

Abbots Bromley Surgery

Quality Report

School House Lane
Abbots Bromley
Rugeley
WS15 3BT

Tel: 01283840228

Website: abbotsbromleysurgery.nhs.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

Good 

Are services safe?

Good 

Are services effective?

Good 

Are services caring?

Good 

Are services responsive to people's needs?

Good 

Are services well-led?

Requires improvement 

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Abbots Bromley Surgery on 14 July 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing safe, effective, caring and responsive services and requires improvement for well led services. It was good overall for providing services for the following population groups; 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).

Our key findings were as follows:

- The practice had not reviewed all past significant events to identify any themes or trends of each event and to show that any action taken had been appropriate and had prevented reoccurrence.

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded and addressed.
- Patients' needs were assessed and care was planned and delivered following best practice guidance.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- Patients said they liked the open access system which enabled them to have a consultation with a named GP or practice nurse and that there was continuity of care.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- The practice proactively sought feedback from staff and patients, which it acted on.
- The practice had limited formal governance arrangements. For example, there was no governance

Summary of findings

or management oversight in place to ensure all staff received regular fire awareness training or written evidence seen of fire drills to ensure staff acted in accordance with fire regulations.

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

Importantly the provider must:

- Ensure effective formal governance systems and arrangements are in place for monitoring, updating and managing: staff training, recruitment, policies and procedures and health and safety.
- Ensure checks are made on the current training status of all staff.
- Have governance arrangements in place to ensure all staff receive regular fire awareness training and regular fire drills take place so that staff act in accordance with fire regulations.

Importantly the provider should:

- Continue to review recruitment procedures to ensure that all staff who are involved in the direct care of patients including chaperone duties are risk assessed to determine if a Disclosure and Barring Service (DBS) check is required.
- Ensure a copy of the latest infection control audit with any action points shared and made accessible to staff.
- Ensure all staff have an awareness of the Mental Capacity Act.
- Ensure all staff are aware of the practice policies and procedures which include whistleblowing and safeguarding.
- Consider introducing regular formal practice meetings.

Professor Steve Field CBE FRCP FFPH FRCGP

Chief Inspector of General Practice

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?

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. There was a recruitment policy and procedure in place to ensure patients safety was protected, however this procedure was not consistently applied. Criminal records checks through the Disclosure and Barring Service (DBS) for non-clinical staff who carried out chaperone duties had not been completed. Risk assessments to determine whether criminal checks were needed were not undertaken. The practice had plans in place to address this. There were enough staff to keep people safe.

Good



Are services effective?

The practice is rated as good for providing effective services. Data showed patient outcomes were mixed and were generally comparable to the local Clinical Commissioning Group (CCG) averages. The CCG are groups of general practices that work together to plan and design local health services in England. They do this by 'commissioning' or buying health and care services. 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. Staff had received training appropriate to their roles, however systems were not in place to ensure training was consistently kept up to date for all staff. There was evidence of appraisals and personal development plans for all staff. Staff worked with multidisciplinary teams within the community, such as health visitors and palliative care teams.

Good



Are services caring?

The practice is rated as good for providing caring services. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. We also saw that staff treated patients with kindness and respect. There was plenty of supporting information to help patients understand and access the local services available.

Good



Are services responsive to people's needs?

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the

Good



Summary of findings

NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. The practice offered mainly open access to see a GP or nurse of their choice on the day of their choosing. Patients were not restricted to 10 minutes appointments, the time allocated reflected the needs of the patient on the day. This approach led to extended waiting times on occasions. Patients we spoke with did not mind this and information in the national patient survey for July 2015 confirmed this as detailed in this report.

The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised.

Are services well-led?

The practice is rated as requires improvement for being well-led. It had a vision and a strategy but not all staff were aware of this and their responsibilities in relation to it. The management team were aware of the longer term plans for the development of the practice; however it was not clear that these had been shared with staff where possible. There was a documented leadership structure and all staff felt supported by management. The practice had a number of policies and procedures to govern activity, but some of these were overdue a review. The practice had an unstructured approach to governance arrangements. For example, regular practice meetings were not held and there was limited recorded information to demonstrate what had been discussed and shared with staff. Governance meetings were not held. The practice proactively sought feedback from patients and had an active patient participation group (PPG). All staff had received inductions and regular performance reviews.

Requires improvement



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

The practice is rated as good for the care of older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in dementia and end of life care. The practice offered proactive, personalised care to meet the needs of the 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.

Good



People with long term conditions

The practice is rated as good for the care of people with long term conditions. Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. Specific consultations were arranged for this group of patients due to the severity of their illness which made them too frail to wait for long periods. All these patients had an annual review to check that their health and medication needs were being met.

Good



Families, children and young people

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk. For example, the practice had identified an increase in attendances at a local minor injuries unit by school-aged children and young people. To address this, the practice implemented a telephone triage and clinic session for school aged children on Friday afternoons. The session was led by the nurse practitioner who is a qualified prescriber with qualifications in paediatric nursing. Immunisation rates for all standard childhood were above the local and national average in all areas. Appointments were available outside of school hours and the premises were suitable for children and babies. The practice provided baby immunisations, weighing and six week checks. The midwife visited the practice once a week and there were immunisation clinics available.

Good



Working age people (including those recently retired and students)

The practice is rated as good for the care of working age people (including those recently retired and students). The needs of the working age population, those recently retired and students had

Good



Summary of findings

been identified and the practice had adjusted the services it offered. Patients had access to printable information on health conditions and disease through the practice website. For example the practice offered open access to the practice for consultations during opening times and telephone consultations were available instead of patients attending the practice.

People whose circumstances may make them vulnerable

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including those with a learning disability. The practice regularly worked with multi-disciplinary teams in the case management of vulnerable patients. It had told vulnerable patients about how to access various support groups and voluntary organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies.

Good



People experiencing poor mental health (including people with dementia)

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). Data showed that only 50% of patients on the practice register for dementia had received an annual physical health check. The practice was aware of this and had commenced work to review this. The practice regularly worked with multi-disciplinary teams in the case management of people who experienced poor mental health, including those with dementia. It carried out advance care planning for patients with dementia.

The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations. It had a system in place to follow up patients who had attended accident and emergency (A&E) where they may have been experiencing poor mental health. Staff had received training on how to care for people with mental health needs and dementia.

Good



Summary of findings

What people who use the service say

We spoke with seven patients during our inspection and spoke with a member of the practice patient participation group (PPG). PPGs are a way for patients and GP practices to work together to improve the service and to promote and improve the quality of the care. The PPG member said the group was encouraged to be actively involved in the development of the practice. We spoke with and received comments from patients who had been with the practice for a number of years and patients who had recently joined the practice. Patients were extremely positive about the service they received. They told us they were treated with respect, were listened to and had plenty of time to talk to the GPs and nurses. Patients described the staff and GPs as polite, caring and approachable.

We reviewed 16 patient comment cards from our Care Quality Commission (CQC) comments box that we had asked to be placed in the practice before our inspection. We saw that the majority of comments made were positive about the service they experienced. Comments in one of the cards expressed concerns about the care received from a member of staff. The patient felt that this had been resolved by the practice. The common themes in comment cards were that of an excellent service, caring staff and that staff always had time to listen and explain treatment.

The July to September 2014 and January to March 2015 national GP patient survey showed that these experiences were also expressed in the survey and the practice performed well in all areas. These included:

- 96% of respondents with a preferred GP said that they usually get to see or speak to that GP as compared with the local CCG average of 65%.
- 99% of respondents said that they found it easy to get through to this surgery by phone as compared with the local CCG average of 73%.
- 94% of respondents described their experience of making an appointment as good as compared with the local CCG average of 73%.
- 98% of respondents said that they had confidence and trust in the last nurse they saw or spoke to as compared with the national average of 98%.
- 99% of respondents said that they had confidence and trust in the last GP they saw or spoke to as compared with the local CCG average of 97%.

However there was one area where patients responded negatively. This was related to the time they waited after their appointment to be seen. Responses showed that:

- 10% of respondents said that they usually waited 15 minutes or less after their appointment time to be seen as compared with the local CCG average of 66%.

This was related to the walk in clinic system the practice operated. The patient views in the comments cards we received showed that patients were happy with the walk in clinic system because they were always seen. Patients said that sometimes they had to wait, however they did not see this as a problem.

Areas for improvement

Action the service MUST take to improve

- Ensure effective formal governance systems and arrangements are in place for monitoring, updating and managing: staff training, recruitment, policies and procedures and health and safety.
- Ensure checks are made on the current training status of all staff.
- Have governance arrangements in place to ensure all staff receive regular fire awareness training and regular fire drills take place so that staff act in accordance with fire regulations.

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Action the service **SHOULD** take to improve

- Continue to review recruitment procedures to ensure that all staff who are involved in the direct care of patients including chaperone duties are risk assessed to determine if a Disclosure and Barring Service (DBS) check is required.
- Ensure a copy of the latest infection control audit with any action points shared and made accessible to staff.
- Ensure all staff have an awareness of the Mental Capacity Act.
- Ensure all staff are aware of the practice policies and procedures which include whistleblowing and safeguarding.
- Consider introducing regular formal practice meetings.

Abbots Bromley Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a Care Quality Commission (CQC) lead inspector. The lead inspector was accompanied by a GP specialist advisor, a practice manager specialist advisor and an expert by experience. Experts by experience are members of the inspection team who have received care and experienced treatments from a similar service.

Background to Abbots Bromley Surgery

Abbots Bromley Surgery is a well-established GP practice. The practice is located in Rugeley, Staffordshire. The practice is a single storey building set in a rural location with good access for cars and with parking bays for patients with a physical disability. There is level access to the building for ease of access for wheelchairs and pushchairs.

The team of clinical staff at Abbots Bromley Surgery consists of two GP Partners (both female), one non GP partner (nurse practitioner), one salaried GP and three further practice nurses (all female). The non GP partner has a dual role as the practice manager and nurse practitioner prescriber. Administration staffing support is provided by reception, administrative and secretarial staff.

The practice is open from 8am to 6.30pm on Monday to Friday and offers an open access system to patients. Patients are able to book in to see a GP every weekday between the hours of 9am and 10.30am each morning (8.30am to see a practice nurse) and 4.30pm to 5.30pm on

Monday, Tuesday and Thursday afternoons. Patients are able to book to see the nurse practitioner from 9am to 10.30am on Mondays, Thursdays and Fridays mornings and from 4.30pm to 5.30pm on Thursdays.

The practice has a Primary Medical Services (PMS) contract with NHS England for delivering care services to their local community. A PMS contract is a contract between General Practices and NHS England for delivering primary care services to local communities. Services provided include the following clinics; asthma, diabetes and a drop in clinic for lifestyle checks and advice for example smoking. The practice treats patients of all ages. The highest percentages of the practice population are within the 15 to 19 and 45 and 70 age groups.

The practice is a dispensing practice. The practice does not routinely provide an out-of-hours service to their own patients but patients are directed to the out of hours service, Staffordshire Doctors Urgent Care (SDUC) when the practice is closed.

Why we carried out this inspection

We carried out a comprehensive inspection of the services under section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. We carried out a planned inspection to check whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008 and to provide a rating for the services under the Care Act 2014.

Detailed findings

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 living in vulnerable circumstances
- People experiencing poor mental health (including people with dementia)

Before visiting the practice we reviewed information we held and asked other organisations and key stakeholders to share what they knew about the practice. We also reviewed policies, procedures and other information the practice provided before the inspection day. We carried out an announced visit on 14 July 2015.

We spoke with a range of staff including three GPs, two practice nurses, the practice manager/nurse practitioner, reception staff and administration staff, on the day. We sought views from patients, a representative of the patient participation group, looked at comment cards and reviewed survey information.

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, a GP had noted that a patient had been incorrectly advised by hospital staff to stop taking a medicine. The patient was advised by the GP to continue to take the medicine and a letter of concern written to the hospital. We saw that appropriate action had been taken and the issue raised as a significant event with clinical staff.

We reviewed safety records, complaints and incident reports that had been followed up. There were records of significant events that had occurred since September 2009 and we were able to review these. We saw that the practice had managed these consistently over time and so could show evidence of a safe track record. The practice manager was responsible for disseminating safety alerts and there were systems in place to ensure they were acted on. However, the practice had not reviewed all of the past events to identify any themes or trends of each event and to show that any action taken had been appropriate and had prevented reoccurrence.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring safety incidents. These were collated by the practice as significant events. Records we examined detailed 19 significant events that had occurred over the past 12 months. Specific formal meetings were not held to discuss significant events. Staff at the practice told us that significant events can be raised at any time. We saw records that showed these were discussed and findings shared with relevant staff. We saw that significant event reports over the last 12 months detailed the event, key issues, positive points, areas of concern, the outcome of investigations, action to be taken to prevent reoccurrence and details of the learning shared with all staff. Staff we spoke with confirmed this.

Staff used significant event forms and sent completed forms to the practice manager. They showed us the system used to manage and monitor incidents. We saw that

records were completed in a timely manner. One of the GPs discussed two of the 19 significant events with us. One of the events detailed concerns about the attitude of a member of staff. This was appropriately investigated, the patient given an apology and informed of the actions taken in keeping with practice policy. The practice also reviewed its recruitment and selection policy to ensure that it was more robust. For example, the practice would follow up references with a telephone call to the previous employer.

National patient safety alerts were disseminated by the practice manager to practice staff. Staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for. One of the clinical staff told us that following receipt of a safety alert a search would be carried out dependent on the content of the alert to identify any patients that might be affected by the medicine or equipment identified as a concern.

We saw that significant events were followed up and referred or shared with other professional agencies outside the practice where appropriate. The local Clinical Commissioning Group (CCG) who monitored the performance of the practice told us they had no concerns about this practice. The CCG are groups of general practices that work together to plan and design local health services in England. They do this by 'commissioning' or buying health and care services.

Reliable safety systems and processes including safeguarding

The practice had safeguarding vulnerable adults and children policies in place which were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. In addition there were flow charts for guidance and contact numbers displayed within the reception area and treatment areas. One of the GPs was the lead for safeguarding.

All staff had received safeguarding children training at a level suitable to their role for child safeguarding, for example all clinical staff had level three training. Staff had also received safeguarding vulnerable adults training and understood their role in reporting any safeguarding incidents. GPs attended safeguarding meetings when possible and always provided reports where necessary for other agencies.

Are services safe?

The practice had a computer system for patients' notes and there were alerts on a patient's record if they were at risk or subject to protection.

A chaperone policy was available on the practice's computer system. A notice was in the waiting room to advise patients that the service was available should they need it. The practice nurses and some of the receptionists acted as chaperones if required. Records showed that the practice nurses had received training to carry out this role and plans were in place to provide receptionists with training. All staff were clear on what their role involved when carrying out chaperone duties. Records also showed that the practice nurses had a Disclosure and Barring Service (DBS) check completed. (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). We saw that the practice manager had stopped receptionists acting as chaperones and was in the process of completing risk assessments and DBS checks for all reception staff to confirm that they were suitable to undertake the role of a chaperone. Plans were also in place for reception staff to receive formal training.

Medicines management

The practice was a dispensing practice. One of the dispensing staff explained the receipt of medicines into the practice and we saw that the staff followed their written procedures. The practice had established a service for patients to pick up their dispensed prescriptions and had systems in place to monitor how these medicines were collected. Arrangements were in place to ensure that patients collecting medicines were given all the relevant information they required.

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

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

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

The practice held stocks of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse) and had standard procedures in place that set out how they were managed. These were being followed by practice staff. For example, controlled drugs were stored in a controlled drugs cupboard and access to them was restricted and the keys held securely. There were arrangements in place for the destruction of controlled drugs. Practice staff undertook regular audits of controlled drug prescribing to look for unusual products, quantities, dose, formulations and strength. Staff were aware of how to raise concerns around controlled drugs with the controlled drugs accountable officer in their area.

We checked medicines stored in the nurses treatment room and found that they were securely stored in a locked cupboard. Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations. We checked the medicine refrigerators and found that medicines were stored securely and were only accessible to authorised staff. Information available showed that daily temperature checks of the medicine fridge in the nurse's treatment room were undertaken. There was a clear policy for ensuring that medicines were kept at the required temperatures. The policy described the action to take in the event of a potential power failure and this information was also included in the practice's business continuity plan.

The nurses administered vaccines using directions that had been produced in line with legal requirements and national guidance. We saw up-to-date copies of both sets of directions and evidence that nurses had received appropriate training to administer vaccines.

Cleanliness and infection control

All areas within the practice were found to be visibly clean and tidy. There were cleaning schedules in place and cleaning records were kept. Patients we spoke with told us they always found the practice to be clean. Treatment rooms had the necessary hand washing facilities and

Are services safe?

personal protective equipment which included disposable gloves and aprons available. Hand gels for patients and staff were available. Clinical waste disposal contracts were in place and spillage kits were available.

One of the practice nurses was the clinical lead for infection control and had undertaken further training to enable them to provide advice on the practice infection control policy, and to carry out staff training. Records we saw showed that all staff had received infection control and prevention awareness training specific to their role during their induction period. Nursing staff had received ongoing training in this area to ensure that they were update. However reception staff had not received this training in infection control and prevention. Reception staff received specimens from patients and were able to explain how to handle these safely. The practice had an infection control policy in place and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. The nurse practitioner/practice manager and one of the practice nurses told us that a full infection control audit had been completed earlier this year. However the report was not available to confirm this.

The practice had a policy for the management, testing and investigation of legionella (a bacterium that can grow in contaminated water and can be potentially fatal). Records were available to confirm that a legionella risk assessment was completed. Further records confirmed that the practice was carrying out regular checks in line with their policy to reduce the risk of infection to staff and patients.

Equipment

Staff we spoke with told us there was enough equipment to help them carry out examinations, assessments and treatments. All electrical and clinical equipment was checked to ensure they were safe to use and worked properly. We saw records that demonstrated that all medical devices had been calibrated in April 2015 to ensure the information they provided was accurate. Records available also confirmed that all portable electrical equipment had been tested in September 2014 to ensure they were safe to use. For example blood pressure measuring devices and weighing scales were calibrated annually. The practice nurses carried out monthly checks on emergency equipment such as the defibrillator.

Staffing and recruitment

The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. Records we looked at contained evidence that appropriate recruitment checks had been undertaken for clinical staff prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks through the Disclosure and Barring Service (DBS).

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. Staff were multi-skilled to cover each other in the event of unplanned absences.

The nurse practitioner/practice manager had identified that administration and reception had not had a DBS check carried out. The manager had commenced this process for this group of staff and staff we spoke with confirmed this.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. We saw records that demonstrated that weekly, monthly and annual checks of the building had been carried out. This included a fire risk assessment; gas safety checks; emergency lighting tests and fire alarm testing. We saw that where risks were identified that action plans had been put in place to address these issues. The practice had completed a risk assessment log where specific risks related to the practice were documented. We saw that each risk was rated and mitigating actions recorded to reduce and manage the risk. For example, the action that staff should take in the event of loss of utilities was clearly documented for staff.

There were emergency processes in place for identifying acutely ill children and young people and staff gave us examples of referrals made. Staff we spoke with told us that children were always provided with an on the day appointment if required.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support; this was last carried out for all staff in September 2014. Emergency equipment was

Are services safe?

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. Practice nurses were responsible for checking the resuscitation equipment and emergency medicines.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis (an allergic reaction) and hypoglycaemia (low blood sugar). Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to. For example, details of the alternative GP practice to be liaised with for support in the event of an emergency.

We found that staff had not received up-to-date training in fire safety. The practice manager was aware of this and had plans in place for staff to receive this training. We were told by the practice manager that fire drills took place once a year. The practice could not provide documented evidence to confirm when fire drills had taken place.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from both the National Institute for Health and Care Excellence (NICE) and from local commissioners. All the GPs and nurses we interviewed were aware of their professional responsibilities to maintain continuous professional development and maintain their knowledge. Patients had their needs assessed and care planned in accordance with best practice.

Clinical staff described how they had used the NICE guidelines for assessing patients with long term conditions such as diabetes, asthma and chronic obstructive pulmonary disease (COPD) and were being referred to other services when required. COPD is the name for a collection of lung diseases, including chronic bronchitis and emphysema. Feedback from patients confirmed they were referred to other services or hospital when required.

Records we looked at showed that a member of the medicines optimisation team from the clinical commissioning group (CCG) attended the practice. This was to provide advice and check that patients had received medicines that were appropriate and there were no unusual patterns of prescribing. We looked at national data from the National Health Service Business Authority (NHSBA) for 2013 - 2014 and saw that prescribing levels for antibiotics and hypnotic (sleeping tablets) medicines were in the expected range.

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

The practice used the Quality and Outcomes Framework (QOF) which is a voluntary system for the performance management and payment of GPs in the National Health Service. This enables GP practices to monitor their performance across a range of indicators including how they manage medical conditions. The 2014 QOF data we

reviewed showed that the practice had either met QOF targets, exceeded or had performed below the local and national average. For example the practice had performed highly in the national childhood immunisation screening programmes.

The practice had identified that improvements were needed to monitor some of the outcomes related to patients with long term conditions. For example, data showed that 43.8% of patients with diabetes had had their blood pressure (BP) checked to ensure it was maintained within a certain range. This was below the local CCG average of 69.2% and the national average of 71.9%. The practice was aware of this and had carried out an audit in November 2014 which identified that the numbers of patients with a diagnosis of hypertension (abnormally high blood pressure) and diabetes who were achieving good BP control was lower than expected. A clinical meeting was held to discuss the action needed to improve this. The practice staff also referred to NICE hypertension Guidance published in 2011. The practice aimed to be more proactive with BP management and more aggressive with treatment. A second cycle of the audit carried out in February 2015 showed a significant improvement from 67.7% in 2013/14 to 95% in 2014/15. The practice planned to repeat the audit in November 2015. Other audits carried out at the practice included antibiotic prescribing and on any overuse of asthma inhalers.

Staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. The patient management IT system flagged up relevant medicine safety alerts when the GP prescribed medicines. We were shown evidence to confirm that following the receipt of an alert the GPs had reviewed the use of the medicine in question. Where a GP made the decision to continue to prescribe the medicine, the reason for this was documented. Patients we spoke with confirmed that their medicines were regularly reviewed.

Effective staffing

The practice had an induction programme for newly appointed members of staff that covered such topics as fire safety, health and safety and confidentiality. All staff had annual appraisals that identified learning needs from which action plans were documented. All nurses had supervision of their practice carried out. Our interviews with the practice nurses confirmed that the practice was proactive in providing training and funding for relevant

Are services effective?

(for example, treatment is effective)

courses. Nurses training records showed that the nurses had received training that included: dementia awareness, moving and handling, domestic abuse, conflict resolution, learning disabilities and information governance. The practice was closed for half a day every three months to accommodate training that was organised by the local CCG.

However, a training schedule we looked at showed that staff were not up to date with health and safety training which included fire safety. We found specifically that the training records for reception and administration staff were not up to date. For example the records did not confirm that staff had received training in safeguarding, mental capacity, and whistleblowing. The practice manager was aware of this and had plans in place to review staff training and up date training records as appropriate. We also found that this group of staff were not knowledgeable in these topics.

We noted a good skill mix among the GPs and practice nurses. The practice nurse attended local practice nurse forums and attended a variety of external training events. The practice nurses were expected to perform defined duties and had extended roles. The nurses were able to demonstrate that they were trained to fulfil these duties. For example, the nurse had completed appropriate training to undertake the administration of childhood immunisations, treatment reviews of patients who presented with diabetes, vaccinations and cervical screening.

One of the partners had a dual role and worked as the nurse practitioner and practice manager at the practice. They had identified the hours that would be dedicated to each of these roles. We saw that the practice manager worked hard to fulfil both roles. It was noted that there was a need for support in this role and plans were in place to recruit a deputy practice manager.

Due to the size of the practice the GPs had maintained their general interests in all areas of patient treatment. However, more recently one of the GPs had received additional training in women's health. A second GP had taken the lead for diabetic care and plans were in place for them to attend a recognised course in diabetic care and treatment.

All the GPs we spoke with were up to date with their yearly continuing professional development requirements and all either had been revalidated or had a date for revalidation.

(Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

Working with colleagues and other services

The practice worked with other service providers to meet patients' needs and manage those of patients with complex needs. The practice encouraged other professionals to work at the practice thereby giving patients local access to a range of professionals. These included community midwives, physiotherapists, podiatrist community staff nurse and the community mental health team. We spoke with the community staff nurse who told us about the close working relationship that had developed with the practice. The nurse described the practice as friendly and open to discussion about patients care. Requests could be made for a GP to carry out a home visit if they had concerns about a patient. We were told that daily discussions took place, monthly palliative care meetings (more often if needed) and the care of patients with long-term conditions and unplanned hospital admissions were also discussed.

Multidisciplinary meetings were held to discuss the needs and treatment of patients with long term conditions and vulnerable and older frail patients who were at high risk of unplanned hospital admissions. These meetings were attended by other professionals including district and palliative care nurses.

The practice received blood test results, X-ray results, and letters from the local hospital including discharge summaries, out of hours GP services and the 111 service both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from communications with other care providers on the day they were received. The GP who saw these documents and results was responsible for the action required. All staff we spoke with understood their roles and responsibilities.

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 information to be shared in a secure and timely manner. We saw evidence that the practice had used

Are services effective?

(for example, treatment is effective)

significant events to learn and improve information sharing between the practice and other providers. For example discussion with staff at a hospital when results were not followed up and appropriate action agreed to prevent incidence re-occurring.

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

Consent to care and treatment

All the clinical staff we spoke with demonstrated a clear understanding of Gillick competencies. (These are used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions). Staff were also aware of the Mental Capacity Act (MCA) 2005 and their duties in fulfilling it. Clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice. However reception and administration staff were unable to demonstrate sufficient awareness of the implications of the act or how it could impact on their role with patients. The practice manager told us that this would be reviewed and planned for when staff training records were updated.

Patients with a learning disability and those with dementia 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). When interviewed, clinical staff gave examples of how patients' best interests were taken into account if a patient did not have capacity to make a decision.

Health promotion and prevention

It was practice policy to offer a health check to all new patients registering with the practice. The practice nurses carried out the checks and the GPs was informed of all

health concerns detected and these were followed up in a timely way. The nurses actively engaged patients in lifestyle programmes. The practice had performed below the local CCG area for monitoring and supporting patients who smoked. Information showed that 78.9% of patients had their smoking status recorded and 70.2% of these patients had accepted support to help them stop smoking. The number of patients that had accepted support was below the local CCG average of 79.1% and national average of 84.3%.

The practice offered a full range of immunisations for children, travel vaccines and influenza vaccinations in line with current national guidance. Data collected by NHS England for 2013 -2104 showed that the practice had performed strongly for all childhood immunisations. Practice nurses used chronic disease management clinics to promote healthy living and health prevention in relation to the person's condition. The practice website contained health advice and information on long term conditions, with links to support organisations.

We saw that the uptake for cervical screening for women between the ages of 25 and 64 years was 80.4%, which was above the local CCG average of 76.9% and national average of 76.9%. The practice was proactive in following these patients up and sent reminder letters and took the opportunity at consultations to carry out these procedures. Public Health England National data showed that the practice was also performing above average for screening for cancers such as bowel and breast cancer when compared with local and national averages.

We saw that up to date health promotion information was displayed, available and easily accessible to patients in the waiting area of the practice. The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance for all immunisations which included vaccinations for older patients was above average for the local CCG. There was a clear policy for following up non-attenders.

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We observed throughout the inspection that members of staff were courteous caring and very helpful to patients both at the reception desk and on the telephone.

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey published in July 2015. The survey included responses collected during July to September 2014 and January to March 2015. There were 253 survey forms sent out of which 130 (51%) responses were returned.

Data from the national patient survey showed the practice rated above the national average when compared to the local and national satisfaction scores on consultations with GPs and nurses and the support received from receptionists.

- 97% said the GP was good at listening to them compared to the CCG average of 91% and national average of 89%.
- 97% said the GP gave them enough time compared to the CCG average of 88% and national average of 87%.
- 98% said the last nurse they saw or spoke to was good at listening to them compared to the CCG average of 94% and national average of 91%.
- 99% said the last nurse they saw or spoke to was good at giving them enough time compared to the CCG average of 95% and national average of 92%.
- 98% said they found the receptionists at the practice helpful compared to the CCG average and national average of 87%.

Patients completed Care Quality Commission (CQC) comment cards to tell us what they thought about the practice. We received 16 completed cards. The cards contained positive comments about the practice and staff. Patient comments said that the service was wonderful and that they were treated very well by GPs and nurses. We also spoke with seven patients on the day of our inspection which included one member of the patient participation group. The PPG member told us that the practice encouraged them to be actively involved in the

development of the practice. PPGs are a way for patients to work in partnership with a GP practice to encourage the continuous improvement of services. Their comments were in line with the comments made in the cards we received.

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 saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. The position of the open reception desk within the waiting room made it difficult for confidential conversations to take place. Staff told us that a quiet area could be made available if patients wanted to have a discussion in private. The practice had a sign at the reception that politely asked patients to allow a comfortable distance between them and the person in front when queuing. The practice had a confidentiality policy in place and all staff were required to sign to say they would abide to the protocols as part of their employment contract. Patients we spoke with felt that their confidence was maintained by all staff.

Care planning and involvement in decisions about care and treatment

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

- 94% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 89% and national average of 86%.
- 95% said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 85% and national average of 81%.
- 98% said the last nurse they saw or spoke to was good at explaining tests and treatments compared to the CCG average of 94% and national average of 91%.
- 96% said the last nurse they saw or spoke to was good at involving them in decisions about their care compared to the CCG average of 90% and national average of 85%.

Are services caring?

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 were 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.

Patients were told how long it would be before their test results were received by the practice. Patients were made aware that they would be advised on whether they needed to make an appointment to discuss their results with the GP. Patients were reminded in an information leaflet that test results could only be released to the person to whom they related or someone who had been given prior permission in keeping with confidentiality and data protection guidance.

Patient/carer support to cope emotionally with care and treatment

Practice staff were knowledgeable about their patients and were aware of patients that were also carers. The practice kept a list of patients who were carers and alerts were on

these patients' records to help identify patients who may require extra support. There was supporting information to help patients who were carers on a notice board in the waiting room.

The patient survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. For example:

- 96% said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 88% and national average of 85%.
- 98% said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 93% and national average of 90%.

A GP and other staff described the support they provided for carers and the organisations patients were signposted to for additional support where needed. These included a counselling service for professional support such as family members after bereavement. One of the practice nurses carried out a bereavement visit to family members of the patient that died with their consent. A patient's comments confirmed this and told us about the empathy and understanding they received following a family bereavement.

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 needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered. For example, the practice had a higher than average number of patients aged between 15 and 19 years and 40 and 74. The practice provided services to ensure their needs could be met. For example, patients were offered health screening and access to family planning and sexual health support. We saw that chlamydia testing kits were easily accessible in toilet areas. Chlamydia testing kits were provided free to patients with instructions for them to carry out the test at home.

The practice worked closely with other professionals to support the care and treatment of patients. Some of the professionals carried out clinics at the practice and included physiotherapists and a podiatrist. Patients who experienced poor mental health were supported by the community mental health team. However we found that only 50% of patients on the practice register for dementia had received an annual physical health check compared to the local CCG average of 67.2% and the national average of 77.9%. The practice was aware of this and had commenced work to review this.

The NHS England Area Team and Clinical Commissioning Group (CCG) told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised. We saw minutes of meetings where this had been discussed and actions agreed to implement service improvements. For example the practice had signed up to a CCG led service for patients with dementia to promote early diagnosis and intervention.

The practice had an established patient participation group (PPG). Adverts encouraging patients to join the PPG were available on the waiting room noticeboard and in the practice newsletters. The PPG met quarterly and patient surveys were sent out annually. We spoke with a member of the group who told us the practice had been responsive to their concerns.

Tackling inequity and promoting equality

The practice recognised the needs of different groups in the planning of its services. The practice was a single storey building, providing clinical treatment for patients in easily accessible consultation and treatment rooms. The waiting area provided easy access to patients with wheelchairs and prams. Accessible toilet facilities were available for all patients attending the practice. Facilities for patients with mobility difficulties included designated parking spaces; level access to the automatic front doors of the practice and toilets for patients with a physical disability. Access to baby changing facilities was available.

Staff told us that they did not use a translation service. Patients that visited the practice had English as a first language. However a translation facility was available on the practice website. Staff told us that the introduction of this service would be considered if the need was identified. The practice had an equal opportunities and anti-discrimination policy which was available to all staff on the practice's computer system.

Training records showed that some staff had received training in equality and diversity, and that there was a policy in place for them to refer to. Staff told us that if they had any concerns or observed any threatening behaviours, instances of discriminatory behaviour or where patients' privacy and dignity was not being respected, they would raise these with the practice manager.

Access to the service

The practice was open from 8am to 6.30pm on Monday to Friday and offered an open access system to patients. Patients were able to book in to see a GP every weekday between the hours of 9am and 10.30am each morning (8.30am to see a practice nurse) and 4.30pm to 5.30pm on Monday, Tuesday and Thursday afternoons. Patients were able to book to see the nurse practitioner from 9am to 10.30am on Mondays, Thursdays and Fridays mornings and from 4.30pm to 5.30pm on Thursdays.

Information was available to patients about how to access a GP on the practice website. The information told patients that the practice was open until 6.30pm, Monday to Friday and that during these hours, reception staff were available to deal with all enquiries and, if necessary, a doctor could be contacted throughout the day. Arrangements were in place to ensure patients received urgent medical assistance when the practice was closed. If patients called

Are services responsive to people's needs?

(for example, to feedback?)

the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients.

Longer appointments were available for older patients, children, those experiencing poor mental health, patients with learning disabilities and those with long-term conditions.

The patient survey information we reviewed for July 2015 showed that patients rated the practice highly in response to questions about access to appointments. For example:

- 90% were satisfied with the practice's opening hours compared to the CCG average of 77% and national average of 75%.
- 73% described their experience of making an appointment as good compared to the CCG average of 71% and national average of 73%.
- 94% said they could get through easily to the surgery by telephone compared to the CCG average of 73% and national average of 73%.

However there was one area where patients responded negatively. This was related to the time they waited after their appointment to be seen. The July 2015 national patient survey response showed that:

- 10% said they usually waited 15 minutes or less after their appointment time compared to the CCG average of 66% and national average of 65%.

This was related to the walk in clinic system the practice operated. The patient views in the comments cards we received showed that patients were happy with the walk in

clinic system because they were always seen. Patients said that sometimes they had to wait, however they did not see this as a problem. Patients also said that they were made aware about any delays. Specific clinics were held at set times and days. For example, long-term conditions screening, counselling, baby clinics and physiotherapist clinics. These clinics were advertised in the practice and on the practice website.

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. There was a designated person who handled all complaints in the practice.

Information about how to make a complaint was available on the practice website and in leaflets in the waiting area. The complaints policy clearly outlined a time framework for when the complaint would be acknowledged and responded to. In addition, the complaints policy and patient complaint leaflet outlined who the patient should contact if they were unhappy with the outcome of their complaint.

We looked at one complaint and saw that staff had responded to this in line with the practice's complaints policy with a full explanation and apology. Complaints were raised as significant events and investigated. The practice discussed complaints with the relevant staff. The practice was able to demonstrate changes made in response to feedback.

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 provide high quality, safe and effective care to patients in appropriate and comfortable surroundings. Care would be monitored, audited and updated in line with best practice guidance. Patients would be involved in all aspects of their care and investment in staff would encourage continuous learning through training. These aims were included in the practice's statement of purpose. We did not observe that these were displayed within the practice. Staff and patients we spoke with were not aware that the practice had a written vision. However, when asked about the vision and values of the practice they all considered the patient to be central to the future development of the practice. The practice manager shared their vision with us during the practice presentation at the inspection.

The PPG member we spoke with confirmed that the group were involved in the development of the practice and any planned changes were also discussed with them. Patients told us that they had confidence in the staff at the practice and were involved in making decisions about their care.

The practice did not have a formal written business plan in place but all staff were clear that the main priority was the development of the premises which included increasing the size of the practice dispensary.

The practice engaged with the local Clinical Commissioning Group (CCG) to ensure services met the local population needs. Comments we received from patients reflected the practice's vision in that patients felt they received high quality safe care and services.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff in folders, on the desktop on any computer within the practice. We looked at five of these policies and procedures for example, health and safety, safeguarding and handling complaints. We found that two of the five policies were dated 2012 although the policies indicated that they would be reviewed annually.

The practice had arrangements for identifying, recording and managing risks. The practice manager showed us the risk log, which addressed a wide range of potential issues,

for example loss of the computer system. In the event of the loss of the main computer operating system, practice staff had identified alternative computers and installed a back-up computer system to allow staff to access patient information. The practice could not confirm whether the risk log was discussed at meetings and updated in a timely way. However there was no governance or management oversight in place to ensure all staff received regular fire awareness training and no written evidence seen of fire drills to ensure staff acted in accordance with fire regulations, such as The Regulatory Reform (Fire Safety) Order 2005. This order states that the employer should ensure that their workers receive appropriate training on procedures they need to follow, including fire drills.

Regular meetings were not held and minutes or an agenda was not available to show that governance issues were discussed. The practice was unable to evidence that arrangements were in place to demonstrate that areas such as practice performance, quality, incidents, complaints and risks had been regularly discussed shared with practice staff and other professionals outside of the practice where appropriate. We also found that these events had not been reviewed to identify any themes or trends and to show that any action taken had been appropriate.

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

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. 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. The QOF data for this practice showed that they had achieved 82% of the points available compared with the local CCG average of 89.4% and national value of 93%. We saw that QOF data was discussed and actions had been taken to maintain or improve patient outcomes.

The practice had a programme of clinical audits to monitor quality and systems to identify where action should be taken. Audits previously carried out were related to the validation of QOF information, clinical audit practice and medicine reviews.

Are services well-led?

Requires improvement 

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

Leadership, openness and transparency

The partners in the practice were visible in the practice and staff told us that they were approachable. Staff told us that they were well supported by GPs and the management team. Staff felt that there was a good team spirit and felt confident to report any concerns. Our discussions with staff particularly reception and administration staff did not confirm that they had been involved in discussions about how to run the practice and how to develop the practice. Although the partners encouraged all members of staff to identify opportunities to improve the service delivered by the practice, we found that staff had very little knowledge of the plans to improve the practice. Minutes of meetings were not available to confirm that these issues had been discussed with staff.

We found that meetings were not held on a regular basis. This included practice meetings and team meetings. We were told that meetings tended to be informal and therefore minutes were not written. Staff told us that there was an open culture within the practice and if they had to raise any issues they could do this at any time. They were confident in doing so and felt supported if they did.

One of the partners had a dual role and worked as the nurse practitioner and practice manager at the practice. They had identified the hours that would be dedicated to each of these roles. We saw that the practice manager worked hard to fulfil both roles. It was noted that there was a need for support in this role. The partners had recognised this and plans were in place to recruit a deputy practice manager.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example recruitment and disciplinary procedures which were in place to support staff. We found that three of the reception and administration staff we spoke with were not aware of the whistleblowing policy.

Seeking and acting on feedback from patients, public and staff

The practice had gathered feedback from patients through patient surveys, compliments and complaints received. We looked at the results of the patient participation group (PPG) patient survey for 2014 and saw appropriate action

was taken to address comments and suggestions made by patients. For example, concerns about lighting in the waiting room had been addressed and a request for clarity on the practice opening times and GP availability had been updated on the practice website. A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care. The practice had an active PPG which consisted of eight members. The PPG included male and female members from mainly the older population group. The group was actively working to recruit members from other population groups. They had posted adverts in the waiting room to encourage patients to join the group. The PPG met quarterly with staff members and a GP from the practice when needed.

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

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

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. Staff files we looked at demonstrated that regular appraisals had taken place which included personal development. Staff told us that the practice was very supportive of training and that they had protected learning time where guest speakers and trainers attended. However staff training records did not demonstrate that all staff were up to date with training which included for example; fire training the mental capacity act and safeguarding.

The practice had completed reviews of significant events and other incidents and shared these with relevant staff. However the practice did not hold regular meetings to share these more widely to ensure that outcomes were improved and maintained for patients.

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	<p>Regulation 17 HSCA (RA) Regulations 2014 Good governance</p> <p>The provider could not demonstrate that systems and processes were established and operated effectively to ensure compliance because:</p> <p>Robust systems were not in place to ensure effective monitoring, updating and management of staff training, recruitment, general policies and procedures, and health and safety.</p> <p>There was no governance or management oversight in place to ensure all staff received regular fire awareness training or written evidence seen of fire drills to ensure staff acted in accordance with fire regulations.</p> <p>This was in breach of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) 2014 Good Governance Regulation 17(1)</p>
Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	<p>Regulation 18 HSCA (RA) Regulations 2014 Staffing</p> <p>The provider was not ensuring that staff received appropriate support, training, professional development, supervision and appraisal as was necessary to enable them to carry out their duties.</p> <p>The provider had not completed checks on the training status of all staff to ensure they had received appropriate ongoing training and updates related to statutory training such as fire safety awareness. All learning and development and required training was not monitored and appropriate action was not taken quickly where training requirements were not met.</p> <p>This was in breach of regulation 18(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.</p>