fire safety company. The practice had fire drills and tested the fire alarms regularly. Staff had received fire safety training approximately three years ago and new staff were shown fire procedures when they started. The practice planned for all staff to complete fire safety training through online training once the training supplier could provide the training.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. We were informed all staff had received training in basic life support. Emergency equipment was available including access to oxygen, pulse adult and paediatric oximeters 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.

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. The practice did not routinely hold stocks of medicines for the treatment of severe pain. We were assured that a full risk assessment had been undertaken and a protocol was in place to manage this, for example, Dial 999 and call an ambulance. 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 had 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 a heating company to contact if the heating system failed. The plan was not dated so we were unable to determine when it had last been reviewed.

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 discussed with the practice manager, GP and nurse how NICE guidance was received into the practice. They told us this was disseminated to staff usually by the practice manager. The practice had a small staffing team and often new guidance would be discussed in informal meetings. We heard from a member of the nursing staff who said when guidance had changed, it was discussed with others in the team and a protocol was updated to reflect this change. 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 offered the opportunity to attend specific clinics held by one of the GPs with a specialist interest and provided with longer appointments.

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. GPs and nursing 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.

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 patient'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 practice told us through all the recent changes in the last 18 months auditing of their practice had been something that had not taken place. The practice planned on completing audits now that staffing was settling down and enabling them to catch up with their day to day workload. The practice was unable to show us evidence of a clinical audit cycle. We were informed that a community pharmacist employed by the CCG visited the practice regularly to review their medicine management and this often showed minor or no changes were required. The nurse practitioner told us they had completed an audit on cervical smears and had a plan in place to review patients with an inadequate result. One area the practice felt they should improve upon was in their anti-psychotic prescribing and they intended that their next audit would be to review patients taking these medicines.

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 the CCG community pharmacist had reviewed medicine use in the practice including the prescribing of antibiotics and nonsteroidal anti-inflammatory medicines. It was noted that antibiotic and nonsteroidal anti-inflammatory prescribing was lower than average and further action was not required. Medicines were reviewed by the pharmacist to ensure they were cost effective and were following the latest guidance. For example, following NICE guidelines regarding a cholesterol lowering medicines that should not be used. The pharmacist had checked this and the practice was not prescribing this medicine for any patients.

The practice also used the information collected for the QOF and performance against national screening

Good

Are services effective?

(for example, treatment is effective)

programmes to monitor outcomes for patients. This practice was not an outlier for any QOF (or other national) clinical targets, They had achieved 99% of the total QOF target in 2014, which was above the national average of 94.2%. Specific examples to demonstrate this included:

- Performance for diabetes related indicators were better and similar to the national average. They were lower than average for checks on cholesterol.
- The percentage of patients with hypertension having regular blood pressure tests was better than the national average.
- Performance for mental health related indicators was better than the national average.
- The dementia diagnosis rate was above the national average

The practice was aware of all the areas where performance was not in line with national figures and we heard how these were being addressed.

The practice's prescribing rates were also better than national figures, with the exception of prescribing non-steroidal anti-inflammatory medicines. Staff regularly checked patients had been reviewed by the GP when receiving repeat prescriptions. They also checked all routine health checks were completed for long-term conditions such as diabetes and the latest prescribing guidance was being used. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines.

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

The practice had a low number of admissions to hospital. They kept a register of patients identified as being at high risk of admission to hospital and patients on this list were discussed regularly at multi-disciplinary meetings involving health visitors, midwifes, community matron and district nurses. Structured annual reviews were also undertaken for patients with long term conditions such as asthma, diabetes and heart failure. We were shown data which indicated 96% of asthma checks, 96.5% of heart disease and 87.4% of diabetes checks had been carried out in the last year.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw staff were up to date with annual basic life support. Basic life support training was provided to all staff every March by an external company who provided advice on life support and how to use all equipment and medicines available in the practice in an event of an emergency. However, some training had not been completed for a significant period for areas such as, infection control, safeguarding vulnerable adults and fire safety. We were assured that this training would be completed as soon as possible and they had been delayed due to changing to a new supplier and were waiting on action from them to enable staff to log on and start the training.

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). GPs had lead roles in their specialist expertise, such as diabetes and heart disease, clinics were held specifically with this GP and longer appointments provided to patients.

The majority of staff had received an annual appraisal which identified learning needs from which action plans were documented. Some staff had their appraisal outstanding, for which the practice manager had an action plan in place to ensure all staff had received their appraisal in the next year. Our interviews with staff confirmed the practice was proactive in providing training and funding for relevant courses, for example a receptionist had received training for phlebotomy and then continued to become a qualified health care assistant. The practice employed a practice nurse who could also prescribe medicines for treating minor illnesses. The nurse received regular clinical supervision from the senior partner GP to ensure they were continually supported in this role.

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, the health care assistant had received additional training in blood pressure monitoring, carrying out electrocardiograms, spirometry and ear syringing.

Good

Are services effective?

(for example, treatment is effective)

We heard from the practice manage that where poor performance had been identified appropriate action had been taken to manage this.

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. They 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. Staff knew their responsibilities in passing on, reading and acting on any issues arising these communications. Out-of hours reports, 111 reports and pathology results were all seen and actioned by a GP when they were received. Discharge summaries and letters from outpatients were usually seen and actioned promptly. 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 7% compared to the national average of 13.6%.

The practice held multidisciplinary team meetings bi-weekly and monthly to discuss patients with complex needs. For example, those with multiple long term conditions, mental health problems, patients from vulnerable groups, those with end of life care needs or children on the at risk register. These meetings were attended by district nurses and community matron. 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.

The practice provided care and treatment to a number of patients who resided in a local nursing home and a residential home. We spoke with a senior member of staff at both homes who provided us with positive feedback about the service provided. They said they had a good relationship with the practice and the practice involved families regularly in decision making, where necessary. If patient's living in the nursing home required urgent attention then this would be dealt with promptly, as were any repeat prescription requests. The majority of residents at the nursing home were patients at the practice and the practice held three monthly meeting with the nursing home, practice manager and GP to discuss any communication improvements and any safeguarding. This was both beneficial for the nursing home and practice.

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.

For patients who were referred to hospital in an emergency there was a policy of providing a printed copy of a summary record for the patient to take with them to Accident and Emergency. The practice had also signed up to the electronic Summary Care Record. (Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours).

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

Consent to care and treatment

We found staff were aware of the Mental Capacity Act 2005 and their duties in fulfilling them. All the GPs we spoke with understood the key parts of the legislation and were able to describe how they implemented them in their practice. 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. For example, one of the GPs described who they would involve when making decisions in patient's best interests for end of life decisions. All GPs and nurses spoken with demonstrated a clear understanding of the 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).

Staff spoken with told us when new patients registered and advanced directives had been agreed, such as 'do not

Good

Are services effective?

(for example, treatment is effective)

attempt cardiopulmonary resuscitation' these were recorded on patient records and GP would discuss decisions previously made to ensure this was still what the patient wanted. Any significant decisions were flagged as a warning on patient records.

Consent for particular treatments was recorded on the patient record system. For example, for immunisations and family planning interventions.

Health promotion and prevention

The practice used information about the needs of the practice population identified by the Joint Strategic Needs Assessment (JSNA) undertaken by the local authority to help focus health promotion activity. The JSNA pulls together information about the health and social care needs of the local area.

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 opportunistic chlamydia screening to patients aged 18 to 25 years and 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 its patients over the age of 16 and actively offered nurse-led smoking cessation clinics to these patients.

The practice's performance for the cervical screening programme was 85.68%, which was above the national average of 81.89%. 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. We were told 232 patients had received bowel cancer screening in the last year.

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 86.26%, and at risk groups 67.39%. These were above national averages, which were 73.24% and 52.29% respectively.

Childhood immunisation rates for the vaccinations given to under twos ranged from 92.3% to 100% and five year olds from 93.3% to 100%. These were either above or comparable to CCG averages.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice from the national GP patient survey from 2014 gaining views from 110 patients.

The evidence from national patient survey showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the national patient survey showed the practice was rated 'among the best' for patients who rated the practice as good or very good with 98.7% in comparison with the CCG average of 84.1% and national average 85.2%. The practice was also well above average for its satisfaction scores on consultations with GPs and either average or lower than average for nurses. For example:

- 96.9% said the GP was good at listening to them compared to the CCG average of 87% and national average of 87.2%.
- 91.4% said the GP gave them enough time compared to the CCG average of 84.1% and national average of 85.3%.
- 100% said they had confidence and trust in the last GP they saw compared to the CCG average of 93% and national average of 92.2%
- 77.2% said the last nurse they saw was good at listening to them compared to the CCG average of 81.5% and national average of 79.1%.
- 79.2% said the last nurse they saw gave them enough time compared to the CCG average of 83.7% and national average of 80.2%.
- 82.3% said they had confidence and trust in the last nurse they saw compared to the CCG average of 88.3% and national average of 85.5%

The nurse's scores may have been lower or average because there had been a number of staffing changes in the practice which had particularly affected the nursing staff. Feedback on the day from patients was positive about the nursing staff.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 14 completed cards and a letter from a patient. 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. One comment was less positive. We also spoke with 11 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 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 consultation and treatment room doors were closed during consultations and conversations taking place in these rooms could not be overheard.

We saw staff were careful when discussing patients' treatments so confidential information was kept private. Administration staff took patient telephone calls in an office behind the reception desk. The reception desk was based within the waiting area, so patient conversations could be overheard. The practice told us they could speak with patients confidentially either in a spare room or in the administration area, which helped keep patient information private. Additionally, 97.2% said they found the receptionists at the practice helpful compared to the CCG average of 87% and national average of 86.9%.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example:

- 91.1% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 80.9% and national average of 82%.
- 87.7% said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 73.4% and national average of 74.6%.
- 77.5% said the last nurse they saw was good at explaining tests and treatments compared to the CCG average of 78.2% and national average of 76.7%.
- 61% said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average of 65.5% and national average of 66.2%.

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

Good

Are services caring?

involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. 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 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 GPs and was lower than average for nurses. For example:

- 93.1% said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 82.2% and national average of 82.7%.
- 72.8% said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 80.8% and national average of 78%.

The patients we spoke with on the day of our inspection and the comment cards we received were also consistent with this survey information except for nursing staff where they were highly positive about the nursing staff. For example, they 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, such as for domestic violence and mental health.

The practice had 51 registered carers at the time of our inspection. The practice's computer system alerted GPs if a patient was a carer. Carers were provided support from their GP and were signposted to various avenues of support available to them.

Staff told us if families had suffered bereavement, their usual GP contacted them. This call was followed by a patient consultation to provide them with advice and if necessary how to find a support service. Patients we spoke with who had had a bereavement confirmed they had received this type of support and said they had found it helpful.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice had been through a number of significant changes in the past 18 months which included two GP partners, a salaried GP and a long standing practice nurse leaving within a few months of each other. This had impacted on the service and locum GPs were needed to cover services over the last 18 months. The practice had recruited three part-time salaried GPs in the last year. Also, the community teams including midwives and health visitors no longer hold clinics at the practice. This all required the practice to change their way of working to ensure they continued to meet patient's needs. One of the areas that fell behind during this period was routine health checks for patients with diabetes. The practice had recognised this was becoming an issue and had responded by prioritising the diabetic patients register to determine who needed to be seen. This was completed by the practice nurse and the lead GP for chronic disease management.

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

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

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 door upon entering the administration area had been changed to a hatch door to improve patient confidentiality.

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 a learning disability. The majority of the practice population were English speaking patients but access to online and telephone translation services were available if they were needed.

The premises and services had been designed to meet the needs of patients with disabilities. The practice was accessible for wheelchair users. Most of the consulting rooms were accessible for patients with mobility difficulties and alternatives were used when necessary. There was an accessible toilet and baby changing facilities. The waiting area had plenty of space for wheelchairs and prams. This made movement around the practice easier and helped to maintain patients' independence.

The practice manager told us they had 48 patients registered who were travellers and of "no fixed abode". 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 GP.

Access to the service

The practice was open from 8:30am Monday to Friday, the practice closed between 12:30pm and 2pm. On a Monday they were open until 7pm, Tuesday 7:30pm, Wednesday 6pm, Thursday 7pm and Friday until 5:30pm. Appointments were from 9am to 11am every morning and varying times between 2:50pm to 5:50pm daily. Extended hours appointments were offered at the following times from 6:30pm to 7:30pm on Tuesdays. Arrangements were in place for patients to contact other services when the practice was not open. Open surgery clinics were held every morning from 9am to 10:30am and two GPs would see any patients who walked into practice for an appointment. The third GP saw patients for routine appointments in the morning.

Comprehensive information was available to patients about appointments on the practice website. This included GP appointment sessions, 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.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Longer appointments were also available for older patients, those experiencing poor mental health, patients with learning disabilities and those with long-term conditions, when required. This also included appointments with a named GP or nurse. Weekly visits were made to a nursing home specialising in dementia care, where the majority of patients were registered at the practice. These visits took place on a specific day each week, by a named GP for those patients who needed to be seen. If these patients required an urgent home visit then this was also accommodated. The practice also looked after a small number of patients in a residential home and visits were organised as and when required.

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:

- 86% were satisfied with the practice's opening hours compared to the CCG average of 76.9% and national average of 75.7%.
- 91.9% described their experience of making an appointment as good compared to the CCG average of 70.7% and national average of 73.8%.
- 68.3% said they usually waited 15 minutes or less after their appointment time compared to the CCG average of 63.3% and national average of 65.2%.
- 96% said they could get through easily to the surgery by phone compared to the CCG average of 66.2% and national average of 71.8%.
- 70.1% said they did not normally have to wait too long to be seen compared to the CCG average of 53.6% and national average of 57.8%.

Patients we spoke with were satisfied with the appointments system and said it was easy to use. They confirmed they could see a GP 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 GP if there was a wait to see the GP of their choice. 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, patients used the open surgery if they needed an appointment urgently.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. There was a designated responsible person who handled all complaints in the practice. We saw information was available to help patients understand the complaints system on the practice website and in the practice patient leaflet. However, this information did not provide any details on how to complain externally to the appropriate authorities or advocacy services that could be used. Patients we spoke with were aware of the process to follow if they wished to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice.

We saw five complaints had been received in the last 12 months and we read one complaint in full and found this had been satisfactorily handled.

The practice reviewed complaints annually to detect themes or trends. We read the report for the last year and saw there were no themes of complaints. However, lessons learned 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 deliver high quality care and promote good outcomes for patients. The practice was a high achieving practice in terms of access and quality of care and their ambition was to maintain these standards for all our patients. Staff had been involved in writing the practice mission statement, and had included what they thought of the service offered. This was being patient focused, caring, appreciated, accessible, professional, dedicated and friendly.

The practice continually thought about the future of the practice and where it would be in five years' time with potential retirement of the partners. Discussions had been held with other services to provide options to consider when necessary.

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 read eight of these policies and procedures. We found policies did not routinely include a date they had been reviewed, this included policies for consent, child protection, whistle blowing and infection control. Some policies did not include detailed information to ensure it followed legislation and latest guidance, such as the consent policy contained no information for staff about mental capacity, the whistle blowing policy did not include details of who staff could raise concerns to if they were unable to speak with the practice manager, neither did it include external support and independent advice. As mentioned previously in the safe domain, the infection control policy also did not include all the information needed to reflect the 'The Health and Social Care Act 2008 Code of Practice on the prevention and control of infections and related guidance'.

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 one of the salaried GPs was the lead for safeguarding. 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 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 with individual GPs and action plans were produced to maintain or improve outcomes. The practice had a medicines management advisor who carried out reviews on medicines, such as medicines that were subject to safety alerts.

The practice was building in an on-going programme of clinical audits which it would use to monitor quality and systems to identify where action should be taken. For example, they planned carry an audit on anti-psychotics prescribed following a review requested by the CCG which identified areas for improvement. We did not see any evidence of any clinical audit cycles completed. This was mainly due to significant staffing changes in the practice. The data provided from QOF and other sources indicated this appeared to be having a minimal impact on patients, however, there was a risk it could begin to affect patient care.

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 action had been taken, when appropriate, in response to feedback from patients or staff.

The practice identified, recorded and managed risks. They had carried out risk assessments where risks had been identified and action plans had been produced and implemented, for example fire risk assessment and health and safety risk assessment of the premises. The practice monitored risks to identify any areas that needed addressing. The practice manager and senior partner regularly discussed governance issues. We noted security between public areas and the reception/administration area were not kept secure throughout the day even though they contained emergency medicines; patient records and

Are services well-led?

Requires improvement

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

patient correspondence. The practice had risk assessed the security of the administration following our inspection and had determined that due to staff always being present in this room that the risk was minimised.

Leadership, openness and transparency

Staff told us the partners in the practice were visible, 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.

Staff meetings were regularly held in the practice including quarterly nursing staff meetings with the practice manager and administration team meeting as and when required. Due to the new salaried GPs being recruited in the last year, GP meetings had been stopped temporarily to enable individual one to ones, these covered QOF and other governance topics. Staff told us there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and were confident in doing so and felt supported if they did. The practice manager also had an open door policy, and staff told us they were easily able to approach their manager to raise concerns. Staff said they felt respected, valued and supported, particularly by the partners in the practice.

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

The practice encouraged and valued feedback from patients. They had gathered feedback from patients through reviewing NHS choices and I want great care websites, friends and family questionnaires and complaints received. The practice did not have an active patient participation group (A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care). This was due to the significant changes in the practice staffing. The practice planned on starting a virtual patient group and was starting to recruit members.

We also saw evidence the practice had reviewed its' results from the national GP survey to see if there were any areas that needed addressing. The practice was actively encouraging patients to be involved in shaping the service delivered at the practice.

The practice had also gathered feedback from staff through staff meetings, appraisals and informal discussions. 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 heard salaried GPs and the nurse practitioner received regular supervision from the senior GP partner. Other staffs appraisals had been delayed and some staff had not received an appraisal for up to two years. However, there was a plan in place to ensure staff received an appraisal within the next few months. Staff told us that the practice was very supportive of training and development opportunities were provided. However, staff had not always received regular update training in infection control, fire safety and safeguarding vulnerable adults.

The practice had completed reviews of significant events and other incidents and shared with relevant staff 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 Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The practice must ensure it evaluates and improves their practice in respect of the processing of the information referred to in sub-paragraphs (a) and (e) of regulation 17 (1)(2) particularly through monitoring performance through clinical audit cycles and ensuring policy and procedures were up to date with legislation and latest guidance.