Ifield Medical Practice

Quality Report

Lady Margaret Road
Ifield
Crawley
West Sussex
RH11 0BF
Tel: 01293 510900
Website: www.ifieldmedicalpractice.co.uk

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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

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection of Ifield Medical Practice on 11 March 2015. We visited the practice location at Lady Margaret Road, Ifield, Crawley, West Sussex RH11 0BF.

Overall the practice is rated as requires improvement. Specifically, we found the practice to be good for providing caring and responsive services. It requires improvement for providing safe, effective and well led services. It also requires improvement for providing services for 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 and people experiencing poor mental health (including people with dementia).

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. 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:

- Patients' needs were assessed and care was planned and delivered following best practice guidance.
- The practice understood the needs of the local population and planned services to meet those needs.
- The practice worked closely with external agencies and community services to meet the needs of patients and ensure continuity of care.
- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses.
- 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.

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- Staff had not always received training appropriate to their roles. Some staff had not received training in the safeguarding of children and vulnerable adults at a level appropriate to their role. Reception staff who acted as chaperones had not always received training to support this role.
- Learning from recorded incidents and clinical audit findings were not always reviewed and followed up to promote continuous improvement.

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

Importantly, the provider must:

- Ensure that all staff are trained in safeguarding of children and vulnerable adults at a level appropriate to their role.
- Ensure all staff acting as chaperones are appropriately trained for the role.
- Ensure the actions identified as a result of auditing of infection control processes are documented and reviewed so that progress and completion can be monitored.
- Ensure regular rehearsal of fire evacuation procedures within the practice in order to assess and monitor the risks associated with such an emergency.
- Ensure effective arrangements are in place to ensure the safe storage of prescription pads at all times, particularly when the practice is closed.

In addition the provider should:

- Establish a process to ensure more formal sharing of information and learning from incidents for all staff.
- Ensure learning points from incidents and audits are followed up and reviewed.
- Develop a programme of clinical audit and ensure audit cycles are completed to promote continuous improvement to patient care.
- Provide regular opportunities for nurses and GPs to meet to reflect on clinical practice and best practice guidance.
- Ensure that all staff who require a DBS checks have received one, including those staff undertaking chaperone duties.

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. Information about safety was recorded, monitored, and appropriate initial actions taken to address the concern. However, lessons learned were not always communicated widely to support improvement. Initial learning points identified were not always followed up and reviewed. The practice had carried out an audit of their infection control procedures. However, areas identified as requiring action had not been followed up or reviewed. We found that there was no clear policy on the safe and secure storage of blank prescription forms. The practice was unable to demonstrate that these were held securely at all times. Staff had some understanding of procedures relating to the safeguarding of children and vulnerable adults. However, not all staff had received training in adult and child safeguarding at a level appropriate to their role. Reception staff who acted as chaperones had not always received training to support their role. The practice had not undertaken a rehearsal of their fire evacuation procedures within the last 12 months.

Are services effective?

Requires improvement

The practice is rated as requires improvement for providing effective services. Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from the National Institute for Health and Care Excellence and used it routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing mental capacity and promoting good health. There was limited evidence to demonstrate completed audit cycles and changes that had resulted from the audits carried out. There was evidence of appraisals and personal development plans for all staff. However, not all staff had received training in adult and child safeguarding at a level appropriate to their role. Reception staff who acted as chaperones had not always received training to support their role. The practice worked closely with multidisciplinary teams and external services.

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

Summary of findings

understand the services available was easy to understand. We also saw that staff treated patients with kindness and respect, and maintained confidentiality. The practice advertised local support groups so that patients could access additional support if required. Staff within the practice felt well supported by management and the wider team.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS England area team and the clinical commissioning group (CCG) to secure improvements to services where these were identified. The practice had recognised the needs of vulnerable patients within the local population and provided services to meet those needs. Urgent appointments were available on the same day, however some patients told us they experienced difficulty in accessing the practice by phone. The practice was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand and the practice responded quickly to issues raised.

Are services well-led?

Requires improvement

The practice is rated as requires improvement 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 well supported by management. Recruitment processes were well documented and induction processes were in place. Some staff had not received up to date training in mandatory areas such as safeguarding children and vulnerable adults. Reception staff who provided chaperone services had not always received training to support their role. The practice had a number of policies and procedures to govern activity and held regular governance meetings. Incidents were recorded and there was some evidence of lessons learned. However, governance arrangements were not formalised to ensure learning was disseminated to the whole practice team. Initial learning points identified were not always followed up and reviewed. There was limited evidence to demonstrate completed audit cycles and changes that had resulted from the audits carried out. GPs told us that other audits which had been conducted had not always been recorded.The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group (PPG) was active. The practice had not undertaken a rehearsal of their fire evacuation procedures within the last 12 months.

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 practice is rated as requires improvement for the care of older patients. The provider is rated as requires improvement for providing safe, effective and well-led services. The concerns which led to these ratings apply to everyone using the practice, including this population group. The provider is rated as good for providing caring and responsive services.

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 older people in its population. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs. The practice used specific funding to provide additional GP and nurse appointments and to improve access to appointments for patients over 75 years of age. The practice employed the use of a risk stratification tool to identify those patients at highest risk of unplanned hospital admission, to ensure care planning was in place.

People with long term conditions

Requires improvement

The practice is rated as requires improvement for the care of patients with long term conditions. The provider is rated as requires improvement for providing safe, effective and well-led services. The concerns which led to these ratings apply to everyone using the practice, including this population group. The provider is rated as good for providing caring and responsive services.

Nurses and GPs had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. All these patients had a named GP and a structured annual review to check that their health and medication needs were being met. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Requires improvement

The practice is rated as requires improvement for the care of families, children and young patients. The provider is rated as requires improvement for providing safe, effective and well-led services. The concerns which led to these ratings apply to everyone using the practice, including this population group. The provider is rated as good for providing caring and responsive services.

Summary of findings

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. Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with midwives and health visitors.

Working age people (including those recently retired and students)

Requires improvement

The practice is rated as requires improvement for the population group of working-age patients (including those recently retired and students). The provider is rated as requires improvement for providing safe, effective and well-led services. The concerns which led to these ratings apply to everyone using the practice, including this population group. The provider is rated as good for providing caring and responsive services.

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. Extended hours appointments were available on one evening per week from 6:30pm until 9.00pm. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflected the needs for this age group.

People whose circumstances may make them vulnerable

Requires improvement

The practice is rated as requires improvement for patients whose circumstances may make them vulnerable. The provider is rated as requires improvement for providing safe, effective and well-led services. The concerns which led to these ratings apply to everyone using the practice, including this population group. The provider is rated as good for providing caring and responsive services.

The practice held a register of patients living in vulnerable circumstances, for example those with a learning disability. It had carried out annual health checks for people with a learning disability. Longer appointments were available when needed to this group of patients. The practice regularly worked with multi-disciplinary teams in the management of vulnerable people. It provided vulnerable patients with information about how to access various support groups and voluntary organisations. Staff understood their responsibilities regarding information sharing,

Summary of findings

documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours. However, some staff had not received training in the safeguarding of children and vulnerable adults at a level appropriate to their role.

People experiencing poor mental health (including people with dementia)

Requires improvement

The practice is rated as requires improvement for patients experiencing poor mental health (including patients with dementia). The provider is rated as requires improvement for providing safe, effective and well-led services. The concerns which led to these ratings apply to everyone using the practice, including this population group. The provider is rated as good for providing caring and responsive services.

People experiencing poor mental health had received an annual physical health check. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. The practice had developed strong links with a mental health liaison practitioner who was attached to the practice. They undertook dementia screening of patients and ensured early referral to memory assessment services. The practice provided patients experiencing poor mental health with information about how to access various support groups and voluntary organisations. The practice patient participation group had recently held a dementia awareness event within the practice.

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 18 comment cards which contained mainly positive comments about the practice. We also spoke with seven patients on the day of the inspection.

The comments we reviewed were generally positive and described the professional, friendly service received by patients. One of the comment cards described the consistency of care received when attending the practice frequently. Four of the comment cards commented on the late running of appointment schedules within the practice when waiting to see a GP or nurse. The majority of the patients we spoke with on the day of inspection told us that all staff were helpful, caring and professional. They told us they felt listened to and well supported. However, one patient we spoke with and one of the comments cards we reviewed described the unhelpful nature of reception staff. All of the patients we spoke with on the day of inspection told us that they had to wait between one and two weeks to obtain a routine appointment with the practice. Three of the patients we spoke with told us they experienced difficulty in accessing the practice by telephone. One of the patients told us that children were always prioritised for urgent appointments.

We reviewed recent GP national survey data available for the practice on patient satisfaction. The survey showed that 85% of respondents described the overall experience of the practice as good, which matched the national average of 85%. However, the survey found that just 68% of patients said the last GP they saw was good at involving them in decisions about their care, compared with a national average of 81%. Over 89% of patients who responded said they found it easy to get through to the practice on the phone, compared with a national average of 75%.

Areas for improvement

Action the service MUST take to improve

- Ensure that all staff are trained in safeguarding of children and vulnerable adults at a level appropriate to their role.
- Ensure all staff acting as chaperones are appropriately trained for the role.
- Ensure the actions identified as a result of auditing of infection control processes are documented and reviewed so that progress and completion can be monitored.
- Ensure regular rehearsal of fire evacuation procedures within the practice in order to assess and monitor the risks associated with such an emergency.
- Ensure effective arrangements are in place to ensure the safe storage of prescription pads at all times, particularly when the practice is closed.

Action the service SHOULD take to improve

- Establish a process to ensure more formal sharing of information and learning from incidents for all staff.
- Ensure learning points from incidents and audits are followed up and reviewed.
- Develop a programme of clinical audit and ensure audit cycles are completed to promote continuous improvement to patient care.
- Provide regular opportunities for nurses and GPs to meet to reflect on clinical practice and best practice guidance.
- Ensure that all staff who require a DBS checks have received one, including those staff undertaking chaperone duties.

Ifield Medical Practice

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 specialist advisor and a practice manager specialist advisor.

Background to Ifield Medical Practice

Ifield Medical Practice provides general medical services to approximately 10,000 registered patients. The practice delivers services to a similar number of patients who are aged 65 years and over, when compared with the local clinical commissioning group (CCG) and England average. Care is provided to a very small number of patients living in local residential and nursing homes. Data available to the Care Quality Commission (CQC) shows the number of registered patients suffering income deprivation is similar to the national average.

The practice is open between 8.30am and 6.00pm Monday to Friday. GP appointments are available from 9.00am to 11am and from 4.00pm to 6.00pm daily. Nurse appointments are available from 9.00am to 12.00pm and 2.00pm and 6pm daily. Extended hours surgeries are offered from 6.30pm to 9.00pm on one evening each week.

Care and treatment is delivered by six GP partners. Three of the GPs are female and three are male. The practice employs a team which comprises three practice nurses and one healthcare assistant. GPs and nurses are supported by the practice manager and a team of reception and administration staff.

The practice is a GP training practice and supports new registrar doctors in training and medical students.

Services are provided from:

Lady Margaret Road, Ifield, Crawley, West Sussex, RH11 0BF

The practice has opted out of providing out of hours services to its own patients and uses the services of a local out of hours service.

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.

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 Crawley Clinical Commissioning Group (CCG). We carried out an announced visit on 11 March 2015. During our visit we spoke with a range of staff, including GPs, practice nurses and administration staff.

We observed staff and patient interaction and spoke with seven patients. We reviewed policies, procedures and

Detailed findings

operational records such as risk assessments and audits. We reviewed 18 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 whose circumstances may make them vulnerable
- People experiencing poor mental health (including people with dementia)

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 systems in place for reporting, recording and monitoring significant events, incidents and accidents. The practice kept records of significant events that had occurred and these were made available to us. The practice told us that significant events were discussed at weekly partners meetings and we saw evidence of this.

We saw that records of incidents were completed in a comprehensive and timely manner and there was evidence of initial action taken as a result. There was some evidence of learning from incidents, as learning points had been recorded on the incident forms. However, it was unclear how this learning was shared with the whole practice team and how the initial learning points noted were followed up and audited. For example, the practice had recently recorded and reviewed a prescribing error in relation to a patient with a chronic condition. Details of the GP team review and learning points had been recorded in the patient's notes and on the incident form. The practice had ensured that GPs were alerted to all patients with the same chronic condition via the patients' electronic notes. However, no further review of this group of patients had taken place to ensure that a repeat of the prescribing error had not occurred.

The practice nurses told us that they did not attend regular clinical meetings with the GPs. We were unable to see evidence that incidents and the learning from them were shared with the practice nurses or the wider practice team.

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. Nurses told us alerts were discussed at nurse 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 in place to manage and review risks to vulnerable children, young patients and adults. A designated GP partner was the practice lead for safeguarding children and vulnerable adults. Safeguarding policies and procedures were consistent with local authority guidelines and included local authority reporting processes and contact details.

The GP partner who was the safeguarding lead had undertaken training appropriate to their role. However, not all staff had received training in the safeguarding of children and vulnerable adults at a level appropriate to their roles. For example, some nurses had undertaken training in the safeguarding of children at level one only. We also found that some GPs within the practice had undertaken training in the safeguarding of children to level two only. We found that not all staff within the practice had received training in the safeguarding of vulnerable adults. Staff had some knowledge to enable them to identify concerns. All of the staff we spoke with knew who the practice safeguarding lead was 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 within the practice.

Staff described the open culture within the practice whereby they were encouraged and supported to share information within the team and to report their concerns. Information on safeguarding and domestic abuse was displayed in the patient waiting room and other information areas.

There was a system to highlight vulnerable patients on the practice computer system and patient electronic record. This included information to ensure that 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.

Requires improvement

Are services safe?

A chaperone policy was in use within the practice and this was clearly advertised to patients in the consulting rooms. 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 act as a chaperone. We were told that some reception staff could also be asked to undertake chaperone duties. However, many of those reception staff had not received training to support them within this role. Reception staff who were acting as chaperones had not been subject to a criminal records check via the Disclosure and Barring Service. However, we saw that the practice had undertaken a risk assessment of each role to support this decision.

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

We checked medicines stored in the treatment rooms and medicine refrigerators. We found they were stored securely and were only accessible to authorised staff. There was a clear process for ensuring medicines were kept at the required temperatures. We reviewed records which confirmed this. The correct process was understood and followed by the practice staff and they were aware of the action to take in the event of a potential power failure.

The practice had processes to check medicines were within their expiry date and suitable for use. All the medicines we checked at the time of inspection were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

The nurses administered vaccines using directions that had been produced in line with legal requirements and national guidance. We saw that nurses had received appropriate training to administer vaccines.

The practice implemented a comprehensive protocol for repeat prescribing which was in line with national guidance. The protocol complied with the legal framework and covered all required areas. For example, how staff who generate prescriptions were trained and how changes to patients' repeat medicines were managed. This helped to ensure that patients' repeat prescriptions were still appropriate and necessary. Reviews were undertaken for patients on repeat medicines. All prescriptions were reviewed and signed by a GP before they were given to the patient.

We found that there was no clear policy on the safe and secure storage of blank prescription forms. These were not handled in accordance with national guidance to ensure they were kept securely at all times. Prescription pad numbers were not recorded to ensure they could all be accounted for and arrangements for the safe storage of blank prescription forms, particularly when the practice was closed, was unclear.

The practice had identified a lead GP for medicines management. The practice prescribing lead worked closely in conjunction with the local clinical commissioning group (CCG) and the practice participated in prescribing audits and reviews.

Cleanliness and infection control

We observed the premises to be clean and tidy. We saw there were cleaning schedules in place and that 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.

Hand washing notices were displayed in all consulting and treatment rooms. Hand wash solution, hand sanitizer and paper towels were available in each room. Disposable gloves were available to help protect staff and patients from the risk of cross infection. Spillage kits were available within the practice.

The practice had identified a lead nurse for infection control and had developed a clear policy for the management of infection control processes. We saw that this had been reviewed in July 2014. The practice had carried out an audit of their infection control processes in February 2014. However, we found that the practice had not developed an action plan to address the findings of the audit. As a result, areas identified as requiring action had not been followed up or reviewed. Actions required had not

been allocated to specific members of the team. For example, the audit had identified that nurses and GPs had not received hand hygiene awareness update training within the last 12 months. No action had been taken to provide this training at the time of our inspection, despite the audit being completed in February 2014. The audit also identified that staff were not always aware of the colour coded cleaning system and that not all sharps containers were located on a secure surface or wall bracket. These audit findings had not been followed up or reviewed.

We saw that the practice had arrangements in place for the segregation of clinical waste at the point of generation. Colour coded bags were in use to ensure the safe management of healthcare waste. An external waste management company provided waste collection services. Sharps containers were available in all consulting rooms and treatment rooms, for the safe disposal of sharp items, such as used needles.

Equipment

Staff we spoke with told us they had sufficient 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. A schedule of testing was recorded. We saw evidence of calibration of relevant equipment which had been carried out in April 2014. For example, digital blood pressure machines and weighing scales. The practice had undertaken a risk assessment of all portable electrical equipment.

Records showed essential maintenance was carried out on the main systems of the practice. For example the boilers and fire alarm systems were serviced in accordance with manufacturers' instructions.

Staffing and recruitment

Staff told us there were usually suitable numbers of staff on duty and that staff rotas were managed well. There was also a system for members of staff, including GPs and administrative staff to cover annual leave. Staff told us there were enough staff to maintain the smooth running of the practice and there were always enough staff on duty to ensure patients were kept safe. The practice experienced a low turnover of staff which staff felt had improved consistency and continuity of care for patients.

We examined the personnel records of five members of staff and found that appropriate recruitment checks were undertaken prior to employment. For example, proof of identification, references, qualifications and registration with the appropriate professional body. The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. The practice had undertaken risk assessment of all roles within the practice to determine the need for criminal records checks through the Disclosure and Barring Service (DBS). We were told that some reception staff could also be asked to undertake chaperone duties. Reception staff who were acting as chaperones had not been subject to a criminal records check via the Disclosure and Barring Service. However, the practice had undertaken a risk assessment of those roles to support this decision.

Monitoring safety and responding to risk

The practice was located in modern, purpose built premises with good access for disabled patients. We observed the practice environment was organised and tidy. Safety equipment such as fire extinguishers and the oxygen and defibrillator were checked regularly and sited appropriately.

The practice had systems and processes to manage and monitor risks to patients, staff and visitors to the practice. These included checks of the building and the risks associated with exposure to legionella bacteria which is found in some water supplies. However, we were told that the practice had not undertaken a full rehearsal of their fire evacuation procedures within the last 12 months and had therefore not recently assessed and monitored the risks associated with such an emergency. The practice had a health and safety policy. Health and safety information was readily available to staff.

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 when necessary. The practice had employed the use of a risk stratification tool to identify patients most in need of high levels of support and who may be at higher risk of frequent accident and emergency attendances and unplanned hospital admissions. The practice held monthly multidisciplinary meetings which

included health visitors, the community matron, community psychiatric nurses and district nurses, in order to identify and minimise the risks to these groups of patients.

The practice had implemented a colour coded alert system to identify individual needs of patients in order to ensure staff were aware of their specific needs and associated risks. For example, patients with mental health conditions and those receiving end of life care.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that 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.

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.

Panic alarms were available to staff in all consulting and treatment rooms in case of an emergency. Records showed that fire alarms and emergency lighting were routinely tested.

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.

Requires improvement

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff were familiar with current best practice guidance, accessing guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. The staff we spoke with and evidence we reviewed confirmed these actions were aimed at ensuring that each patient was given support to achieve the best health outcome for them. We found from our discussions with the GPs and nurses that staff completed, in line with NICE guidelines, thorough assessments of patients' needs and these were reviewed when appropriate.

GPs within the practice held lead roles in specialist clinical areas such as diabetes and mental health. The practice nurses supported this work which allowed the practice to focus on specific conditions. A practice nurse told us how they attended regular forums on the management of patients with diabetes.

National data showed the practice was in line with referral rates to secondary and other community care services for all conditions. GPs used national standards and best practice for all referrals to secondary care. For example, patients requiring a referral into secondary care with suspected cancers were referred and seen within two weeks.

The practice ensured that patients had their needs assessed and care planned in accordance with best practice. We saw that patients received appropriate treatment and regular review of their condition. Patients with palliative care needs were supported using the Gold Standards Framework. The practice participated in regular palliative care meetings and worked closely with a local hospice and palliative care nurses. The practice used computerised tools to identify and review registers of patients with complex needs.

GPs and nurses were clear about how they would apply the Mental Capacity Act 2005 (MCA) and how they would assess mental capacity. All GPs within the practice had received training in the Mental Capacity Act 2005. Patients who were either unable or found it difficult to make an informed decision about their care could be supported appropriately.

Management, monitoring and improving outcomes for people

Staff from across the practice had key roles in the monitoring and improvement of outcomes for patients. These roles included data input and quality, clinical review scheduling, long term condition management and medicines management. The information staff collected was used to determine clinical audits.

The practice had some limited systems in place for completing and recording clinical audit cycles. We saw evidence of three clinical audits which had been completed within the last two years. There was limited evidence to demonstrate completed audit cycles and changes that had resulted from the audits carried out. GPs told us that other audits which had been conducted had not always been recorded. 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 review of patients with osteoporosis who were prescribed a particular medicine in the management of their condition**.** (Osteoporosis is a condition where decreased bone strength increases the risk of a broken bone.) The audit review had been undertaken as a result of safety update information issued by the Medicines and Healthcare products Regulatory Agency (MHRA). Patients who required a review and change to their prescribed medicine were identified by the practice and their management was reviewed three months later. The practice had identified that 33% of those patients had not had their prescribed medicine reviewed at three months and those patients were sent a letter by the practice. However, we saw no evidence that the practice had reviewed this group of patients again after 12 months, as planned within the original audit review. Examples of other audits undertaken included a review of the management of patients with vitamin D deficiency and a review of cervical cytology sampling.

The practice achieved 96.5% of the maximum Quality and Outcomes Framework (QOF) results 2013/14. The practice also used the information they collected for the QOF and their performance against national screening programmes

Requires improvement

Are services effective?

(for example, treatment is effective)

to monitor outcomes for patients. QOF data showed the practice performed well in comparison to the regional and national average. For example, the number of patients with diabetes who had received an influenza immunisation was recorded as 94.6%, with the national average being 93.5%. The percentage of patients with diabetes whose last measured total cholesterol was five mmol/l or less was 91.6% compared with a national average of 81.6%. The practice was not an outlier for any QOF clinical targets.

The GPs we spoke with discussed how as a group they reflected upon the outcomes being achieved and areas where this could be improved. This included for example, information relating to unplanned admissions rates, secondary referrals, home visits and all QOF data.

Effective staffing

Practice staffing included GPs, nursing, managerial and administrative staff. We reviewed staff training records and saw that most staff were up to date with attending mandatory training courses. However, not all staff had received training in the safeguarding of children and vulnerable adults at a level appropriate to their role. For example, practice nurses had undertaken training in the safeguarding of children at level one only. We found that some GPs within the practice had undertaken training in the safeguarding of children at level two only. We also found that not all staff had received training in the safeguarding of vulnerable adults.

A good skill mix was noted amongst the GPs. The practice had identified GPs to undertake lead roles in clinical areas such as palliative care, diabetes and mental health. All GPs were up to date with their yearly continuing professional development requirements and had either 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 practice and remain on the performers list with NHS England).

Staff we spoke with told us they had participated in regular appraisals which gave them the opportunity to discuss their performance and to identify future training needs. Personnel files we examined confirmed this. A practice nurse told us they recently had an appraisal with a GP partner. This had included a review of performance and the setting of objectives and learning needs. We saw evidence which confirmed this.

Staff interviews confirmed that the practice was proactive in providing training and funding for relevant courses. We spoke with the lead nurse who told us the practice supported education and ongoing professional development. The nursing team were able to attend additional training in specialist areas such as spirometry, cervical screening and immunisations. Those nurses with extended roles had undertaken advanced training in the management of conditions such as chronic obstructive pulmonary disease, asthma and diabetes. We spoke with a healthcare assistant who told us they felt well supported in their role and had been provided with relevant training. For example, they had recently received training to carry out ear syringing and patient health checks. The healthcare assistant also received regular updated training in phlebotomy in order to support this aspect of their role. The practice also employed an apprentice who worked as a supernumerary member of the reception team. We found they had been provided with appropriate induction into their role and training to support their ongoing development. The apprentice told us they felt well supported in their role.

Working with colleagues and other services

The practice worked with other service providers to meet patient needs and manage complex cases. The practice effectively identified patients who needed ongoing support and helped them plan their care.

For example, the practice demonstrated they had developed effective working relationships with community mental health teams to support patients with poor mental health. A dedicated mental health liaison practitioner worked closely with the practice and attended the regular multidisciplinary team meetings within the practice. The practice also provided care to a significant number of children who were subject to child protection plans. There was good communication between the practice and midwives, health visitors and local support organisations. Weekly meetings between the practice and the health visitor enabled them to share concerns when they arose.

The practice provided care to a small number of patients living in local residential and nursing homes. Those care

Requires improvement

Are services effective?

(for example, treatment is effective)

homes were visited by request to see individual patients. The practice worked closely with several supported housing facilities to provide care to patients with a learning disability. Longer appointments were available to patients with a learning disability in order to support their attendance with a carer.

The practice held regular multidisciplinary team meetings to discuss all patients with complex needs. For example, patients requiring end of life care. Those meetings were attended by community nurses, social workers and palliative care nurses and decisions about care planning were documented in a shared care record.

Blood results, X ray results, letters from the local hospital including discharge summaries, out of hours providers and the 111 service were received both electronically and by post. We noted the structured approach adopted by the practice in the distribution of the daily workload to GPs. All relevant staff were clear on their responsibilities for passing on, reading and acting upon any issues arising from communications with other care providers on the day they were received. The GP seeing these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system worked well. The practice had a policy for communicating with the out of hours service via a system of special notes.

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 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

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.

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.

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 healthcare 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. GPs we spoke with told us that regular health checks were offered to those patients with long term conditions and those experiencing mental health concerns. We also noted that medical reviews took place at appropriately timed intervals.

The practice had ways of identifying patients who needed additional support, and were pro-active in offering additional help. For example, the practice kept a register of all patients with learning disabilities, for whom they carried out annual health checks. Longer appointments were available to patients with a learning disability in order to support their attendance with a carer.

Requires improvement

Are services effective?

(for example, treatment is effective)

We noted a culture amongst the GPs and nurses of using their contact with patients to help maintain or improve mental, physical health and wellbeing. Patients requiring smoking cessation support were referred by the practice to a community support service.

The practice's patient participation group had organised a well-being event within the practice in November 2014. This event provided patients with the opportunity to access information from community specialists with regards to conditions such as dementia and asthma. Members of the patient participation group told us how much patients valued such health promotion events.

The practice offered a full range of immunisations for children, travel vaccines, flu, pneumococcal and shingles vaccinations in line with current national guidance. We reviewed our data and noted that 97% of children aged up to 24 months of age had received their mumps, measles and rubella vaccination. This was equivalent to the clinical commissioning group regional average. Data we reviewed showed that 94.6% of patients with diabetes had a flu vaccination within the six month period between September and March. This was compared with a national average of 93.5%.

We noted that a wide range of health promotion information was available in leaflets in the waiting rooms and on the practice website. Such information was also given to patients during consultations and clinics. The practice had developed an extensive child health and wellbeing notice board to provide information for parents and carers.

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 18 completed cards and they were generally 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 seven patients on the day of our inspection. All told us they were generally satisfied with the care provided by the practice and said their dignity and privacy was respected. One patient we spoke with and one of the comments cards we reviewed described the unhelpful nature of reception staff. However, this was not reflected in other comments we received. One patient described the excellent care received by the practice in supporting the end of life care of a relative.

We reviewed 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 85.4% of patients rated their overall experience of the practice as good. The practice was just below average for its satisfaction scores on consultations with doctors, with 73% of practice respondents saying the GP was good at treating them with care and concern. We noted that 95% of patients who had responded said that the nurse was good at treating them with care and concern.

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 main reception area and waiting room were combined but patients were requested to wait before coming forward to the reception desk. Some 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, speaking in lowered tones and 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 that patients had not always responded positively to questions about their involvement in planning and making decisions about their care and treatment. For example, data from the national patient survey showed that just 68% of practice respondents said the GP involved them in decisions about their care, compared with a national average of 81%. However, 86% felt the nurse was good at involving them in decisions about their care, compared with a national average of 85%.

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

Patient/carer support to cope emotionally with care and treatment

The results of the national GP survey showed that 73% of patients said the last GP they saw or spoke to was good at treating them with care and concern and that 95% of patients said the nurses were also good at treating them with care and concern. Patients we spoke with on the day of our inspection and some of the comment cards we received gave examples of where patients had been supported by the practice.

The practice held a register of patients who were carers and new carers were encouraged to register with the practice. The practice computer system then alerted GPs and nurses if a patient was also a carer. We saw written information was available for carers to ensure they understood the various avenues of support available to them. Notices in the patient waiting room and patient website signposted patients to a number of support groups and organisations.

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 clinical commissioning group (CCG) told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised.

The needs of the practice population were well 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 the vulnerable patients within the local population. The practice told us they provided care and support to high numbers of patients experiencing poor mental health. Practice nurses and GPs were able to give examples of ways in which they had worked closely with community mental health teams to ensure patients received timely and appropriate care and support. This included a dedicated mental health liaison practitioner who was attached to the practice. The practice had identified a lead GP for the management of patients with poor mental health.

The practice held a register of all patients with a learning disability. They offered them annual health checks and longer appointments as required. The nurse manager told us the practice provided care and support to residents with a learning disability living within several local supported housing facilities. The practice worked closely with community services if additional support needs were determined following a review.

The practice supported patients with complex needs and those who were at risk of unplanned 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.

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 disorder (COPD), diabetes, dementia and mental health conditions.

The practice had 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) and virtual patient reference group (VPRG). The VPRG was a group of patients who did not meet but provided feedback to the practice by completing survey questionnaires. The practice manager showed us the analysis of the last patient survey, which was considered in conjunction with the PPG. We noted that a total of 162 patients had responded to this survey. The results and actions agreed from these surveys were available on the practice website.

We saw for example, the most recent survey indicated that patients sometimes found it difficult to obtain an appointment with their GP of choice. The practice had prepared an overview of the days each GP worked in order to improve the level of information provided to patients in this regard. This information was made available to patients within the practice and on the practice website. The practice offered extended hours appointments from 6.30pm – 9.00pm on one evening each week in order to improve access to appointments for patients.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. Vulnerable patients were well supported.

The practice was located in modern purpose built premises. Patient services were provided on the ground and first floor levels. The premises and services had been adapted to meet the needs of patients with disabilities. Access to the premises by patients with a disability was supported by an automatic door and accessible front reception desk which had been installed with wheelchair users in mind. The waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Lift services were available to the first floor. We noted there were car parking spaces for patients with a disability. Toilet facilities were accessible for all patients and contained grab rails for those with limited mobility and an emergency pull cord. Baby changing facilities were available for mothers with young babies.

The number of patients with a first language other than English was low. Staff knew how to access language translation services if these were required.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Access to the service

The practice was open between 8.30am and 6.00pm Monday to Friday. GP appointments were available from 9.00am to 11am and from 4.00pm to 6.00pm daily. Nurse appointments were available from 9.00am to 12.00pm and 2.00pm and 6pm daily. Extended hours surgeries were offered from 6.30pm to 9.00pm on one evening each week. Appointments could be booked via the practice's website, in person or by telephoning the practice directly. There was good access to home visits for those patients who were housebound and unable to attend the practice.

Routine appointments could be booked up to two weeks in advance. A number of urgent appointments were available on the day. The practice provided a system of GP led triage for patients when all urgent same day appointments had been allocated. Patients received a call back from the GP on call that day and were then invited to be seen within the practice according to need. Patients who had opted to receive the service received a text reminder about their appointment at the time of booking and 48 hours before their appointment.

Patients were generally satisfied with their ability to access the practice by phone. Results of a recent GP patient survey showed that 89% of respondents found it easy to get through to the practice by phone. This was compared to a national average of 75.4%.

Information was available to patients about appointments on the practice website. This included how to arrange home visits, how to book appointments and the number to call outside of practice hours. There were arrangements in place to ensure patients received urgent medical assistance when the practice was closed. Patients were advised to call the out of hours' service.

Patients spoken with and comments left on CQC comment cards provided feedback about the practice's appointment system. We spoke with seven patients on the day of inspection. All of the patients we spoke with told us that they had to wait between one and two weeks to obtain a routine appointment with the practice. Three of the patients we spoke with told us they experienced difficulty in accessing the practice by telephone. One of the patients told us that children were always prioritised for urgent appointments. Four of the comment cards commented on the late running of appointment schedules within the practice when waiting to see a GP or nurse. The results from a recent GP patient survey indicated that 72.7% of patients were very satisfied or fairly satisfied with the practice's opening hours. This was compared with a national average of 79.8%.

During our inspection we noted that the receptionist made patients aware of the late running of one GP's appointments by up to 15 minutes.

Listening and learning from concerns and complaints

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

We saw that information was available to help patients understand the complaints system on the practice website. Information was available within the practice to describe the process should a patient wish to make a suggestion or complaint. Comment boxes were available to patients within the practice waiting area. Reception staff were able to clearly describe the process they would follow if a patient raised a complaint directly with them. Patients we spoke with were aware of the process to follow should they wish to make a complaint. None of the patients we spoke with had raised a complaint with the practice.

We reviewed the practice complaints log. We found there had been 10 complaints within the last 12 months. The practice had investigated all the complaints and implemented appropriate actions.

Are services well-led?

Requires improvement

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. The practice's statement of purpose stated that their philosophy was to provide high quality general practice care to individuals and families.

We spoke with 15 members of staff and they all knew and understood the vision and values of the practice and were clear about what their responsibilities were in relation to these.

Six monthly meetings away from the practice provided the GP partners and the practice manager with the opportunity for consolidation and strategic review. The practice had a business development plan in place.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff. All policies and procedures we looked at had been reviewed annually and were up to date.

The practice used the Quality and Outcomes Framework (QOF) to measure their performance. The QOF data for this practice showed it was performing in line with or above national standards.

A series of regular meetings took place within the practice which enabled staff to keep up to date with practice developments and facilitated communication between the GPs and the staff team.

These included weekly GP partner meetings which were attended by the practice manager and regular team meetings which included the whole practice team. We looked at minutes from the most recent partner's weekly meetings and found that performance, quality and risks had been discussed. The last whole practice team meeting had been held the week prior to our inspection. Minutes of this meeting were available to staff on the staff notice board and on the practice intranet. The practice had held a team meeting in January 2015 of which minutes had not been recorded. The practice manager told us that this meeting had been a 'brain storming session' which had provided staff with the opportunity to share their thoughts about the appointments system and to discuss ways in which improvements could be made.

The practice manager told us that clinical meetings between the GPs and nurses were held every few months. Nurse team meetings were held on a monthly basis but the minutes of these meetings were not documented. The practice nurses told us that they did not attend regular clinical meetings with the GPs but would value the opportunity to do so.

The practice had some limited systems in place for completing and recording clinical audit cycles. We saw evidence of three clinical audits which had been completed within the last two years. There was limited evidence to demonstrate completed audit cycles and changes that had resulted from the audits carried out. GPs told us that other audits which had been conducted had not always been recorded.

The practice had systems and processes to manage and monitor risks to patients, staff and visitors to the practice. These included checks of the building and the risks associated with exposure to legionella bacteria which is found in some water supplies. However, we were told that the practice had not undertaken a full rehearsal of their fire evacuation procedures within the last 12 months and had therefore not recently assessed and monitored the risks associated with such an emergency. The practice had a health and safety policy. Health and safety information was readily available to staff. The practice had implemented a colour coded alert system to identify individual needs of patients in order to ensure staff were aware of their specific needs and associated risks. For example, patients with mental health conditions and those receiving end of life care.

Leadership, openness and transparency

Staff told us that there was an open culture within the practice. They had the opportunity to raise issues at any time with the GP partners and practice manager and were happy to do so.

The practice had developed a clear leadership structure which included named members of staff in lead roles. For example, there was a lead GP for mental health and a GP partners was the lead for child and adult safeguarding. Staff

Are services well-led?

Requires improvement

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

were aware of the leadership structure within the practice. Reception, administration and nurses we spoke with were clear about their own roles and responsibilities. They all told us that they felt valued and well supported.

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 via a patient survey which had last been published in March 2014 and via comments and complaints received. The practice had a small but active patient participation group (PPG) which had been running since 2008 and which met regularly. The practice also had a larger virtual patient reference group (VPRG) which did not meet but from whom the practice sought feedback. The practice manager showed us the analysis of the last patient survey, which was considered in conjunction with the PPG. We noted that a total of 162 patients had responded to this survey. The results and actions agreed from these surveys were available on the practice website.

We saw for example, the most recent survey indicated that patients sometimes found it difficult to obtain an appointment with their GP of choice. The practice had prepared an overview of the days each GP worked in order to improve the level of information provided to patients in this regard. This information was made available to patients within the practice and on the practice website. The practice offered extended hours appointments from 6.30pm – 9.00pm on one evening each week in order to improve access to appointments for patients.

The practice gathered feedback from staff through informal discussions and via team meetings. Staff told us they felt able to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged within the practice to improve outcomes for both staff and patients.

The practice had a whistleblowing policy which was available to all staff. Staff we spoke with were aware of the policy and how they could whistleblow internally and externally to other organisations.

Management lead through learning and improvement

The practice had systems in place for reporting, recording and monitoring significant events, incidents and accidents. The practice kept records of significant events that had occurred and these were made available to us. The practice told us that significant events were discussed at weekly partners meetings and we saw evidence of this.

We saw that records of incidents were completed in a comprehensive and timely manner and evidence of initial action taken as a result. There was some evidence of learning from incidents, as learning points had been recorded on the incident forms. However, it was unclear how this learning was shared with the whole practice team and how the initial learning points noted were followed up and audited. For example, the practice had recently recorded and reviewed a prescribing error in relation to a patient with a chronic condition. Details of the team review and learning points had been recorded in the patient's notes and on the incident form. The practice had ensured that GPs were alerted to all patients with the same chronic condition via the patients' electronic notes. However, no review of this group of patients had taken place to ensure that a repeat of the prescribing error had not occurred.

All of the GPs within the practice had undergone training relevant to their lead roles and areas of special interest such as diabetes. All of the GPs had undergone annual appraisal and had been revalidated or had a forthcoming date for revalidation.

However, we reviewed staff training records and found that not all staff had received training in the safeguarding of children and vulnerable adults at a level appropriate to their roles. For example, some nurses had undertaken training in the safeguarding of children at level one only. We also found that some GPs within the practice had undertaken training in the safeguarding of children to level two only. We found that not all staff within the practice had received training in the safeguarding of vulnerable adults. Reception staff undertaking chaperone duties had not always received training to support them in this role. The practice nurses had been provided with appropriate and relevant training to fulfil their roles. For example, the nurses had undertaken advanced training in the management of diabetes, asthma and chronic obstructive pulmonary disorder (COPD).

Are services well-led?

Requires improvement

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

Staff we spoke with told us they had undergone regular appraisals which gave them the opportunity to discuss their performance and to identify future training needs. Personnel files we examined confirmed this.

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 18 HSCA (RA) Regulations 2014 Staffing We found that the registered provider did not ensure that persons employed for the purposes of carrying out the regulated activity received appropriate training. This was in breach of regulation 23 (1) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 18 (2) 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 We found that the registered provider did not ensure that effective systems were in place to assess the risk of, and to prevent, detect and control the spread of infections, including those that are health care associated. This was in breach of regulation 12 (1) (a) (b) (c) (2) (a) (c) (i) (ii) (iii) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12 (1) (2) (h) 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

This section is primarily information for the provider

Requirement notices

We found that the registered provider did not ensure that the premises used by the service provider were safe to use for their intended purpose and were used in a safe way.

This was in breach of regulation 15 (1) (a) (b) (c) (i) (ii) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12(1) (2) (d) 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 We found that the registered provider did not ensure the proper and safe management of medicines. This was in breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12(1) (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.