Burdwood Surgery

Quality Report

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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?	**Good**
Are services effective?	**Requires improvement**
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 Burdwood Surgery on 16 June 2015. Overall the practice is rated as good.

Specifically, we found the practice to require improvement for providing effective services. It was good for providing safe, caring and responsive services and for being well-led. These ratings also meant the practice was rated as good for providing services and meeting the needs of the six population groups.

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 including incidents and complaints was recorded, investigated and acted on to ensure improvements to safety and effectiveness were made.
- Most risks to patients were assessed and well managed, including fire, medical concerns which may affect their care and the risks associated with storing medicines.
- Data showed patient care outcomes for patients were similar to the locality.
- Audits had been carried out, but out of seven current audits only three were repeated and completed. From the three completed audits we saw improvements to patient care were achieved. However, audit did not always lead to improvements in patient care due to the lack of re-auditing.
- 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.
- Availability of appointments for advanced and same day appointments was adequate to meet the needs of the local population. There was positive feedback from patients regarding appointments.

Summary of findings

- The practice had a number of policies and procedures to govern activity. They were regularly updated and shared with staff.
- The practice held regular governance meetings and issues were also discussed at ad hoc meetings. All staff had opportunities to attend meetings and all practice staff met together twice a year.
- The practice had proactively sought feedback from staff and patients.
- The Patient Participation Group (PPG) had 122 members and there was a meeting four times a year. There was also a virtual group and which had 667 members.

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

The areas where the provider must make improvements are:

- Ensure staff are able to follow the principles of the Mental Capacity Act 2005.
- Review the clinical audit programme to ensure that audits lead to any changes in patient care where necessary.

The areas the provider should make improvements are:

- Provide the infection control lead with training of an appropriate standard.
- Advertise the translation service on the website.
- Undertake all actions noted from the legionella risk assessment.

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. There were systems for monitoring hygiene and infection control, the infection control lead did not have the required additional training to fulfil the role but they were supported by the regional General Practice infection control lead. There was no assessment for the risk of legionella in the practice, but this was completed within two days of the inspection. Staff understood their responsibilities to raise concerns, and to report incidents and near misses. When things went wrong, reviews and investigations were undertaken and learning was communicated widely to support improvement. Most risks to patients who used services were assessed. Recruitment checks were undertaken in line with national requirements. Medicines management processes ensured the safe use of medicines and prescriptions could only be generated by authorised personnel. Emergencies were planned for such as medical emergencies and loss of the premises.

Are services effective?

Requires improvement

The practice is rated as requires improvement for providing effective services. There were audits undertaken but many audits did not lead to improvements in care. Only three of seven clinical audits had been repeated and completed to ensure improvements were incorporated in the service. Most staff had an awareness of the Mental Capacity Act 2005 but were not always certain of how to implement it. 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. Training was delivered and where it was needed there was a plan to deliver it. 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

Summary of findings

saw that staff treated patients with kindness and respect, and maintained confidentiality. Patients experiencing emotional challenges such as bereavement were considered in the planning of the service.

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 ensured improvements to services where these were identified. Patients said they found it easy to make an appointment with a GP and that there was continuity of care. There was good availability of advanced and same day appointments. Patient feedback suggested this worked well. 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. The practice had a number of policies and procedures to govern activity. Monitoring of the service identified risks and improvements where necessary. These were followed up to ensure the improvements were embedded in the service. There was a vision and a strategy which placed patients at the heart of the service. There was clear leadership structure and most staff felt supported by management. Governance and clinical meetings were held regularly. The practice proactively sought feedback from patients and had a physical and a virtual patient participation group (PPG). All staff had received inductions and all staff had received regular performance reviews or 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. There were audits undertaken but many audits did not lead to improvements in the care of older patients. Only three of seven clinical audits had been repeated and completed to ensure improvements were incorporated in the service. Most staff had an awareness of the Mental Capacity Act 2005 but were not always certain of how to implement it. There was a low prevalence of elderly patients compared to the national average. 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. Patients had a named GP.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. There were audits undertaken but many audits did not lead to improvements in the care of long term conditions where there was the potential for them to. Only three of seven clinical audits had been repeated and completed to ensure improvements were incorporated in the service. Most staff had an awareness of the Mental Capacity Act 2005 but were not always certain of how to implement it. 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. The practice indicated that 87% of medicine reviews were within date. 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. Nurses worked with GPs at clinical team meetings to discuss and act on the most relevant guidance for treating long term conditions.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. There were audits undertaken but many audits did not lead to improvements in care. Only three of seven clinical audits had been repeated and completed to ensure improvements were

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incorporated in the service. There was a high prevalence of patients in the age range of 10 to 19 years old. 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. 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. The practice had considered the preferences of teenage patients, specifically in reference to confidentiality and communications about their health.

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). There were audits undertaken but many audits did not lead to improvements in care. Only three of seven clinical audits had been repeated and completed to ensure improvements were incorporated in the service. 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. Pre-bookable appointments and same day appointments were available. Patient feedback regarding appointments was very positive.

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. There were audits undertaken but many audits did not lead to improvements in care. Only three of seven clinical audits had been repeated and completed to ensure improvements were incorporated in the service. Most staff had an awareness of the Mental Capacity Act 2005 but were not always certain of how to implement it. The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability. Staff told us they would register homeless patients at the practice's address. A local drug and alcohol service was encouraged to run clinics in the practice to ensure local patients with addiction problems would be able to access the service onsite. It had carried out annual health checks 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). There were audits undertaken but many audits did not lead to improvements in care. Only three of seven clinical audits had been repeated and completed to ensure improvements were incorporated in the service. Most staff had an awareness of the Mental Capacity Act 2005 but were not always certain of how to implement it. National data showed 90% of people experiencing poor mental health had a care plan. 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 screening for dementia but not data was available on this. The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations.

Summary of findings

What people who use the service say

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey published in January 2015 with 115 responses, the practice's 2014 survey of 100 patients and the Patient Participation Group (PPG) virtual reference group action plan from 2014/5 (736 patients were part of the virtual reference group as well as 44 on the PPG which was a forum of patients who met but the exact figure who participated in the feedback which led to the action plan was not available).

The evidence from all these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. In the national survey 93% said their GP gave them enough time (local average 86%) and 84% said the same of nurses (local average 80%). The practice survey found the vast majority of patients responded positively to their experience of consultations in the practice with approximately 99% saying they either felt cared for, respected involved or other positive responses.

Patients completed CQC comment cards to tell us what they thought about the practice. We received six completed cards and all were positive about the service experienced. Comments included that staff were pleasant and professional and helpful and caring. Patients said they felt the practice offered a caring service and staff treated them with respect and dignity. The eight patients we spoke with on the day of inspection told us they were all satisfied with the care provided by the practice and said their dignity and privacy was respected.

Ninety two per cent of respondents to the national survey said the last GP they saw or spoke to was good at explaining tests and treatments (83% regional average) and 85% said the same about nurses (80% regional average). Eighty nine per cent of patients said the last GP they saw or spoke to was good at involving them in decisions (75% regional average) about their care 78% reported the same of nurses (65% regional average).

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.

The patient survey information we reviewed showed patients responded very positively to questions about access to appointments. Seventy six per cent were satisfied with the practice's opening hours compared to the CCG average of 75% and national average of 76%. Eighty two per cent described their experience of making an appointment as good compared to the CCG average of 78% and national average of 74%. Ninety two per cent were able to get an appointment to see or speak to someone the last time they tried compared to 89% locally and 85% nationally. Ninety one said they could get through easily to the surgery by phone compared to the CCG average of 76% and national average of 72%.

Areas for improvement

Action the service MUST take to improve

- Ensure staff are able to follow the principles of the Mental Capacity Act 2005
- Review the clinical audit programme to ensure that audits lead to any changes in patient care where necessary

Action the service SHOULD take to improve

- Provide the infection control lead with training of an appropriate standard.
- Provide chaperone information for patients in consultation rooms
- Undertake all actions noted from the legionella risk assessment.

Burdwood Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a GP, and a second CQC inspector.

Background to Burdwood Surgery

Burdwood Surgery is located in the town of Thatcham, Berkshire. Approximately 10,000 patients are registered with the practice. The premises were purpose built in 1987 with additional consultation rooms added in 2003. Patients are registered from the town and local area. The practice population has a young population with minimal economic deprivation, low numbers of elderly (under 10% are over 65 compared to the national average of 17%) and no patients in care homes for the elderly. There are 30 patients registered with learning disabilities some of whom live in care homes. The practice works with a local drug and alcohol service under a shared care protocol and some clinics for these patients are run onsite. The proportion of patients with a long standing health condition is 46% compared to 54% nationally.

It is open from 8am to 6.30pm. Extended hours appointments are available on Saturday mornings once a month.

Care and treatment is delivered by eight GPs, with five male and three female GPs, a nurse practitioner, three practice nurses and two health care assistants. There is a management team, administration team and reception staff.

The practice is a member of Newbury and district Clinical Commissioning Group. The practice had a Primary Medical Services (PMS) contract. PMS contracts are directly negotiated locally between NHS England and the practice. This practice is a training practice.

We visited Burdwood Surgery, Wheelers Green Way, Thatcham, RG19 4YF as part of this inspection.

The practice has opted out of providing out-of-hours services to its own patients. There are arrangements in place for patients to access care from an out-of-hours provider and NHS 111.

The practice was inspected in November 2013 and we looked six outcomes related to patient care and identified that no regulatory action was required following the inspection.

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, Regulated Activities Regulations 2014, 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.

Detailed findings

How we carried out this inspection

Before visiting we checked information about the practice such as clinical performance data and patient feedback. This included information from the clinical commissioning group (CCG), local Healthwatch, NHS England and Public Health England. We visited Burdwood Surgery on 16 June 2015. During the inspection we spoke with GPs, nurses, members of the management team, a member of the patient participation group, administration and reception staff. We obtained patient feedback from speaking with patients, comment cards, the practice's surveys and the GP national survey. We looked at the outcomes from investigations into significant events and audits to determine how the practice monitored and improved its performance. We checked to see if complaints were acted on and responded to. We looked at the premises to check the practice was a safe and accessible environment. We looked at documentation including relevant monitoring tools for training, recruitment, maintenance and cleaning of the premises.

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

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

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

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

Good

Are services safe?

Our findings

Safe track record

The practice used 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. Significant event forms were available to staff for recording any incidents which occurred. Staff knew where they were stored.

Medicine and safety alerts were disseminated around the practice by a lead staff member. An IT lead for the practice then searched any relevant patient records regarding alerts, such as specific medicines they may be taking which may need to be reviewed. The GP prescribing lead would decide what medicine alerts would need discussing at clinical meetings.

Learning and improvement from safety incidents

The practice had a system in place for reporting and recording significant events. Staff spoke about significant events which had been raised and which they were aware had led to changes in practice. We reviewed records of the five significant events that had occurred during 2015 to see the process for reviewing these. We saw there had been investigation and discussion among the partners. Staff told us they were reported back to regarding any significant events which related to their roles and duties. Two significant events related to confidentiality. One of these led to a change in the protocol for communicating with young patients who may be registered at their parent's address but might not want to be contacted at that address. The other event led to discussions with staff about the confidentiality policy to ensure it was embedded in their practices.

Complaints were reported and reviewed in the same way. They were escalated to partners' meetings and investigated. Any leaning outcomes were shared with staff. One complaint related to an external community service. This had led the practice support the patient by providing the service to the patient themselves. Significant events and complaints were reviewed a year following the event to ensure that the learning from them was embedded.

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 children and adults. GPs had received safeguarding children training at level three. Members of nursing staff and GPs we spoke with were able to tell us about potential identifiers for abuse and actions they would take if they had concerns. We saw safeguarding policies were stored on the practice's shared computer drive. They included contact details for relevant local organisations such as safeguarding teams. There was also a whistleblowing policy available for staff. This included external organisations staff could contact and the rights and protection whistleblowers have. The practice had appointed a dedicated GP as lead in safeguarding vulnerable adults and children.

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 district nurses and the local authority. We saw minutes from a child protection meeting in April 2015 where nine children were discussed.

There was a chaperone policy, which was visible on the waiting room wall and through a variety of patient information, such as leaflets. 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 had been trained to be a chaperone and they were the only staff who performed this role.

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 power failure. Records showed fridge temperature checks were carried out daily which ensured medicine was stored at the appropriate temperature. There were measures to reduce the risk of

fridges becoming detached from the power supply. Two monitoring systems were used to ensure staff were alerted if temperatures varied outside the appropriate range for storing vaccines (2-8C). A data logger was used and a spreadsheet produced weekly as a record of the temperatures and a note book recorded the maximum and minimum daily temperatures. Staff were trained to ensure the cold chain was maintained during the delivery of vaccines. Receptionists brought vaccine deliveries straight to the nurses' treatment rooms and they were placed directly into the fridges. We saw this process take place.

Processes were in place to check medicines were within their expiry date and suitable for use. Records showed medicines were checked regularly for expiry dates. All the medicines we checked were within their expiry dates. There was a protocol for disposing of expired and unwanted medicines.

The practice stored small boxes of drugs which were monitored by the nursing team which could be picked up by GPs and placed in their bags used on home visits. This ensured medicines taken on home visits were always up to date. We saw two drugs which were approaching expiry. The monitoring records showed the drugs had been placed on order to ensure they were available when needed.

We spoke with a staff member responsible for repeat prescriptions and they explained the system for checking patients' prescription requests and whether they needed GP reviews. They told us if patients were approaching a medicine review, the system would indicate this to them. They would then red stamp the request before passing it on to indicate to the GP they needed to review the patients' medicine. The staff member had been given guidance to enable them to request certain reviews such as blood pressure or blood sample tests for patients with hypertension. This enabled these reviews to be requested without GP input.

Blank prescription forms were handled in accordance with national guidance. They were tracked through the practice and logged upon receipt. Prescription forms were locked away to ensure they could not be taken away by anyone other than authorised personnel.

The practice had systems in place to monitor the prescribing of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse). Controlled drugs kept on site were received, checked and stored appropriately. There was a standard operating procedure for the handling of controlled drugs and this had been signed by staff who accessed them. The controlled drugs register showed appropriate entries for receiving, prescribing and destroying controlled drugs.

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. The health care assistant administered flu vaccines and other medicines, for example Vitamin B12 injections, using Patient Specific Directions (PSDs) that had been produced by the prescriber.

Cleanliness and infection control

We observed the premises to be clean and tidy. The practice manager told us they regularly undertook checks of cleanliness with the cleaning contractor. 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. These had recently been reviewed by the local infection control nurse lead for the area. The practice had asked the regional lead to review their infection control processes to ensure they were meeting national standards. We saw national guidance was being followed with the layout of the practice, equipment and cleaning. Hand wash basins with liquid soap and paper towels, pedal operated clinical waste bins and gel for the appropriate disposal of urine samples were available. Curtains used for treatment benches were not disposable but staff told us they were washed twice a year and they appeared clean.

There was a protocol for the receipt of specimens from patients to ensure staff were protected from potential sources of infection. Staff told us there was a policy for needle stick injuries (sharps injuries) but we could not find this within the existing infection control policy. Staff that we asked about this procedure knew the action to follow in the event of an injury and this reflected national guidance. Sharp bins for disposal of used sharps were stored appropriately as were clinical waste bins awaiting collection. We saw collections notes were stored when provided by the external contractor who collected the waste.

Good

Are services safe?

Staff had last received infection control training in January 2015. The practice had a lead for infection control but had not undertaken further training to fulfil this specialist role. They may not have been able to identify potential infection control risks as a result. However, they had been supported by an external infection control lead and external training was planned for them. We saw regular infection control audits were undertaken. The last was in December 2014 and there was an action plan resulting from the audit. Staff told us regular carpet cleaning was in place as a result of the audit for example. All nurses we spoke with told us they were immunised for Hepatitis B.

The practice had not undertaken a full risk assessment for legionella and no testing on water supplies was undertaken. A risk assessment had been completed within two days of the inspection visit with an action plan.

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 there was a log which indicated when the equipment had last been tested. This was due to be tested again and we saw confirmation an external testing contractor had been booked. We saw evidence of calibration of relevant equipment. For example oximeters, spirometers and blood pressure measuring devices had been calibrated.

Staffing and recruitment

The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. We reviewed staff records and saw appropriate recruitment checks had been undertaken prior to employment. A staff check list was available listing which checks were required for clinical staff. Staff registrations with the General Medical Council and Nursing and Midwifery Council were checked annually. 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) were listed for nursing staff. References were sought for staff to ensure their conduct in previous health or social care roles was accounted for. The practice manager requested all staff to show proof of their hepatitis B vaccination records and the records were available for us to check.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. 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 there was a staff planner in place for all the different staffing groups to ensure that enough staff were on duty. The use of locum cover was minimal.

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. Health and safety information was displayed for staff.

Identified risks were assessed and managed. For example, there was a Control of Substances Hazardous to Health (COSHH) risk assessment. There was a record of fire safety checks and drills.

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 saw they were in working order.

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 anaphylaxis, meningitis, asthma and cardiac arrest. 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.

Good

Are services safe?

A business continuity plan was in place and this listed foreseeable emergencies that be reasonably expected to occur. There was reference to pandemic outbreaks, such as flu, and action to take in the event that the building was no longer accessible.

Requires improvement

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners.

We discussed with the practice manager, GP and nurses how NICE guidance was received into the practice. They told us this was identified through various sources including alerts, from the NICE website and from regional events. Guidance was disseminated to staff. Staff we spoke with all demonstrated a good level of understanding and knowledge. We saw that templates used for patient care reflected NICE guidance.

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. Structured annual reviews were also undertaken for patients with long term conditions (e.g. Diabetes, asthma, hypertension and heart failure). We were shown data that 85% of these had been carried out in the last year. Staff we spoke with informed us that patients were referred to other services as and when required. Feedback from patients confirmed they were referred to other services or hospital when required.

The GPs told us they led in specialist clinical areas such as diabetes, dementia, heart disease and asthma and the practice nurses supported this work, which allowed the practice to focus on specific conditions. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support. GPs told us this supported all staff to review and discuss new best practice guidelines, for example, respiratory disorder templates were reviewed. Our review of the clinical meeting minutes confirmed that this happened.

The practice participated in specific enhanced services (services beyond usual contractual obligations). This included identifying patients who were at high risk of admission to hospital and 147 patients had care plans in place as a result. These patients had multidisciplinary care plans which were documented in their records. This was in order to reduce the need for them to go into hospital. We saw that after patients were discharged from hospital they were reviewed to ensure that all their needs were continuing to be met. The surgery also undertook advanced screening for dementia. However, due to a fault with the system there was no data on how many patients had been screened in the last year.

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, urgent care response, diabetes reviews, infection control, scheduling clinical reviews, and managing child protection alerts and medicines management. The information staff collected was then collated by the practice manager and IT administrator to support the practice to carry out clinical audits. The team was making use of clinical audit tools, clinical supervision 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 had a system in place for completing clinical audit cycles but some repeat audits were still due and recommendations from one audit were not followed properly. The practice showed us seven clinical audits. We found three of these audits identified changes to treatment or care were recommended and the audit repeated to ensure continuous monitoring. An audit on the use of anti-biotics in the treatment of conjunctivitis in March 2014 was repeated after one month and showed an improvement in the rates of prescribing anti-biotics. However, not all repeated audits showed any improvement after being repeated. For example, following an alert from the Medicines and Healthcare Products Regulatory Agency (MHRA) regarding a medicine used to prevent heart attacks and strokes, a clinical audit was carried out. The aim of the

Requires improvement

Are services effective?

(for example, treatment is effective)

audit was to deduce how many patients were prescribed a medicine in combination with a particular stomach acidity drug that could put patients at risk. The first audit in April 2014 demonstrated that 16% patients were receiving the combined dose. The information was shared with GPs and second clinical audit was completed in May 2015 which demonstrated instructions were not followed and 22% patients were receiving the combined dose on repeat prescription and further 12% as one off prescription. The initial audit and resulting discussions with GPs had not had the impact it intended on reducing the risk to patients.

Further action was discussed between GPs following this re-audit in 2015. It was recommended to arrange patient's medical reviews and warning to be added at the prescribing levels on the computer and this learning had been shared with all relevant staff. GPs and the practice manager told us there had been a centralised programme of clinical audit where the practice manager would prompt GPs to complete their audits. This system was changed within the last two years and now GPs managed their own audit cycles. There was evidence that GPs did not always complete the audits they had undertaken.

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, the practice identified some patients with diabetes were not having a specific check. Performance for diabetes related indicators was lower than the national average, only 60% patients with diabetes had regular blood pressure tests done as compared to the national average of 78%. GPs explained this had happened as a result of a diabetic nurse leaving. A GP carried out an audit, identified the cause of the problem, implemented an action plan and then re-audited after six months. This showed improvements to diabetic checks.

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 92% of the total QOF target in 2015, which was below the national average of 94% in 2014.

Performance for mental health related and dementia QOF indicators were lower than the national average. Ninety per cent patients with mental health conditions had comprehensive agreed care plan in last 12 months as compared to national average of 86%. 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.

The practice's prescribing rates were 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. Eighty seven per cent patients on four or more repeat medications were reviewed in last 12 months. 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 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 11 patients on the end of life register.

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. The practice had 30 learning disabilities registered patients and had offered annual health checks to 21 patients so far this year and was planning to complete the rest later in the year.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as annual basic life support. We noted a good skill mix among the doctors and 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, for example we witnessed

records for online, face to face and video training. As the practice was a training 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.

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. Those with extended roles (for example, seeing patients with long-term conditions such as asthma, diabetes and coronary heart disease) were also able to demonstrate that they had appropriate training to fulfil these roles. Staff files we reviewed showed 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 out of hours service providers to meet patient's 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 7% compared to the national average of 14%. The practice was commissioned for the unplanned admissions enhanced service and had a process in place to follow up patients discharged from hospital.

The practice held multidisciplinary team meetings monthly to discuss patients with complex needs. For example, those with multiple long term conditions, mental health problems, people from vulnerable groups, those with end of life care needs or children on the at risk register. These meetings were attended by district nurses, social workers, palliative care nurses and decisions about care planning were documented in a shared care record. Staff felt this system worked well.

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.

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 and GPs had received training to support them in its implementation. However, nurses had not received full training on the Act in order to be able to implement its key principles of assessing capacity when appropriate and ensuring that any decisions about patients' care were lawful and in their best interests should they lack capacity to consent. There was no protocol on the Act to support staff. All clinical staff 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).Patients with a learning disability and those with mental health 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).

There was a practice policy for documenting consent for specific interventions. For example, for 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

Requires improvement

Are services effective?

(for example, treatment is effective)

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.

Health promotion and prevention

It was practice policy to offer a health check to all new patients registering with the practice but not mandatory unless on medication. 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, smoking cessation advice was given to 95% of smokers. Cessation clinics had been offered offsite to patients but they had recently had started being provided by a nurse onsite. We saw from recent figures there were five smokers who had gone 12 weeks without smoking who were currently on the programme

The practice had 30 patients with learning disabilities on a register. Of these 70% had an annual health check recorded in line with the learning disabilities enhanced service so far in 2015/16 and there was a plan to review the other patients in November.

The practice's performance for the cervical screening programme was 95%, which was above the national target of 80%. The practice also encouraged its patients to attend national screening programmes for bowel cancer and 68% of patients had been screened. For patients eligible for screening of breast cancer 89% had been screened.

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 73%, and at risk groups 62%. These were above to national averages of 73% and 52% respectively.

Childhood immunisation rates for the vaccinations given to under ones were 96% which was above CCG average of 91%, under twos were 95% which was above CCG average of 94% and five year olds were 97% but CCG data was not available for comparison.

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 published in January 2015 with 115 responses and the practice's 2014 survey of 100 patients.

The evidence from all these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. In the national survey 93% said their GP gave them enough time (local average 86%) and 84% said the same of nurses (local average 80%). The practice survey found the vast majority of patients responded positively to their experience of consultations in the practice with approximately 99% saying they either felt cared for, respected involved or other positive responses. Staff we spoke with understood and respected patients' cultural, social and religious needs.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 6 completed cards and all were positive about the service experienced. Comments included that staff were pleasant, professional, helpful and caring. Patients said they felt the practice offered a caring service and staff treated them with respect and dignity. The eight patients we spoke with on the day of inspection told us they were all 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 and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. There was a policy of not mentioning patients' names when taking calls so that patients' personal information was protected.

Ten of the 11 patients who responded to the practice survey said they found the receptionists at the practice helpful. On the national survey 96% of respondents said receptionists were helpful.

We noted that staff were compassionate and empathetic in their approach to care. The ethos of patient centred care was evident in discussions with all staff.

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. Ninety two per cent of respondents to the national survey said the last GP they saw or spoke to was good at explaining tests and treatments (83% regional average) and 85% said the same about nurses (80% regional average). Eighty nine per cent of patients said the last GP they saw or spoke to was good at involving them in decisions (75% regional average) about their care 78% reported the same of nurses (65% regional average).

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 information on translation in the practice booklet was available but not on the website. We saw that care planning involved patients and noted preferences and wishes.

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

Good

Are services caring?

example, data from the national patient survey showed 96% of patients felt their GP treated them with care and concern (83% regional average) and 88% felt nurses did also (77% regional average).

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 on the website told patients how to access a number of support groups and organisations. The practice had a carer register available and flags on the patient record system for receptionists to identify carers. The website had extensive information for carers about the services the practice provided, including annual carer health-checks. There was also reference and information to external support information at reception and on the website. The practice manager told us that patients who had experienced a bereavement of another family member registered at the service were sent a card. We saw a bereavement counselling service was advertised for patients. The practice manager told us this service had provided some training to their staff to help them understand how to support patients experiencing loss.

Staff spoke about the individual needs and concerns they had about their patients, even if their concerns were not defined under a specifically recognisable group, such as carers. For example, GPs we spoke with were aware of some local young families and parents who they believed were potentially isolated and were conscious that these families may want and need greater contact time with services such as their local GP practice. Therefore GPs said they did not discourage these patients from attending the practice through telephone consultations or alternative services if they requested contact time with clinical staff.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patient's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered. GPs spoke of the demographic of their local population; specifically many young families and young professionals living in the local area. They were aware that commuting caused specific difficulties in accessing appointments during normal working hours for these patients and so trialled different extended hours to see what met patients' needs (the extended hours are detailed below under 'Access to the service'). The practice considered patents' preferences and needs in the planning of the service. Choices of female or male GPs were offered to patients.

The practice had responded to potential concerns that young patients may wish to have correspondence about their health kept private from their families, if living at their address. Therefore the surgery wrote to patients at 14 and 16 offering differing protocols of how these patients could be contacted in order to meet their preferences and maintain confidentiality.

The practice also considered the very small number of patients who may be homeless or without a fixed address and ensured they would be able to access care and treatment even if they did not have an address with which to register at the surgery. Staff told us they would register homeless patients at the practice's address. A local drug and alcohol service was encouraged to run clinics in the practice to ensure local patients with addiction problems would be able to access the service onsite.

Individual patient preferences were respected. For example, patients who did not want their records to be made available on screen when they phoned for an appointment had a flag to alert receptionists this was the case.

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. There was a carers' flag on the computer system to identify patients who may need additional support or priority when booking appointments. 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 people with disabilities. The practice was accessible to patients with mobility difficulties as facilities were all on one level. The consulting rooms were also accessible for patients with mobility difficulties and there were access enabled toilets and baby changing facilities. There was disabled parking close to the main entrance. The front door and connecting reception door were automatic. A hearing aid loop was available for deaf patients. Staff had received training from a relative of a deaf patient to improve their understanding of the experience of accessing services when someone is deaf.

There was a robust system for flagging vulnerability in individual patient records, so that any staff needing to be alerted to specific needs were informed. The practice had provided some staff with equality and diversity training.

Access to the service

The surgery was open from 8:00am to 6:30pm Monday to Friday. Appointments were available from 8:00am to 6:30pm on weekdays. The surgery was open one Saturday morning per month for patients who found it difficult to attend during normal working hours and the hours were extended further during winter months, when there were additional pressures on appointments. In 2015 the additional Saturday hours normally provided in winter had been continued into the summer months. 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. Patients could book appointments up to four weeks in advance but 20% of appointments were kept for same day booking to ensure patients who needed an urgent appointment could get one. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed.

Longer appointments were also available for older patients, those experiencing poor mental health, patients

Good

Are services responsive to people's needs?

(for example, to feedback?)

with learning disabilities and those with long-term conditions. This also included appointments with a named GP or nurse. Home visits were available to patients the same day if they called before 11am.

The patient survey information we reviewed showed patients responded very positively to questions about access to appointments. Seventy six per cent were satisfied with the practice's opening hours compared to the CCG average of 75% and national average of 76%. Eighty two per cent described their experience of making an appointment as good compared to the CCG average of 78% and national average of 74%. Ninety two per cent were able to get an appointment to see or speak to someone the last time they tried compared to 89% locally and 85% nationally. Ninety one per cent said they could get through easily to the surgery by phone compared to the CCG average of 76% and national average of 72%.

We spoke with eight patients and received six comments cards. Patients were satisfied with the appointments system and said it was easy to use. Most said 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. 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.

Listening and learning from concerns and complaints

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

We saw that information was available to help patients understand the complaints system in the practice leaflet and online. This included information on how to escalate a complaint externally if a patient was not satisfied with the outcome provided by the practice.

We looked at four complaints received in 2015 and found they were investigated and responded to. The practice reviewed complaints periodically in clinical team meetings and other meetings where relevant to different staff groups.

The practice manager explained that verbal feedback was responded to by the practice. There was also a comments box which patients frequently used. One example where this led to quick change was when a patient complained that the toilet paper bin was frequently overflowing with used paper towels. The practice replaced these bins with larger bins immediately and informed the patient. The practice manager told us they also considered feedback periodically from NHS Choices but did not always respond as some of the feedback was old when it had been reviewed by the practice.

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's vision was based on the premise that the partners and practice manager wanted the service to 'the practice they would want to go to'. During discussions staff consistently placed patients at the centre of the services they delivered. There was a clear strategy for succession planning for staff who had identified they would be leaving the practice. This included GPs. We saw evidence the practice's strategy was regularly reviewed at regular away days attended by the partners. There was an annual away day for all staff to attend. The practice was having to reflect and significantly review the provision of its services in response to a large reduction in funding taking place over five years. The surgery had identified that three options were open to it regarding staff remuneration, staff retention and how services were delivered. The demands on the surgery over this time were being carefully considered and planned for.

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 several of these policies and procedures and found they were up to date. Staff were required to read a number of policies during their inductions and periodically. We saw staff signed cover sheets to indicate they had read the policies.

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. Where the practice required additional support it sought external expertise. For example, the regional infection control lead was asked to support the practice in developing better infection control protocols. Staff were 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. Nurses told us they valued being part of clinical team meetings as this meant they understood clinical decisions about care planning and delivery and what these decisions meant to patients.

The GPs and practice manager took an active leadership role for overseeing the systems used to monitor the quality of the service. This 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 monthly team meetings and action plans were produced to maintain or improve outcomes. GPs led in specific areas of QOF to ensure they were able to account for various clinical outcomes.

The practice also had some completed clinical audits which it used to monitor quality and systems to identify where action should be taken. But out of seven audits which were due to be repeated and completed, only three had been. Incidents were reported and investigated and the reviewed annually to ensure changes resulted from learning outcomes.

The practice identified, recorded and managed most risks. It had carried out risk assessments where risks had been identified and action plans had been produced and implemented, for example there was a fire risk assessment and related protocols.

All staff attended meetings where governance issues were discussed. Nurses attended clinical team meetings which took place monthly. We looked at minutes from these meetings and found that performance, quality and risks had been discussed.

We were shown the electronic staff handbook that was available to all staff, which included sections on equality and harassment and bullying at work.

Leadership, openness and transparency

The partners were available to staff who told us that partners and the manager were approachable and always took the time to listen to them. Staff told us they were involved in discussions about how to run the practice and how to develop the practice. The practice manager told us there was a whole staff meeting once a year which was used to gather staff feedback.

The practice was open to areas of improvement. It had identified that there were problems with the service patients received regarding prescriptions potentially due to

Are services well-led?

Good

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

the systems used by local pharmacies and had changed the process for this to ensure that when prescriptions were collected by pharmacies, they were recorded so they could be tracked.

Seeking and acting on feedback from patients, public and staff

The practice encouraged and valued feedback from patients. It had gathered feedback from patients through the patient participation group (PPG) (which had a virtual group and a number of members who attended meetings), surveys and complaints received. We spoke with a member of the PPG, which had 122 members, and they said the practice manager took PPG feedback on board and referred to how concerns were dealt with effectively by the practice. The virtual PPG was a large reference group of 667 members which the surgery used to gather feedback about their services.

We saw analysis of the last patient survey, which was a small survey. The results and actions agreed from the surveys were available on the practice website. The friends and family test was undertaken by the practice and the findings were advertised on the website.

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

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at four staff files and training logs. We saw that staff development was monitored and supported. Staff told us that the practice was very supportive of training. Nurses valued the regional external training days where they could share best practice. Significant events and complaints were investigated, acted on and reviewed to ensure where improvements could be made, they were embedded in the service.

This was a training practice and GPs explained how they supported the trainees and mentored them. There were no trainee GPs available to speak with during the inspection.

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 12 HSCA (RA) Regulations 2014 Safe care and treatment **The practice was not always identifying and acting on risks through clinical audit.** Regulation 12(1)(2)(a) **Regulation: 12 Safe care and treatment** **The provider did not ensure that staff were supported with guidance to provide them with the skills and competence to ensure they always followed the principles of the Mental Capacity Act 2005.** Regulation 12(1)(2)(c)