Buxted Medical Centre

Quality Report

Framfield Road,
Buxted,
Uckfield,
East Sussex
TN22 5FD
01825 732333
Tel: 01825 732333
Website: www.buxtedandeasthoathlymedicalcentres.co.uk

Date of inspection visit: 10 February 2015
Date of publication: 08/05/2015

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?	Requires improvement
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We undertook a comprehensive inspection of Buxted Medical Centre on the 10 February 2015. The practice has an overall rating of good.

We visited the practice location at Buxted Medical Centre, Framfield Road, Buxted, Uckfield, East Sussex, TN22 5FD. Buxted Medical Centre also operates a branch surgery at East Hoathly Medical Centre, Juziers Drive, East Hoathly, BN8 6AE. We did not visit the branch surgery as part of our inspection.

Specifically, we found the practice to be good for providing well-led, effective, caring and responsive services. It required improvement for providing safe services. It was also good for providing services for people with long-term conditions, older people, families, children and young people, working age people (including those recently retired and students), people whose circumstances may make them vulnerable and people experiencing poor mental health (including people with dementia).

Buxted Medical Centre provides primary medical services. At the time of our inspection there were approximately 10,200 patients registered at the practice with a team of five GP partners. The practice was also supported by an advanced nurse practitioner, a lead practice nurse plus four practice nurses, three healthcare assistants, a paramedic, a team of receptionists and administrative staff and a practice manager. The practice is involved in the education and training of doctors and is also able to dispense medicines to it patients.

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

Our key findings across all the areas we inspected were as follows:

Summary of findings

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Risks to patients were assessed and well managed, with the exception of those relating to recruitment checks.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.
- The practice was a training practice and there was a culture of continuous development
- The practice had the appropriate equipment, medicines and procedures to manage foreseeable patient emergencies.
- The practice recognised the needs of its older population and had systems in place to support patients through care plans, hospital avoidance schemes and providing extra support for those patients with dementia.

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

Importantly, the provider must:

- Ensure that all recruitment checks are carried out and recorded as part of the staff recruitment process, including criminal record checks via the Disclosure and Barring Service (DBS) for staff who have chaperone duties, and that the recruitment policy reflects accurately the procedures necessary.
- Ensure the practice carries out a risk assessment for legionella and has a corresponding policy.

In addition the provider should:

- Ensure that patient information is clearly displayed for requesting chaperones
- Ensure that patient information is clearly displayed in relation to the complaints system and contains information of other organisations that can support a complainant.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

The practice is rated as requires improvement for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Although risks to patients who used services were assessed, the systems and processes to address these risks were not always implemented well enough to ensure patients were kept safe. For example, recruitment checks were not documented and there was no system in place for the management of legionella. There were enough staff to keep patients safe. The practice was clean and tidy and appropriate hygiene standards were maintained. Emergency procedures were in place to respond to medical emergencies. In the event of an emergency the practice had policies and procedures in place to help with the continued running of the service.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from the National Institute for Health and Care Excellence (NICE) and used it routinely. Patient's needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs had been identified and planned. There was evidence of appraisals and personal development plans for all staff. Staff worked with local multidisciplinary teams to provide patient centred care.

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 to help patients understand the services available was easy to understand. We also saw that staff treated patients with kindness and respect, and maintained confidentiality. During the inspection we witnessed staff

Summary of findings

interacting with patients in a way that was respectful, friendly and maintained confidentiality. We observed a patient-centred culture. The practice advertised local support groups so that patients could access additional support if required.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the local clinical commissioning group (CCG) to secure improvements to services where these were identified. The practice had excellent facilities and was well equipped to treat patients and meet their needs. The practice had a minor surgery operation room with up to date facilities and equipment. The practice held specialist clinics including, tissue viability, ear micro-suction and minor operations. Patients were able to attend the community hospital for musculoskeletal x-rays with the lead GP for these conditions and have their results the same day. Information about how to complain was available and easy to understand. However, we did not see this actively displayed within the waiting area. Evidence we reviewed showed that the practice responded quickly to issues raised. There was evidence of shared learning from complaints with staff and patients. Patients with disabilities were able to easily access the practice. Home visits were also available.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular meetings. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group (PPG) was active and worked closely with the practice. Staff we spoke with told us they felt valued and were appreciated. Staff had received inductions, regular performance reviews and attended staff meetings and events. There was an open culture and staff knew and understood the lines of responsibility and accountability to report incidents or concerns.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older 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 dementia and end of life care. The practice had several leads for the care of their elderly patients. For example, there was a lead GP for elderly care and nursing homes and another GP was the dementia lead. The practice was ensuring it was dementia friendly and taking part in a dementia 'Golden Ticket' pilot. Elderly patients with complex care needs all had personalised care plans that were shared with local organisations to facilitate the continuity of care. The practice employed a paramedic who could visit older patients within their own homes, who were at risk of hospital admission to complete care plans. The practice was responsive to the needs of older patients and offered ward rounds to nursing homes and home visits with rapid access appointments for those with enhanced needs. Patients were able to speak with or see a GP when needed and the practice was accessible for patients with mobility issues. The practice had a safeguarding lead for vulnerable adults. The practice had good relationships with a range of support groups for older patients. There were arrangements in place to provide flu and pneumococcal immunisation to this group of patients. Clinics included diabetic reviews and blood tests. Blood pressure monitoring was also available.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. All these patients had a structured annual review to check that their health and medicine needs were being met. The GPs followed national guidance for reviewing all aspects of a patient's long term health. For those patients with the most complex needs, the GP worked with relevant health and care professionals to deliver a multidisciplinary package of care. The practice nurses were trained and experienced to support patients with managing their conditions and preventing deterioration in their health. Diabetic patients were supported by the advanced nurse practitioner who managed their condition but was able to

encourage patients to monitor their own condition and set health goals. Flu vaccinations were routinely offered to patients with long term conditions to help protect them against the virus and associated illness.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. Monthly meeting were held with a lead health visitor to discuss any children of concern. Immunisation rates were relatively high for all standard childhood immunisations. The premises were suitable for children and babies. We saw good examples of joint working with midwives and health visitors. Practice staff had received safeguarding training relevant to their role and knew how to respond if they suspected abuse. Safeguarding policies and procedures were readily available to staff. The practice ensured that children needing emergency appointments would be given priority telephone triage slots.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered 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. The practice offered NHS health-checks and advice for diet and weight reduction. Nurses were trained to offer smoking cessation advice and patients could request routine travel immunisations.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances for example those with complex health needs. The practice ensured that patients classed as vulnerable had annual health checks. It offered longer appointments for patients when required. The practice regularly worked with multi-disciplinary teams in the case management of vulnerable patients. 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

Summary of findings

information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours. Translation services were available for patients who did not use English as a first language. The practice could accommodate those patients with limited mobility or who used wheelchairs. Carers and those patients who had carers were flagged on the practice computer system and were signposted to the local carers support team. A lead GP held a weekly clinic at Uckfield Community Hospital for substance misuse patients.

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). Patients with severe mental health needs had care plans and received annual physical health check. New cases had rapid access to community mental health teams. There was a weekly clinic held at the practice by the community mental health nurse who offered counselling. The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those with dementia. The practice carried out advance care planning for patients with dementia and was ensuring the practice was dementia friendly. It was also a pilot site for a dementia 'Golden Ticket' service. The pilot would provide rapid access and priority to those patients whilst trying to reduce hospital admissions and improve care. We noted that two GPs and a pharmacist had taken part in Dementia Fellowship training. 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

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

We reviewed the results of the national patient survey from 2013/2014 which contained the views of 128 patients registered with the practice. The national patient survey showed patients were consistently pleased with the care and treatment they received from the GPs and nurses at the practice. The survey indicated 88% of respondents would recommend the surgery to someone new to the area and 92% of respondents describe their overall experience of this surgery as good. We also noted that 94% of respondents had confidence and trust in the last GP they saw or spoke to, 89% said the last GP they saw or spoke to was good at listening to them and 92% said the last nurse they saw or spoke to was good at explaining tests and treatments.

We viewed the practice patient survey results from 2013/2014. The findings indicated that over 87% of respondents were satisfaction with their visit and 86% were happy with the time of their visit.

We spoke with seven patients on the day of the inspection and reviewed 41 comment cards completed by patients in the two weeks before the inspection. Both the patients we spoke with and the comments we reviewed were positive. Comments about the practice included that patients felt supported, listened to, cared for and respected. Comments also included that staff were friendly, professional, helpful and responsive. Comments in regards to the new telephone system were mixed. We received comments from nine patients expressing their dissatisfaction with the new system and six patients told us they thought the system worked better. We reviewed the national patient survey from 2013/2014 where 77% or respondents describe their experience of making an appointment with the practice as good.

Areas for improvement

Action the service MUST take to improve

- Ensure that all recruitment checks are carried out and recorded as part of the staff recruitment process, including criminal record checks via the Disclosure and Barring Service (DBS) for staff who have chaperone duties, and that the recruitment policy reflects accurately the procedures necessary.
- Ensure the practice carries out a risk assessment for legionella and has a corresponding policy

Action the service SHOULD take to improve

- Ensure that patient information is clearly displayed for requesting chaperones
- Ensure that patient information is clearly displayed in relation to the complaints system and

Buxted Medical Centre

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, a Practice Manager specialist, pharmacy specialist and a second CQC inspector.

Background to Buxted Medical Centre

Buxted Medical Centre is a semi-rural practice which offers general medical services. The practice has a smaller branch surgery (East Hoathly Medical Centre) which we did not inspect. The practice is involved in the education and training of doctors and is also able to dispense medicines to it patients. There are approximately 10,200 registered patients.

The practice is run by five partner GPs. The practice was also supported by an advanced nurse practitioner, a lead practice nurse plus four practice nurses, three healthcare assistants, a paramedic, a team of receptionists and administrative staff and a practice manager.

The practice runs a number of services for it patients including asthma clinics, child immunisation clinics, diabetes clinics, new patient checks and holiday vaccinations and advice.

Services are provided from two location:

Buxted Medical Centre, Framfield Road, Buxted, Uckfield, East Sussex, TN22 5FD

East Hoathly Medical Centre, Juziers Drive, East Hoathly, BN8 6AE

However, we only inspected Buxted Medical Centre

There are arrangements for patients to access care from an Out of Hours provider through NHS 111.

The practice population has a higher number of patients between 45 and 85 years of age than the national and local CCG average, with a significant higher proportion of 65-69 year old and over 85 year olds than the national average. There are a higher number of patients with a long standing health condition and patients within nursing homes. The percentage of registered patients suffering deprivation (affecting both adults and children) is significantly lower than the average for England.

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

Why we carried out this inspection

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

Detailed findings

How we carried out this inspection

Before visiting the practice we reviewed a range of information we hold. We also received information from local organisations such as NHS England, Health watch and the NHS High Weald, Lewes, and Havens Clinical Commissioning Group (CCG). We carried out an announced visit on 10 February 2015. During our visit we spoke with a range of staff, including GPs, practice nurses and administration staff.

We observed staff and patients interaction and talked with seven patients. We reviewed policies, procedures and operational records such as risk assessments and audits. We reviewed 41 comment cards completed by patients, who shared their views and experiences of the service, in the two weeks prior to our visit.

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

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

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

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

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

Requires improvement

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts, as well as comments and complaints received from patients. The staff we spoke to were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses.

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

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. There were records of significant events that had occurred and we were able to review these. Significant events were discussed at monthly meeting. There was evidence that the practice had learned from these and that the findings were shared with relevant staff. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

Staff used incident forms on the practice intranet and sent completed forms to the practice manager. They showed us the system used to manage and monitor incidents. We saw records for incidents were completed in a comprehensive and timely manner. We saw evidence of action taken as a result. For example, we saw a recorded incident of a non-member of staff gaining access to a staff only area. As a result of this incident coded door locks were placed on all doors so that only members of staff have access to these areas.

National patient safety alerts were disseminated to practice staff. Staff we spoke with were able to give examples of recent alerts relevant to the care they were responsible for. They also told us alerts were discussed at meetings and if needed during one to one meetings to ensure all staff were aware of any that were relevant to the practice and where they needed to take action.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young patients and adults. We noted that a nurse had taken on the dedicated lead for safeguarding vulnerable adults and children. They had been trained and could demonstrate they had the necessary training to enable them to fulfil this role (level 3 safeguarding children training). All GPs were also trained to safeguarding children level 3. Staff could demonstrate they had received the necessary training to enable them to identify concerns. All of the staff we spoke with knew who the practice safeguarding leads were and who to speak to if they had a safeguarding concern. We saw that safeguarding flow charts and contact details for local authority safeguarding teams were easily accessible in.

There was a system to highlight vulnerable patients on the practice computer system and patient electronic record. This included information so staff were aware of specific actions to take if the patient contacted the practice or any relevant issues when patients attended appointments. For example, children subject to child protection plans.

The practice had a chaperone policy. A chaperone is a person who can offer support to a patient who may require an intimate examination. The practice policy set out the arrangements for those patients who wished to have a member of staff present during clinical examinations or treatment. All nursing staff, including health care assistants, could be asked to be a chaperone. We were told that some reception staff had also been trained to undertake chaperone duties, however these staff had not received a criminal records check through the Disclosure and Barring Service. We noted that there were no posters on display within the waiting room or clinical rooms. However, this information was available on the information screen as well as in the practice leaflet. The practice manager informed us that posters would be displayed in the future so that patients would be reminded of this service.

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

GPs were appropriately using the required codes on their electronic system to ensure risks to children and young

people who were looked after or on child protection plans were clearly flagged and reviewed. GPs were aware of vulnerable children and adults and records demonstrated good liaison with partner agencies such as social services.

Medicines management

This practice was a dispensing GP practice and provided medicines from their own dispensary.

We checked medicines stored in the dispensary, treatment rooms medicine refrigerators and emergency medicines and found they were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. The practice staff followed the policy.

Processes were in place to check medicines were within their expiry date and suitable for use. Records of when checks were conducted were kept, highlighting medicines that were to expire soon. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

The nurses and healthcare assistants administered vaccines using directions that had been produced in line with legal requirements and national guidance. We saw up-to-date copies of directions and evidence that nurses and healthcare assistants had received appropriate training to administer vaccines. A member of the nursing staff was qualified as an independent prescriber.

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

The practice held stocks of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse) and had in place standard procedures that set out how they were managed. These were being followed by the practice staff. For example, controlled drugs were stored in a controlled drugs cupboard and access to them was restricted and the keys held securely. There were arrangements in place for the destruction of controlled drugs.

Dispensing staff at the practice were aware prescriptions should be signed before being dispensed. We saw that this process was working in practice. The practice had a system in place to assess the quality of the dispensing process and had signed up to the Dispensing Services Quality Scheme, which rewards practices for providing high quality services to patients of their dispensary.

Records showed that all members of staff involved in the dispensing process had received appropriate training and their competence was checked regularly.

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.

The practice had a lead for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. All staff received induction training about infection control specific to their role and received annual updates. We saw evidence that the lead had carried out audits and that any improvements identified for action were completed in a timely manner. However, we noted that although some improvements identified had been actioned, we found this information or the date it had been completed, had not been recorded.

An infection control policy and supporting procedures were available for staff to refer to including a policy for needle stick injury. This enabled staff to plan and implement measures to control infection. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use. Staff were able to describe how they would use these to comply with the practice's infection control policy.

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

We spoke with the practice manager regarding testing for legionella (legionella is a germ found in the environment which can contaminate water systems in buildings). The practice itself was a new building with modern water systems. However, the practice had not undertaken a risk

assessment. This would ensure the practice was aware of any potential risk of infection to staff and patients. We did note that the practice was routinely checking the water in the staff shower room in order to minimise any risks.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example weighing scales, spirometers and blood pressure measuring devices. The practice had invested in a state of art minor surgery room including up to date medical equipment used. We saw this was maintained and tested on regular basis.

Staffing and recruitment

Records we looked at did not contain all the evidence required to show that appropriate recruitment checks had been undertaken prior to employment. For example, files reviewed did not contain proof of identification including photographic identification, references, or full employment histories so that gaps in employment could be investigated. These checks would help to ensure staff employed were of good character.

The practice manager told us that the practice had considered whether administration and reception staff should have a criminal check through the Disclosure and Barring Service (DBS). The decision had been taken that this was not necessary and we noted there were written risk assessments supporting this discussion. However, some reception staff had been trained to be chaperones but had not had the required criminal check through the Disclosure and Barring Service (DBS). The practice manager informed us that this would be reviewed as the normal practice was to use nurses and healthcare assistants as chaperones.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. There was also an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual leave.

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

Safety equipment such as fire extinguishers and emergency oxygen were checked and sited appropriately.

Identified risks were included on a risk log. Each risk was assessed and rated and mitigating actions recorded to reduce and manage the risk. The practice manager told us they carried out regular visual inspections of the practice environment at regular intervals throughout the day, in order to identify immediate risks. We saw that any risks were discussed at GP partners' meetings and within team meetings.

We saw that staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies. For patients with long term conditions and those with complex needs there were processes to ensure these patients were seen in a timely manner. Staff told us that these patients could be urgently referred to a GP and offered double appointments when necessary.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that most staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly.

Requires improvement

Are services safe?

Emergency medicines were available in a secure area of the practice and all staff knew of their location. Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Risks identified included power failure, adverse weather, unplanned sickness and access to the building.

The practice had carried out a fire risk assessment that included actions required to maintain fire safety. However, we noted that although some improvements identified had been actioned, we found this information or the date it had been completed, had not been recorded. Records showed that fire alarms were routinely tested.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We saw minutes of practice meetings where new guidelines were disseminated and the implications for the practice's performance were discussed and required actions agreed. The staff we spoke with and the evidence we reviewed confirmed that these actions were designed to ensure that each patient received support to achieve the best health outcome for them. We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate.

The 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. The practices appointment triage system also meant that patients could be referred to the most appropriate GP for patient conditions. GPs and nurses we spoke with were open about asking for and providing colleagues with advice and support. GPs told us this supported all staff to continually review and discuss new best practice guidelines. For example, the management of respiratory disorders. Our review of the clinical meeting minutes confirmed that this happened.

The practice used computerised tools to identify patients with complex needs who had multidisciplinary care plans documented in their case notes. We were shown the process the practice used to review patients at risk of hospital admissions who had been recently discharged from hospital, which required patients to be reviewed by their GP within three working days and according to need.

National data showed that the practice was in line with referral rates to secondary and other community care services for all conditions. All GPs we spoke with used national standards for the referral of patients with suspected cancers referred and seen within two weeks.

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

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, clinical reviews and medicines management. The information staff collected was then collated by the assistant practice manager to support the practice to carry out clinical audits.

The practice had a system in place for completing clinical audit cycles. The practice showed us clinical audits that had been completed recently. Following each clinical audit, changes to treatment or care were made where needed and dates recorded for the audit to be repeated to ensure outcomes for patients had improved.

The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). (QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). For example, we saw an audit regarding the prescribing of medicines for patients with chronic kidney disease (CKD). CKD can mean that recommended medicine dosages need to be adjusted due to the patient's condition. Following the audit, we saw that majority of patients were on correct dosages of their medicines but where necessary GPs carried out medicine reviews to take into account their condition.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. For example, 94% of patients with diabetes had a record of retinal screening in the preceding 12 months. We also noted that 90% of patients diagnosed with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive, agreed care plan documented in their records, in the preceding 12 months and 92% of patients with chronic obstructive pulmonary disease (COPD) had a review, undertaken by a healthcare professional, including

Good

Are services effective?

(for example, treatment is effective)

an assessment of breathlessness in the preceding 12 months. The practice met all the minimum standards for QOF in diabetes/asthma/chronic obstructive pulmonary disease (lung disease). This practice was not an outlier for any QOF (or other national) clinical targets.

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.

There was a protocol for repeat prescribing which was in line with national guidance. In line with this, staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also checked that all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines. We saw evidence to confirm that, after receiving an alert, the GPs had reviewed the use of the medicine in question and, where they continued to prescribe it outlined the reason why they decided this was necessary. The evidence we saw confirmed that the GPs had oversight and a good understanding of the best treatment for each patient's needs.

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 provided an enhanced service to patients attending the practice who may require a more multi-disciplined service of care. For example, patients who were most likely to be subject to unplanned hospital admissions. The practice employed a paramedic who was also a care plan co-ordinator. They worked closely with high risk housebound patients and visited patients within their own home to created agreed care plans. Patients were also highlighted on the practice computer system so that their care could be prioritised. We also noted the practice had a patient register for fragility fractures and vulnerable patients identified could be referred to the falls service available.

The practice also participated in local benchmarking run by the Clinical Commissioning Group. This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area. This benchmarking data showed the practice had outcomes that were comparable to other services in the area.

Effective staffing

Practice staffing included 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. All GPs were up to date with their yearly continuing professional development requirements and all either had been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

All staff undertook annual appraisals that identified learning needs from which action plans were documented. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses. For example, a healthcare assistant we spoke with told us how they were being supported in their foundation degree and how the advanced nurse practitioner was their mentor. As the practice was a training practice, doctors who were training to be qualified as GPs had access to a senior GP throughout the day for support.

Practice nurses were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties. For example, on administration of vaccines and cervical cytology. Those with extended roles for example seeing patients with long-term conditions such as asthma, chronic obstructive pulmonary disease (COPD), diabetes and coronary heart disease, were also able to demonstrate that they had appropriate training to fulfil these roles. We received positive feedback from the trainee we spoke with.

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 service providers to meet patients' needs and manage those of patients with complex needs. It received blood test results, X ray results,

Good

Are services effective?

(for example, treatment is effective)

and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. Relevant staff were aware of their responsibilities in passing on, reading and acting on any issues arising from communications with other care providers on the day they were received. The GP who saw these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well. There were no instances identified within the last year of any results or discharge summaries that were not followed up appropriately.

The practice held multidisciplinary team meetings to discuss the needs of complex patients, for example those with end of life care needs or children on the at risk register. We noted that the practice held bi-monthly multi-disciplinary team meetings. These meetings were attended by district nurses, health visitors, representatives from Community Mental Health and Adult Social Care and decisions about care planning were documented in a shared care record. Staff felt this system worked well and remarked on the usefulness of the forum as a means of sharing important information

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. Electronic systems were also in place for making referrals, and the practice made some referrals through the Choose and Book system. (Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital).

The practice had systems to provide staff with the information they needed. Staff used the electronic patient record EMIS Web, 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. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005 and their duties in fulfilling it. The GPs and nurses we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice. We noted that some clinical staff had attended Mental Capacity Act training and Deprivation of Liberty training in February 2015. The practice had a mental capacity act policy which contained an assessment to capacity checklist and there was a separate flow chart for the Deprivation of Liberty which staff could refer to. GPs and nurses demonstrated a clear understanding of Gillick competencies. (These are used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions).

The GPs we spoke with told us they always sought consent from patients before proceeding with treatment. GPs told us they would give patients information on specific conditions to assist them in understanding their treatment and condition before consenting to treatment. Patients consented for specific interventions for example, minor surgical procedures, by signing a consent form. Patient's verbal consent was also documented in the electronic patient notes with a record of the relevant risks, benefits and complications of the procedure discussed with the patient.

Patients with more complex needs, for example dementia or long term conditions, were supported to make decisions through the use of care plans, which they were involved in agreeing. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it) and had a section stating the patient's preferences for treatment and decisions.

Health promotion and prevention

It was practice policy to offer a health check with the health care assistant 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 smoking cessation advice to smokers. The practice also offered NHS Health Checks to all its patients aged 40 to 75 years.

The practice had numerous ways of identifying patients who needed additional support, and it was pro-active in

Good

Are services effective?

(for example, treatment is effective)

offering additional help. For example, the practice kept a register of all patients with long term conditions and offered an annual physical health check. We noted that 90% of patients between 50 and 91 years of age with rheumatoid arthritis had an assessment for fracture risk and that 74% of patients diagnosed with dementia had a face-to-face review in the preceding 12 months.

The practice's performance for cervical smear uptake was 82%, which was comparable with other practices nationally. There was a mechanism of following up patients who did not attend such as telephone reminders for patients who did not attend for cervical smears.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance for all immunisations was above average for the Clinical Commissioning Group, and again there was a clear policy for following up non-attenders.

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

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

Patients completed CQC comment cards to tell us what they thought about the practice. We received 41 completed cards and all were positive about the service experienced. Patients said they felt the practice offered a caring service and staff were efficient, helpful and took the time to listen to them. They said staff treated them with dignity and respect. We also spoke with eight 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. One patient told us how the GP had made home visits out of normal hours when they had called about a health concern for a family member. Another told us that they appreciated their GP knew them and their condition. They told us they felt the GP understood and addressed their concerns.

We reviewed the most recent GP national survey data available for the practice on patient satisfaction. The evidence from the survey showed patients were satisfied with how they were treated and this was with compassion, dignity and respect. Data from the national patient survey showed that 92% of patients rated their overall experience of the practice as good. The practice was also above average for its satisfaction scores on consultations with doctors and nurses, with 89% of practice respondents saying the GP was good at listening to them and 91% said the last GP they saw or spoke to was good at giving them enough time. We also noted that 94% of patients had responded that they had confidence and trust in the last GP they saw or spoke to and 95% said the same about the last nurse they saw.

We also reviewed a practice patient survey from 2014 of which the practice. Results showed that 91% of patients thought they were treated with respect and 91% of patient thought the GP listened to them.

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

We observed staff were careful to follow the practice's confidentiality policy when discussing patient treatment in order that confidential information was kept private. The reception area and waiting room were combined but patients were requested to wait before coming forward to the reception desk. We noted that music was played in the waiting area to ensure that conversations at the front desk could not be overheard. Telephone calls were taken away from the reception desk so staff could not be overheard. Staff were able to give us practical ways in which they helped to ensure patient confidentiality. This included not having patient information on view, asking patients if they wished to discuss private matters away from the reception desk.

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, data from the national patient survey showed 83% of practice respondents said the GP involved them in care decisions and 82% felt the GP was good at explaining treatment and results. The results from the practice's own satisfaction survey showed that 87% of patients thought they were able to express their concerns or fears and were satisfied with their visit to the GP.

Patients we spoke to on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. 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 survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. The results of the national GP survey showed that 86% of patients said the last GP they saw or spoke to was good at treating them

Good

Are services caring?

with care and concern and that 93% of patients said the nurses were also good at treating them with care and concern. Patients we spoke to 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, on the TV screen and patient website also told patients how to access a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer. We saw information was available for carers to ensure they understood the various avenues of support available to them. Staff told us they were made aware of patients or recently bereaved families so they could manage calls sensitively and refer to the GP if needed. Advice on how to access support services would also be given if appropriate.

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. For example, the practice had recognised the needs of their older patients and was ensuring the practice was dementia friendly and taking part in a dementia 'Golden Ticket' pilot. The pilot idea is to ensure that as dementia progresses, there is increasing support for patients, families and carers and that the condition is managed in a pro-active and holistic way like other long-term conditions. The pilot would provide rapid access and priority to those patients whilst trying to reduce hospital admissions and improve care. We noted that two GPs and a pharmacist had taken part in Dementia Fellowship training.

The practice had an impressive minor surgery operation room with up to date facilities and equipment. The practice held specialist clinics including, tissue viability, ear micro-suction and minor operations. Patients were able to attend the community hospital for musculoskeletal x-rays with the lead GP for these conditions and have their results the same day.

The 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. We saw minutes of meetings where this had been discussed and actions agreed to implement service improvements.

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from patients and through the patient participation group (PPG). For example, patients had commented that would like more patient information and so the practice had installed an electronic patient information screen within the waiting area.

The practice had decided to change its appointment system in order to accommodate its growing population size. Patients were now triaged by GP's when phoning for an appointment. Receptionist asked patients for a brief description of their concern so that they could place the triage appointment with the most appropriate GP or the GP who was lead in a specialist area. Patients were given timed slots for when the GP would call them and then if necessary a face to face appointment could be arranged. We noted that home visits could be requested when necessary. Patients could also book appointments and order repeat prescriptions on line. The practice had late night and early morning appointments as well as alternate Saturday opening.

The practice supported patients with either complex needs or who were at risk of hospital admission. Personalised care plans were produced and were used to support patients to remain healthy and in their own homes. Patients with palliative care needs were supported. The practice had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss patient and their families care and support needs. The practice employed a paramedic who could visit elderly at risk patients to create an agreed plan of care to help them remain in their own homes.

Patients with long term conditions had their health reviewed in one annual review. This provided a joined up service working with the patient as a whole rather than just their individual condition. The practice provided care plans for asthma, chronic obstructive pulmonary disease (COPD), diabetes, dementia and severe mental health.

Tackling inequity and promoting equality

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

The practice was situated on a lower ground and first floor of a purpose built building. The main entrance to the practice was from the first floor. Services for patients were on the first floor and patients were able to enter the practice via a sloping pathway. To gain access to the practice there were doors with an automatic opening mechanism. There was lift access to the ground floor which was only for staff members.

We saw that the waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Several chairs had arm rests to aid patients when

Good

Are services responsive to people's needs?

(for example, to feedback?)

getting up from their seats. We noted there was a lower section in the reception desk to accommodate patients who used wheelchairs. Accessible toilet facilities were available for all patients attending the practice.

Access to the service

The practice had recently changed its appointment system in order to accommodate its growing population size. The practice was open from 8am to 6:30pm. Extended hours were also available on Monday evenings 6:30pm till 8pm and two early mornings, Tuesday and Friday 7am till 8am. The practice was also able to offer pre-bookable appointments on a Saturday twice a month. Patients were booked a telephone triage appointment with a GP at an agreed time slot and if necessary a face to face appointment could them be booked. Patients were able to book appointments for routine clinics in advance.

There was comprehensive information available to patients about appointments on the practice website and in their practice leaflet. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients.

Longer appointments were available for patients who needed them and those with long-term conditions. For example, patients with learning difficulties were offered 45 minute appointments for annual reviews. Home visits could be arranged and GPs visited several local residential and care homes.

Patients were generally satisfied with the appointments system, although we had mixed views from patients we spoke with on the day of the inspection and through comment cards received. Some patients thought the system was working well and the system ensured they spoke to a GP on the day they called the surgery. They told us that if it were urgent they would be given a face to face appointment after speaking with the GP. Others told us they disliked not being able to see the GP straight away. The practice was gathering the views of the patients on the new system.

Listening and learning from concerns and complaints

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

We saw that information was available to help patients understand the complaints system. We saw that information was in the practice leaflet and on the electronic patient information screen . However, we noticed that there was no information on display in the waiting area or on the practice website. Patients we spoke with told us they would speak with the practice manager or a GP partner 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 looked at complaints received in the last nine months and found these were handled in a timely way with openness and transparency. Staff we spoke with knew how to support patients wishing to make a complaint and told us that learning from complaints was shared with the relevant team or member of staff.

The practice reviewed complaints to detect themes or trends. We looked at the report for the last review and saw that the practice had received a number of complaints regarding the new appointment system. We saw that lessons learned from individual complaints had been acted on.

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 staff we spoke with told us that they felt well led. All the staff we spoke with told us there was a 'no blame culture' in the practice and they felt that senior staff members were always available to talk with. The practice was clinically well led with a core ethos to deliver high quality care and promote good outcomes for patients. The practice's statement of purpose included the statements to provide high quality, safe, professional services to their patients. To work in partnership with patients, their families and carers towards a positive experience and understanding and involving patients in decision making about their treatment and care. To treat patients as individuals. The practices mission statement was to provide an appropriate and rewarding experience of the highest quality for patients whenever they need help and support.

We spoke with members of staff during our inspection, including partner GPs, advanced nurse practitioner, lead practice nurse, practice manager, healthcare assistant and reception and administration staff. They all knew and understood the values and knew what their responsibilities were in relation to these. Many of the staff had worked at the practice for a number of years and spoke very positively about the practice. They told us there was good team work and they were actively supported to provide good care for their patients.

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 some of the policies and procedures and found they were up to date and held relevant information for staff. This included the consent protocol, infection control and the whistleblowing policy.

The practice had a business development plan which set out the practice's objectives for patients and the practice over the next three years. For example, the plan indicated the continued importance of patient feedback and ensuring a good skill mix of staff with job satisfaction and regular training.

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead nurse for safeguarding and the partner GP took on lead roles such as paediatric, minor operations, and dementia. Staff we spoke with knew who were the leads in different roles and were all clear in relation their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed it was performing in line with national standards. We saw that QOF data was regularly discussed at monthly team meetings and action plans were produced to maintain or improve outcomes.

The practice had an on-going programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. For example, we saw audits relating to the new appointment system, minor surgery and diabetic care reviews.

The practice had arrangements for identifying, recording and managing risks. Risk assessments had been carried out where risks were identified and action plans had been produced and implemented. For example, we saw a recent risk assessment for infection control and fire risk.

The practice held regular meetings, including weekly and monthly GP partner meetings, clinical review meetings with GP's nurses and healthcare assistants and bi-monthly team meetings which included administration and reception staff. We looked at minutes from the most recent meetings and found that performance, quality and risks had been discussed. Clinical audits and significant events were regularly discussed at meetings. Meetings were held which enabled staff to keep up to date with practice developments and facilitated communication between the GPs and the staff team.

Leadership, openness and transparency

We saw from minutes that team meetings were held regularly and there were weekly and monthly management / clinical meetings. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at any time and not just at team meetings.

Are services well-led?

Good

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

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example recruitment and whistleblowing policies which were in place to support staff. Staff we spoke with knew where to find these policies if required.

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

The practice had gathered feedback from patients through patient surveys, patients comment and complaints received. We looked at the actions from the complaints received. We noted that there had been a complaint regarding a patient not being notified of a change in their appointment time. The practice manager had sent an apology to the patient and this was discussed at a meeting. Due to this complaint raised the practice introduction a further member of staff to help with the work load.

The practice had a patient participation group (PPG) and we saw that the group was advertising for new members on the practice website and through posters in the waiting room. The practice manager showed us the analysis of the last patient survey, which was considered in conjunction with the PPG. The results and actions agreed from these surveys are available on the practice website.

The practice had gathered feedback from staff through staff meetings, appraisals and 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. For example, as Mondays are a busy day for appointments a member of staff had made the suggestion of where possible the 45 minute diabetic reviews were not pre-booked for that day of the week. This suggestion had been implemented.

Most staff we spoke with were aware of the whistleblowing procedure and there was also a whistleblowing policy which was available to all staff via any computer within the practice. They all told us they would have no hesitation of talking with senior staff members if they felt they needed to because of a concern.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at staff files and saw that regular appraisals took place which included a personal development plan. Staff told us that the practice was very supportive of training either organised with the local clinical commissioning group or by the practice.

The practice was a GP training practice and supported new registrar doctors in training. During the inspection we spoke with a registrar GP. They told us that they had protected learning time with their GP trainer and discussed guidelines from the National Institute for Health and Care Excellence (NICE) if applicable to clinical cases. Registrars were supported in their role by experienced, trained GPs and received supervision and mentoring throughout their period in the practice.

The practice had completed reviews of significant events and other incidents and shared with staff at meetings to ensure the practice improved outcomes for patients and staff. For example, we noted a significant event of a patient collapsing in the waiting room. This had been recorded and discussed as to what went well and any concerns this had raised. We noted that although the event was well coordinated it was also thought that scenario training for staff would be useful. A date for the all staff to practice an emergency scenario was being organised.

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 19 HSCA (RA) Regulations 2014 Fit and proper persons employed How the regulation was not being met: We found that the registered provider did not ensure they operated effective recruitment procedures and that information specified in Schedule 3 was available in respect of a person employed for the purposes of carrying out the regulated activity, and such other information as appropriate. This was in breach of regulation 21 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 19 (1)(a)(2)(3)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: We found that the registered provider did not ensure that effective systems were in place to assess the risk of, and to ensure that patients and staff were protected against the risk of infection from legionella bacteria which is found in some water systems. This was in breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12(2)(h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.