Bearwood Medical Centre

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Bearwood Medical Centre on 4 March 2015. Overall the practice is rated as requires improvement.

Specifically, we found the practice to require improvement for providing safe ,effective and well-led services. We found the service to be good for providing caring and responsive services.

The areas for improvements that led to these ratings also applied to all of the six population groups that we inspected and which are also rated as requires improvement. These were, people with long term conditions, families, children and young people, working age people, older people, people in vulnerable groups and people experiencing poor mental health.

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed, with the exception of legionella, risks associated with the premises, responding safely to a medical emergency and staff with portable DBS checks.
- There were effective arrangements in place to identify, review and monitor patients with long term conditions. However, we saw out of date clinical polices and no evidence that NICE guidance was discussed in clinical meetings to share best practice. Staff were not confident in using the clinical system and information was sometimes recorded outside the system which did not allow a clear audit trail.
- Patients said they were treated with dignity and respect and they were involved in their care and

Summary of findings

decisions about their treatment. However, patient feedback from the 2014-2015 national GP patient survey showed areas where the practice needed to improve.

- The practice was responsive to the needs of the practice population. There were services aimed at specific patient groups for example, there were vaccination clinics for babies, children and those in high risk groups and women were offered cervical cytology screening. The practice acted on complaints raised and learning was shared with staff.
- There was visible leadership with defined roles and responsibilities and staff felt supported by the management team. However, the governance arrangements at the practice was not robust as not all essential risks had been assessed and managed.

We saw one area of outstanding practice:

- The practice proactively followed up vulnerable patients who did not attend (DNA) their appointment which included liaising with other agencies for example the police where it may be considered that a patient may be at risk for example, if their DNA was out of character.

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

Importantly, the provider must:

- Have robust systems in place for the management of risks to patients and others against inappropriate or unsafe care. This must include completion of risks assessments in areas such as legionella, risks associated with the premises, responding safely to a medical emergency and staff with portable DBS checks.
- Fully train staff on utilising the clinical system to ensure patient information is managed safely and effectively.

In addition the provider should ensure that:

- Care and treatment records reflect national guidance such as NICE and there are arrangements to share best practice with staff.
- Training is provided for staff on the Mental Capacity Act to ensure staff are up to date with the regulation.
- Feedback from the 2014-2015 national GP patient survey is reviewed and acted on to improve patients experience of the service.
- Patient identifiable information is stored securely at all times.
- Actions are taken so that reasonable adjustments are made to enable people who require the use of a wheelchair are able to access the service.
- A risk assessment is carried out regarding the position of the baby changing unit to ensure safety and hygiene.

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. Guidance was available on local reporting arrangements for safeguarding children and vulnerable adults so that any concerns could be appropriately reported and investigated. However, essential risks such as, legionella and risks associated with the premises had not been assessed and managed. There was no evidence of regular checks of emergency medicines and equipment and we identified expired medicines.

Are services effective?

Requires improvement

The practice is rated as requires improvement for providing effective services. Data showed patient outcomes were mostly about average compared to practices nationally. Multidisciplinary working was taking place and there was evidence to support this. There was evidence of completed clinical audit cycles to improve patient outcomes. Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. There was evidence of appraisals and personal development plans for all staff. However, staff had not received any training on the Mental Capacity Act.

Staff told us that they referred to guidance from the National Institute for Health and Care Excellence (NICE) and used it routinely. However, we saw out of date clinical polices and no evidence that NICE guidance were discussed in clinical meetings to share best practice.

Staff were not all confident in using the clinical system which resulted in patient information not always being recorded on to the system.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice about average for several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information for patients about the services available was easy to understand and accessible. We also saw that staff treated patients with kindness and respect. However, patient feedback from the 2014-2015 national GP patient survey showed areas where the practice needed to improve.

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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 Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. A CCG is an NHS organisation that brings together local GPs and experienced health professionals to take on commissioning responsibilities for local health services.

Patients were able to access urgent appointments usually on the same day. Access to routine appointments and the ability to get through on the telephone were issues that patients felt needed to improve. The practice had identified this and were working to improve access to appointments. Improvements were needed to ensure reasonable adjustments are made to enable people who require the use of a wheelchair are able to access the service.

Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.

Are services well-led?

Requires improvement 

The practice is rated as requires improvement for being well-led. It had a vision and strategy. Staff were committed to providing a high quality service and felt supported by the management team. Staff had received inductions, regular performance reviews and attended staff meetings and events. The practice had a number of policies and procedures to govern activity but some of these needed updating. There were regular meetings to monitor and review the practice performance. However, the governance arrangements at the practice was not robust as not all essential risks had been assessed and managed.

Summary of findings

The six population groups and what we found

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

Older people

Requires improvement

The provider was rated as requires improvement for providing safe, effective and well-led services. The areas for improvement which led to these ratings apply to everyone using the practice, including this population group. Therefore the practice is rated as requires improvement for the care of older people. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people and had a range of services, for example, dementia screening including referral to the memory clinic where appropriate and flu vaccinations for patients aged 65 years and over. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs. The practice worked in conjunction with the multidisciplinary team to identify and support older patients who were at high risk of hospital admissions and those receiving end of life care.

People with long term conditions

Requires improvement

The provider was rated as requires improvement for providing safe, effective and well-led services. The areas for improvement which led to these ratings apply to everyone using the practice, including this population group. Therefore the practice is rated as requires improvement for the care of people with long-term conditions. Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. All these patients had a named GP and a structured annual review to check that their health and medication needs were being met. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care. The practice held two monthly diabetic clinics which were led by a diabetic consultant and nurse specialist to review patients with poorly controlled diabetes. The practice had started a project designed to improve identification and management of patients with Chronic Obstructive Pulmonary Disease (COPD).

Families, children and young people

Requires improvement

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

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improvement for the care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. Immunisation rates were relatively high for all standard childhood immunisations. Appointments were available outside of school hours. There was evidence of joint working arrangements with the health visitors and midwives.

There were baby changing facilities at the practice. However, the practice should risk assess the position of the baby changing unit to ensure safety and hygiene as when in use the changing mat rested over a bin and the toilet.

Working age people (including those recently retired and students)

Requires improvement

The provider was rated as requires improvement for providing safe, effective and well-led services. The areas for improvement which led to these ratings apply to everyone using the practice, including this population group. Therefore the practice is rated as requires improvement 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 had extended opening times and was open until 7pm four days a week.

People whose circumstances may make them vulnerable

Requires improvement

The provider was rated as requires improvement for providing safe, effective and well-led services. The areas for improvement which led to these ratings apply to everyone using the practice, including this population group. Therefore the practice is rated as requires improvement for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including those with a learning disability and those with caring responsibilities. It had carried out annual health checks for people with a learning disability and offered longer appointments. The practice regularly worked with multi-disciplinary teams in the case management of vulnerable patients. Staff knew how to recognise signs of abuse in vulnerable adults and children and were aware of contacting relevant agencies in normal working hours and out of hours.

The practice provided an enhanced service to avoid unplanned hospital admissions .This service focused on coordinated care for

Summary of findings

the most vulnerable patients and included emergency health care plans. The aim was to avoid admission to hospital by managing their health needs at home. An enhanced service is a service that is provided above the standard general medical services contract (GMS). The practice proactively followed up vulnerable patients who did not (DNA) attend their appointment which included liaising with other agencies for example the police where it may be considered that a patient may be at risk for example, if their DNA was out of character.

People experiencing poor mental health (including people with dementia)

Requires improvement

The provider was rated as requires improvement for providing safe effective and well-led services. The areas for improvement which led to these ratings apply to everyone using the practice, including this population group. Therefore the practice is rated as requires improvement for the care of people experiencing poor mental health (including people with dementia). Patients experiencing poor mental health had received an annual physical health check. Staff worked closely with local community mental health teams to ensure patients with a mental health need were reviewed, and that appropriate risk assessments and care plans were in place. The practice proactively screened patients for dementia and referred eligible patients to the memory clinic for additional assessment and support. Staff had received training on how to care for people with dementia and mental health conditions and offered counselling services and cognitive behavioural therapy.

Summary of findings

What people who use the service say

We looked at the results of the 2014-2015 national GP patient survey. Findings of the survey were based on comparison to other practices nationally, 379 surveys were sent and 109 were completed and returned. The results showed that the practice performance in a number of areas were above the Clinical Commissioning Group (CCG) and national average. For example, waiting times and patients experience of the care provided by nurses. There were also areas where the practice was similar to the CCG average but below the national average, this included phone access and patients overall experience of making appointments. However, patients experience of the care provided by the GPs were below the CCG and national average, this included being treated with care and concern, being listened to and having enough time with the GPs. Patient satisfaction with practice opening times, overall experience of the practice and recommending the practice to someone new to the area was below CCG and national average.

We reviewed comments made on the NHS Choices website to see what feedback patients had given. There were seven comments posted on the website in the last nine months, a common theme from the feedback related to difficulty accessing appointments. The practice had not replied to any of the comments.

As part of the inspection we sent the practice comment cards so that patients had the opportunity to give us feedback. We received 10 completed cards. The feedback we received was positive overall. Patients described staff who were polite and helpful and took time to discuss and explain their health needs. On the day of the inspection we also spoke with eight patients including one member of the patient participation group (PPG). PPGs are a way in which patients and GP surgeries can work together to improve the quality of the service. Patients told us that they were involved in their care and staff took time to explain their treatment in a way that they understood. However, the feedback received from patients suggested access to appointments was an area that the practice should improve on.

Areas for improvement

Action the service MUST take to improve

- Have robust systems in place for the management of risks to patients and others against inappropriate or unsafe care. This must include completion of risks assessments in areas such as legionella, risks associated with the premises, responding safely to a medical emergency and staff with portable DBS checks.
- Fully train staff on utilising the clinical system to ensure patient information is managed safely and effectively.

Action the service SHOULD take to improve

- Care and treatment records reflect national guidance such as NICE and there are arrangements to share best practice with staff.
- Training is provided for staff on the Mental Capacity Act to ensure staff are up to date with the regulation.
- Feedback from the 2014-2015 national GP patient survey is reviewed and acted on to improve patients experience of the service.
- Patient identifiable information is stored securely at all times.
- Actions are taken so that reasonable adjustments are made to enable people who require the use of a wheelchair are able to access the service.
- A risk assessment is carried out regarding the position of the baby changing unit to ensure safety and hygiene.

Summary of findings

Outstanding practice

- The practice proactively followed up vulnerable patients who did not attend (DNA) their appointment which included liaising with other agencies for example the police where it may be considered that a patient may be at risk for example, if their DNA was out of character.

Bearwood Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector and a second CQC inspector. The team also included a specialist advisor GP and a specialist advisor practice manager who have experience of primary care services.

Background to Bearwood Medical Centre

Bearwood Medical centre provides primary medical services to approximately 4100 patients in the local community. There are three GPs (two male and one female) working at the practice together with a long term locum GP. The GPs are supported by a practice nurse and a health care assistant. The non-clinical team consists of a practice manager, secretaries, administration staff and receptionists.

The practice has a Personal Medical Services (PMS) contract with NHS England. A PMS contract is agreed locally and is an alternative to a General Medical Services (GMS) contract for providers of general practice but still provides essential services for people who are sick as well as for example, chronic disease management and end of life care. The practice offers a range of clinics and services including, asthma, diabetes, child health and development, contraception and chronic obstructive pulmonary diseases (COPD).

The practice opening times are Monday from 9am until 1pm and 2pm to 7pm with the exception of Wednesday then the surgery closes at 1pm and does not re-open during the afternoon.

The practice has opted out of providing out-of-hours services to their own patients. When the practice is closed an out of hours answerphone message informs patients to contact the NHS 111 service which would assess and refer patients to the out-of-hours service provider 'Primecare'. When the practice is closed during core hours on a Wednesday afternoon the answerphone provides patients with the direct contact details for Primecare.

We reviewed the most recent data available to us from Public Health England which showed that the practice is located in an area with a low deprivation score compared to other practices nationally. Data showed that the practice has a lower than average practice population aged 65 years over in comparison to other practices nationally. The practice has a lower than the national average number of patients with caring responsibilities with a rate of 15.9 % compared to the national average of 18.2%.

The practice achieved 97.5% points for the Quality and Outcomes Framework (QOF) for the financial year 2013-2014. This was above the national average of 94.2%. The QOF is the annual reward and incentive programme which awards practices achievement points for managing some of the most common chronic diseases, for example asthma and diabetes.

This provider was last inspected using our previous methodology on 9 June 2014. The provider was not meeting regulation 10 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2010 which related to assessing and monitoring the quality of service provision. This comprehensive rated inspection included a follow up of the outstanding actions from the previous inspection.

Detailed findings

Why we carried out this inspection

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

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

How we carried out this inspection

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

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

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

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

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 4 March 2015. During our visit we spoke with a clinical and non-clinical staff and spoke with patients who used the service and carers.

Requires improvement

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. For example, we saw an example of a medication error that had been reported, we found that it was well documented and appropriate action had been taken.

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

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. We reviewed records of six significant events that had occurred during the last 12 months and saw this system was followed appropriately. Significant events were discussed at practice meetings and 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.

National patient safety alerts were disseminated by the senior GP to practice staff via email. Patient safety alerts are issued when potentially harmful situations are identified and need to be acted on. Staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for. We saw an example of an audit undertaken in response to a medication alert.

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 most staff had received relevant role specific training on safeguarding children although not all staff had received training in safeguarding vulnerable adults. However, staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details were easily accessible.

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

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments; for example children subject to child protection plans. There were meetings with the health visiting team which provided the opportunity to share information and concerns about at risk children this was supported by our discussion with the health visiting team who told us that important information was shared in a timely manner.

There was a chaperone poster which was visible on the waiting room noticeboard and in consulting rooms. (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). The practice manager showed us evidence that staff had received chaperone training. Reception staff would act as a chaperone if nursing staff were not available. However, two reception staff reported that they had not undertaken training and had not read the practice policy although they understood their responsibilities when acting as chaperones. All staff undertaking chaperone duties had received Disclosure and Barring Service (DBS) checks. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).

Medicines management

There was a dedicated secure fridge where vaccines were stored. There were systems in place to ensure that regular checks of the fridge temperatures were undertaken and recorded. This provided assurance that the vaccines were stored within the recommended temperature ranges and were safe and effective to use. A cold chain policy was in place to guide and support staff and ensure consistency.

Requires improvement

Are services safe?

The practice routinely used electronic prescribing and systems were in place to ensure all prescriptions including paper prescriptions could be accounted for.

There were arrangements in place for repeat prescribing so that patients were reviewed appropriately to ensure their medications remained relevant to their health needs. The practice employed a prescribing support pharmacist who undertook a session a week to support effective prescribing at the practice. The practice had undertaken a number of medicine audits for example to ensure cost effective prescribing and to reduce inappropriate prescribing. Findings from the audits had been acted to ensure efficiency.

National prescribing data available to us for 2013-2014 showed us that the practice prescribing rates for some medicines for example, the prescribing of non-steroidal anti-inflammatory medicines were in line with the national average. The practice rates for antibacterial prescriptions were better than the national average.

Cleanliness and infection control

During this inspection we observed that the practice was visibly clean and tidy. There were systems in place to reduce the risk of cross infection. This included the availability of personal protective equipment and posters promoting good hand hygiene.

There was an infection control policy and a named lead for infection control with responsibility for overseeing good infection control procedures. We saw evidence that all of the staff had received training in infection prevention and control so that they were up to date with good practice

We found that suitable arrangements were in place for the storage and the disposal of clinical waste and sharps. Sharps boxes were dated and signed to help staff monitor how long they had been in place. A contract was in place to ensure the safe disposal of clinical waste.

The practice employed cleaners for the general cleaning of the environment and there were records to demonstrate the cleaning undertaken.

At our last inspection in June 2014, we identified that the practice had completed an action plan from an infection control audit form July 2013. However, this audit did not include actions outstanding from the previous audit.

During this inspection we saw that infection control audit had been completed in July 2014 and actions identified had been addressed for example ensuring staff had completed training.

There were no records of a legionella test or risk assessment to assess the level of risk associated with building. Legionella is a term for particular bacteria which can contaminate water systems in buildings.

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 which was August 2014. A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example weighing scales and blood pressure measuring devices.

Staffing and recruitment

At our last inspection in June 2014, the practice was meeting the standard in relation to requirements relating to workers. However, improvements were required to ensure information was obtained about any physical or mental health conditions relevant to staff carrying out their role and ensuring proof of identity was obtained as part of the recruitment process. We also identified that the practice had not ensured all clinical staff were covered by indemnity insurance, for example, the practice nurse. Indemnity insurance is required to cover the GPs and practice staff for claims against negligent practice.

During this inspection we saw that the practice had a recruitment policy that set out the standards it followed when recruiting staff. Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification which included a recent photograph, references, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service (These checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable). We saw evidence that clinical staff had appropriate indemnity insurance. However, we saw one member of non clinical

staff had no medical health information. The practice manager told us that this was checked but not recorded. This member of staff also had a DBS check from a previous employer which had not been risk assessed.

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. We identified that although there were two permanent GPs working at the practice between them their hours were equivalent to one full time GP; along with the full time locum GP the total GP to patient ratio was relatively high. The practice manager told us that they were looking to recruit a salaried GP to provide additional sessions. However, any sickness were covered between the GPs to reduce disruption to the service.

Monitoring safety and responding to risk

The practice had some systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. This included data log sheets for the control of substances hazardous to health (COSHH) to ensure an accurate record of all COSSH products medicines management, staffing, dealing with emergencies and equipment. The practice had a health and safety policy however, no risk assessment had been completed to ensure risks had been assessed and managed for example, risks associated with access for patients with a disability and the position of the baby changing unit .The practice manager assured us that this would be completed by April 2015.

At our last inspection in June 2014 we saw that a fire risk assessment had been completed in November 2013. Following this risk assessment actions requiring immediate attention had been identified. We saw that a number of these urgent actions had not been addressed such as fire detection systems including alarms. During this inspection we saw that most of the staff had received training in fire safety, this included specific training for staff who were the nominated fire marshal. There was evidence that regular fire drills took place to ensure staff were prepared in the event of a fire emergency. Fire equipment were tested to ensure they were in god working order. All of the actions from the fire risk assessment undertaken in November 2013 had now been completed including the installation of a fully integrated fire detection system.

Arrangements to deal with emergencies and major incidents

There were some arrangements to deal with foreseeable medical emergencies. Most of the staff had received training in responding to a medical emergency although some staff were due updates to ensure their knowledge and skills were in line with current best practice. There were emergency medicines including oxygen so that staff could respond in the event of a medical emergency. All of the staff asked (including receptionists) knew the location of the emergency medicines. Staff told us that emergency medicines and equipment were checked daily to ensure that they were safe to use and in good working order and the practice protocol stated checks should be done monthly. However, we did not see any records of the checks undertaken of the medicines or oxygen. There was no automated external defibrillator (AED). This is a piece of life saving equipment that can be used in the event of a medical emergency and is recommended piece of equipment that reflects national standards. The practice manager told us that this was out of order and in the process of being repaired. However, there was no risk assessment in place to ensure staff were able to respond safely in its absence. There was no list of the medicines that should be in the emergency box. We saw that the oxygen had expired in January 2015 and a medicine had expired in April 2014. Following our inspection the manager sent us evidence that the oxygen cylinder had been changed and confirmed that the expired medicine had been removed and replaced.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. For example, power failure and adverse weather. The document also contained relevant contact details for staff to refer to and was easily accessible to all staff.

Requires improvement

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

We saw clinical policies and procedures for managing some common conditions such as diabetes, hypertension and ambulatory blood pressure that were in a paper format. They were not detailed or up to date and did not reflect guidelines from the National Institute for Health and Care Excellence (NICE). The practice nurse and GP partner told us that they were aware that clinical policies and procedures that were in a paper format needed to be up dated to reflect NICE guidance. Clinical staff spoken with were familiar with current best practice guidance, and told us they accessed guidelines from the NICE website, we saw that a link was available to staff via the desktop on any computer within the practice. However, there was no evidence that NICE guidance was discussed in clinical meetings to share best practice.

The GPs and nursing staff provided examples of implementing best practice in line with NICE. For example, for the management and treatment of patients with diabetes and Chronic Obstructive Pulmonary Disease (COPD) and high blood pressure. COPD is the name for a collection of lung diseases, including chronic bronchitis and emphysema. Typical symptoms are increasing shortness of breath, persistent cough and frequent chest infections.

We looked at several patient records to review the care provided to patients with diabetes and found that that they lacked sufficient detail to demonstrate that comprehensive assessments had been undertaken in line with NICE guidance. However, staff described how they carried out comprehensive assessments which covered all health needs and was in line with national and local guidelines. They explained how care was planned to meet identified needs and how patients were reviewed at required intervals to ensure their treatment remained effective. For example, patients with diabetes were having regular health checks and were being referred to other services when required. Feedback from patients confirmed they were referred to other services or hospital when required. There was a GP lead for diabetes who had undertaken courses in diabetes this included a recent course on insulin initiation. The practice hosted a consultant lead diabetic clinic every two months. A GP had also attended a recent course on COPD and a project was in progress to help improve diagnosis and management. Data from the Quality and Outcomes Framework (QOF) showed patient outcomes for diabetes were in line with the national average. QOF indicators for blood pressure monitoring of patients with high blood pressure as well as the ratio of reported versus expected prevalence for COPD were also in line with the national average. The QOF is the annual reward and incentive programme which awards practices achievement points for managing some of the most common chronic diseases, for example asthma and diabetes.

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 as part of the QOF. Weekly meetings were held to discuss QOF performance. 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 clinical targets; It achieved 97% of the total QOF target in 2013/2014, which was above the national average. For example,

- Performance for diabetes related indicators were similar to the national average.
- The percentage of patients with hypertension having regular blood pressure tests was similar to the national average.
- The dementia diagnosis rate were similar to the national average

The practice showed us their current performance for QOF which was 89% and there was an effective plan in place to meet the target.

The practice had a system in place for completing clinical audit cycles. The practice had completed 14 clinical audits in the last two years. We reviewed two audits which were completed cycles which showed improvements made to patients care and treatment and demonstrated learning and reflection. For example, an audit to identify patients who could be managed effectively in primary care for their health condition.

Requires improvement

Are services effective?

(for example, treatment is effective)

The practice implemented the gold standards framework for end of life care (GSF) and there were 12 patients who were receiving end of life care at the time of the inspection. This framework helps doctors, nurses and care assistants provide a good standard of care for patients who may be in the last years of life. This included a palliative care register and regular multidisciplinary meetings to discuss the care and support needs of patients and their families.

Effective staffing

The practice team included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that most staff were up to date with courses such as basic life support, safeguarding children and vulnerable adults, fire safety and infection control and further training was planned for staff who were due updates. Practice nurses were expected to perform defined duties for example, the administration of vaccines and cervical cytology and they were able to demonstrate that they were trained to fulfil these duties Those with extended roles were involved in reviewing patients with long-term conditions such as diabetes and respiratory conditions, were also able to demonstrate that they had appropriate training to fulfil these roles.

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 the practice nurse had attended a practice nurse conference.

There were two monthly practice meetings which included staff such as administrative and clinical staff which enabled important information to be shared with staff as well providing an opportunity or staff to discuss any issues.

Working with colleagues and other services

The practice worked with other service providers to meet people's needs and support those patients with complex needs. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. There were systems in place to ensure that the results of blood tests and investigations were reviewed and acted on as clinically necessary by a GP. However, we saw evidence that the GP sometimes used paper notes to refer any actions to the practice nurse and did not utilise the clinical system to ensure a clear audit trail.

The number of emergency hospital admission for 19 ambulatory care sensitive conditions was similar to the national average. The practice was commissioned for the unplanned admissions enhanced service and had a process in place to follow up patients discharged from hospital. (Enhanced services require an enhanced level of service provision above what is normally required under the core GP contract).

The practice held regular multidisciplinary team meetings to discuss patients with complex needs. For example, those with end of life care needs and children on the at risk register. These meetings were attended by various professionals such as the district nurses, health visitors palliative care nurses and elder care co-ordinator. We spoke with the district nurses, health visitors and elder care co-ordinator who told us that these meetings provided an opportunity to discuss and share information effectively. Care plans were in place for patients with complex needs and shared with other health and social care workers as appropriate.

The practice had systems in place to identify patients who were at high risk of admission to hospital and were proactive in following up these patients. The practice had exceeded the 2% required target and had identified 3% of at risk patients. These patients were reviewed regularly to ensure multidisciplinary care plans were documented in their records and that their needs were being met to assist in reducing the need for them to go into hospital.

Information sharing

The practice had arrangements in place to share information with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. However, we found that the practice had implemented a new clinical system over a year ago but not all staff were confident in using it. This resulted in some staff using paper templates that were scanned on to patient records instead of those available on the clinical

Requires improvement

Are services effective?

(for example, treatment is effective)

system as well as tasking staff outside of the system which did not provide a clear audit trail. Following our inspection the practice reported that training had been provided to staff on the clinical system.

There was evidence of joint working arrangements with for example the midwife, health visitor, district nurse and mental health services to ensure information was shared in a timely manner. We received positive feedback from the district nursing and health visiting team who told us that there was good communication systems in place to share information.

The practice had an effective referral system to secondary care services such as the hospital and undertook case reviews of referrals to secondary care to assess there appropriateness

Consent to care and treatment

Staff had not received training on the Mental Capacity Act. However, the practice had polices in place which covered the Mental Capacity Act (2005) and Gillick competencies (This helps clinicians to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment).

The practice was able to provide us evidence that patients with a learning disability and those with mental health needs were supported to make decisions through the use of care plans, which they were involved in agreeing.

Health promotion and prevention

Information leaflets and posters were available in the patient waiting area relating to health promotion and prevention. The practice had a patient information screen which was used to disseminate health promotion and prevention advice.

The practice's performance for the cervical screening programme was 84%, which was above the national average of 82%. There was a policy to offer telephone reminders for patients who did not attend for their cervical screening test. A practice nurse had responsibility for following up patients who did not attend. Findings were audited to ensure good practice was being followed.

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 about average for the majority of immunisations where comparative data was available. For example, flu vaccinations for patients aged 65 and older and at risk groups. The most recent data for childhood vaccination rates provided by the practice showed that the practice was achieving between 92-100% of childhood immunisations.

The practice offered advice and support in areas such as smoking cessation, weight management, family planning and sexual health. A health trainer visited the practice once a week to provide health promotion advice. The practice had an in house counsellor who visited once a week to review patients referred for support and advice.

NHS health checks were available for people aged between 40 years and 74 years. We saw evidence that the practice had invited all eligible patients at least once. Some patients were now being screened for the second time as there had been five years since they were first screened.

The practice had a protocol in place for new patients registering with the practice. This included a new patient health check with the healthcare assistant or nurse. All concerns were referred to the GPs.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

The practice patient participation group (PPG) had undertaken a practice survey and had reported on its findings in February 2015, 100 patients were surveyed, of which 68 responded. The results showed positive patient feedback in relation to satisfaction with service and the quality of the care provided by both the GPs and nurses. For example, 82% of respondents said that at their last appointment with a GP they had received the care and treatment that mattered to them.

We received 10 completed cards and the majority were positive about the service experienced. Patients said they felt staff were helpful and caring and treated them with dignity and respect. We also spoke with eight patients on the day of our inspection, all told us they were satisfied that their dignity and privacy was respected.

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the 2014-2015 national GP patient survey. The results of the national GP survey highlighted that the practice generally rated the practice well in these areas in relation to nursing staff. For example,

- 96% said the nurse was good at listening to them compared to the CCG average of 88% and national average of 91%
- 97% said the nurse gave them enough time compared to the CCG average of 88% and national average of 92%
- 99% said they had confidence and trust in the last nurse they saw compared to the CCG average of 95% and national average of 97%

Although the practice had analysed and acted on the feedback from the 2013-2014 national GP survey in which the feedback was mostly similar to the national average. The practice had not reviewed the most recent 2014-2015 survey which showed a decline in a number of areas compared to the previous survey. For example,

Patients experience of the GPs

- 74% said the GP was good at listening to them compared to the CCG average of 84% and national average of 89%.
- 72% said the GP gave them enough time compared to the CCG average of 82% and national average of 87%.
- 83% said they had confidence and trust in the last GP they saw compared to the CCG average of 92% and national average of 95%.

We discussed this with the practice manager who told us that as the results of the 2014-2015 patients survey were relatively new they had not yet had the opportunity to analyse and act on the feedback. However, this would be done as a priority. They told us that they were already trying to improve the service provided by the GPs by recruiting a salaried GP which was in progress.

The layout of the reception area meant that patient's confidentiality was not always maintained. Staff taking incoming calls could be overhead and patients records were visible as the shutters of the cabinets where records had been stored were left open. There was no information on display informing patients that they could discuss any issues in private, away from the main reception desk. However, staff told us that they were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. For example, not discussing any sensitive information at the reception desk and they explained that the shutters where patient records were stored were usually closed.

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

Care planning and involvement in decisions about care and treatment

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.

Good

Are services caring?

The 2014-2015 national GP patient survey 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 in relation to nursing staff. For example,

- 96% said the last nurse they saw was good at explaining tests and treatments compared to the CCG average of 86% and national average of 90%.
- 86% said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average of 82% and national average of 85%.

Although the practice had analysed and acted on the feedback from the 2013-2014 national GP survey in which the feedback was mostly similar to the national average. The practice had not reviewed the most recent 2014-2015 survey which showed a decline in a number of areas compared to the previous survey. For example,

- 69% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 82% and national average of 86%.
- 64% said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 76% and national average of 81%.

We discussed this with the practice manager who told us that as the results of the 2014-2015 patients survey were relatively new they had not yet had the opportunity to analyse and act on the feedback. However, this would be done as a priority. They told us that they were already trying to improve the service provided by the GPs by recruiting a salaried GP which was in progress.

Patient/carer support to cope emotionally with care and treatment

There was information in the patient waiting area for carers which included details of how to access support groups and organisation to ensure this vulnerable group understood the various avenues of support available to them. The practice also had a register for identifying people who were carers to ensure their needs were identified and support could be offered and there were multidisciplinary meetings to discuss patients needs. However, patients computer records did not include an alert system that would highlight to staff that a patient was also a carer.

The 2014-2015 national GP patient survey showed patients were overall positive about the emotional support provided by the nurse and rated it well in this area. For example, 94% said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 87% and national average of 90%. The results in relation to the last GP appointment was less favourable, 69% said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 80% and national average of 85%. The practice had not yet acted on the findings of the survey although they told us that findings would be acted once the results had been analysed.

The patients we spoke with on the day of our inspection and the comment cards highlighted that staff responded compassionately when they needed help and provided support when required.

Staff told us that if families had suffered bereavement, a GP would contact them. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service. A patients we spoke with who had had a bereavement confirmed they had received this type of support and said they had found it helpful.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patients' needs and had systems in place to maintain the level of service provided. The practice delivered core services to meet the needs of the patient population they treated. For example, screening services were in place to detect and monitor the symptoms of long term conditions such as diabetes. Patients over the age of 75 years had a named GP to ensure their care was co-ordinated. There were vaccination clinics for babies and children and those in high risk groups, women were offered cervical cytology screening.

National data from the Quality Outcomes Framework (QOF) for the year 2013-2014 showed that the practice performance in areas such as cervical cytology screening, flu vaccinations for at risk groups including those over 65 years were in line with national average. The QOF is the annual reward and incentive programme which awards practices achievement points for managing some long term conditions, for example asthma and diabetes. There was evidence to support that the practice was monitoring its performance and taking action to ensure improvements were made. The practice manager had regular meetings with clinical staff to review and monitor its QOF progress and ensure patients with long term conditions were being identified and reviewed.

The practice undertaken innovative projects to improve the health and wellbeing of patients this included previously offering yoga to patients suffering musculoskeletal problems and those experiencing poor mental health. The practice was proactive in delivering in house services to its patients which included a consultant lead diabetic clinic. This enabled patients to be assessed and reviewed locally without the need to travel to the hospital.

There was evidence that the practice was seeking patient feedback in order to improve the service provided implemented suggestions for improvements and made changes to the way it delivered. For example, the practice patient participation group (PPG) had undertaken a practice survey and had reported on its findings in February 2015. The results showed positive patient feedback in relation to satisfaction with service and the quality of the care provided by the GPs and nurses. However, access to appointments with the nurse and getting through on the telephone were areas for improvement and plans were in progress to address the issues. PPGs are a way in which patients and GP surgeries can work together to improve the quality of the service. The report showed actions that the practice would be taking and the time frame for change. There was evidence that some of the actions identified had been addressed for example, ensuring information in the patient area was updated and displayed in a more organised manner and increasing administrative staff during busy times. Other actions had a six month time frame and therefore still in progress. This included improving telephone access and increasing appointment slots with the nurse.

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. Staff told us that translation services were available for patients who did not have English as a first language. However, we did not see any notices in the reception areas informing patents this service was available.

There were baby changing facilities at the practice which would be helpful for parents with babies and young children. However, the baby changing unit was based inside the disabled toilets and the changing mat was not positioned in a suitable place that would ensure safety and hygiene as when in use the changing mat rested over a bin and the toilet.

There were accessible toilets facilities for patients with mobility issues. However, there were no automatic doors to the main entrance into the building and no designated disabled parking spaces. The practice had not completed an audit to assess compliance with the Equality Act (2010). This Act ensures providers of services do not treat disabled people less favourably, and must make reasonable adjustments so that there are no physical barriers to prevent disabled people using their service. The practice manager told us that they had identified these areas for action. The plan was to secure funding to make the necessary improvements and address the actions within the next three months.

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

Good

Are services responsive to people's needs?

(for example, to feedback?)

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

Access to the service

The practice opening times were Monday from 9am until 1pm and 2pm to 7pm with the exception of Wednesday then the surgery closed at 1pm and did not re-open during the afternoon.

Telephone consultations were available with the GPs and nurses. Patients could book appointments in advance and urgent appointments were available on the same day.

Information regarding appointments was available on the practice website. The website informed patients how to arrange a home visit and advised that patients requiring an urgent appointment would be seen on the same day. There was advice available to ensure patients received urgent medical assistance when the practice was closed, however some of this information was out of date. One of the GP partners told us that they were working with a web development agency to help improve the website. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances.

We identified that although there were two permanent GPs working at the practice between them their hours were equivalent to one full time GP; along with the full time locum GP the total GP to patient ratio was relatively high. The practice manager told us that they were looking to recruit a GP to provide additional sessions. The national patient survey information we reviewed showed varying responses in relation to access to the service. For example, 59% were satisfied with the practice's opening hours this was below the CCG average of 72% and national average of 75%. Patients describing their experience of making an appointment as good was 67% which was above the CCG average of 64% but below the national average of 73%. When asked if patients could get through to the practice easily by telephone the practice response was 65% compared the national average of 73%. However, the feedback received from patients on the day of the inspection suggested access to appointments was an area that the practice should improve on.

The practice had surveyed 100 patients, of which 68 responded. The results from the survey were analysed and showed that 58% of those responding were satisfied with the opening times. 65% found it easy to get through on the telephone to make an appointment. We saw that following the survey an action plan had been developed in order to address areas for improvement. This included increasing appointments for the nurse, raising patients awareness of the option of a GP telephone consultation and improving telephone access. At the time of the inspection the impact of these changes had not yet been fully assessed as the proposed time frame for achievement had not yet been met.

Patients who required additional time were given longer appointments for example, patients with a learning disability.

The practice had a high rate of patients who did not attend their appointment (DNA) with about, 40-50 DNA every week. There was a system in place to monitor and respond to patients that DNA to ensure effective use of resources. This included sending the patient a letter and displaying a weekly poster in the patient waiting area which informed patients how many had DNA each week. The practice proactively followed up vulnerable patients who did not attend their appointment which included liaising with other agencies for example the police where it may be considered that a patient may be at risk for example, if their DNA was out of character.

Listening and learning from concerns and complaints

The practice has a system in place for handling complaints and concerns. Its complaints policy is in line with recognised guidance and contractual obligations for GPs in England and there was a designated responsible person who handles all complaints in the practice.

There was a poster displayed in the patient waiting area which informed patients to contact the practice manager or ask reception staff for the complaints procedure. However, we saw that the practice complaints leaflet included detail of organisations that patients could also refer to for advice and support on raising a complaint. Patients we spoke with had not ever needed to make a complaint about the practice but were aware of what to do in the event they did need to raise a complaint or concern.

The practice had received four complaints in the last 12 months which were handled satisfactorily and resolved. There was evidence that lessons learned from complaints were shared with staff in meetings.

Are services well-led?

Requires improvement

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

Our findings

Vision and strategy

The practice had a vision to deliver high quality care and promote good outcomes for patients by working more closely with local practices. The vision and strategy had not been formally documented however, the aim was to develop more innovative ways to work with other practices. Staff spoken to demonstrated a commitment to providing a high quality service that reflected the vision. We identified an area of outstanding practice that supported the practices vision and aspirations.

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 these policies and procedures and found that most had been reviewed and were up to date. However, we saw clinical policies and procedures for managing some common conditions such as diabetes, hypertension and ambulatory blood pressure that were in a paper format were not detailed or up to date and did not reflect guidelines from the National Institute for Health and Care Excellence (NICE). Staff told us they accessed guidelines from the NICE website, we saw that a link was available to staff via the desktop on any computer within the practice

The practice had a whistleblowing policy which was also available to all staff in the staff handbook and electronically on any computer within the practice.

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. Staff we spoke with were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

The GP and practice manager took an active leadership role for overseeing that the systems in place to monitor the quality of the service were consistently being used and were effective. The included using the Quality and Outcomes Framework (QOF) to measure its performance. The QOF is the annual reward and incentive programme which awards practices achievement points for managing some of the most common chronic diseases, for example asthma and diabetes. The QOF data for this practice showed it was performing in line with national standards. We saw that QOF data was regularly discussed at weekly team and action plans were produced to maintain or improve outcomes.

The practice had an ongoing programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. For example, audits to help improve prescribing.

The practice identified, recorded and managed some risks for example fire. However, not all essential risks had been identified and addressed. For, example the practice had not completed risk assessments relating to health and safety, legionella, responding safely to a medical emergency without appropriate equipment and staff with portable DBS checks. Checks undertaken of emergency medicines had not identified expired medicines. There were risks associated with a lack of staff knowledge and awareness of the clinical system which meant that information could be potentially lost as there was no clear audit trail.

Leadership, openness and transparency

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

Staff told us that there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and confident in doing so and felt supported if they did. We also noted there were protected learning time held by the CCG which staff were given the opportunity to attend. Staff said they felt respected, valued and supported.

The GP partners at the practice attended meetings with the local CCG. This ensured they were up to date with any changes.

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), surveys and complaints received. It had an active PPG and the PPG had carried out surveys and met every quarter. PPGs are a way

Are services well-led?

Requires improvement

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

in which patients and GP surgeries can work together to improve the quality of the service. 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. We spoke with a member of the PPG and they were very positive about the role they played and told us they felt engaged with the practice. However, patient feedback from the 2014-2015 national GP patient survey showed areas where the practice needed to improve. We discussed this with the practice manager who told us that as the results of the 2014-2015 patients survey were relatively new they had not yet had the opportunity to analyse and act on the feedback. However, this would be done as a priority. They told us that they were already trying to improve the service provided by the GPs by recruiting a salaried GP which was in progress.

The practice had also 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. One member of staff told us that they had asked for specific training and this was being arranged. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at staff files and saw that appraisals took place which included a personal development plan. Staff told us that the practice was supportive of training and that they were able to attend protected learning events.

There was a visible leadership structure and staff members who we spoke with were clear about their roles and responsibilities. They told us that they felt valued, well supported and knew who to go to in the practice with any concerns.

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.

The practice had participated in innovative projects with the aim to improve patient care. This included a project aimed at improving the diagnosis and management of patients with COPD, providing yoga to patients with musculoskeletal conditions and mental health needs.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The registered person must protect service users, and others who may be at risk, against the risks of inappropriate or unsafe care and treatment, by means of the effective operation of systems designed to enable the registered person to: Identify, assess and manage risks relating to the health, welfare and safety of service users and others who may be at risk from them carrying on of the regulated activity. The practice had not assessed and managed all essential risks in areas such as legionella, risks associated with the premises, responding safely to a medical emergency and staff with portable DBS checks. The practice had not identified or acted on risks associated with a lack of staff knowledge and awareness of the clinical system. This was in breach of regulation 10 of the Health and social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014