Sackville Medical Centre

Quality Report

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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this service	Good
Are services safe?	Requires improvement
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Sackville Medical Centre on 17 June 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing well-led, effective, caring and responsive services. It was also good for providing services for all of the population groups. It required improvement for providing safe services.

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Risks to patients were assessed and well managed, with the exception of those relating to the safe storage of medicines.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- Patients said they generally found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day.
- The practice had adequate facilities and was equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.

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

Summary of findings

Importantly the provider must;

- Ensure medicines are stored securely at all times.
- Ensure there is a cleaning schedule and documented record for all clinical equipment and toys kept in treatment rooms.
- Ensure risk assessments are undertaken for the risk of legionella and the use of a mercury sphygmomanometer.
- Ensure the audit process for prescription pads is monitored and effective.

The provider should:

- Ensure GP training records are held centrally and incorporated into the practice training management system.
- Ensure all GPs are trained to level 3 safeguarding and that the practice maintains a record of all GP mandatory training.
- Maintain regular infection control audits so that improvements over time are recorded.

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 as there are areas where it should make improvements. Staff understood their responsibilities to raise concerns, and to report incidents and near misses. When things went wrong, reviews and investigations were carried out and lessons learned were communicated to support improvement. Although risks to patients who used services were generally assessed, the systems and processes to address these risks were not implemented well enough to ensure patients were kept safe. For example medicines in one treatment room were unlocked, there was no cleaning schedule or record for equipment and toys in treatment rooms and the audit trail for prescription pads did not capture a pad that had been left in a doctor's bag. In addition the practice had not carried out a legionella risk assessment and we found a mercury sphygmomanometer on site with no access to mercury spill kits.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from the National Institute for Health and Care Excellence and used it routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. However, there was no central record of GP training and we were told that GPs would take responsibility their own attendance at mandatory training. There was evidence of appraisals and personal development plans for all staff. Staff worked with multidisciplinary teams.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice higher than others for several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information for patients about the services available was easy to understand and accessible. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Summary of findings

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 to secure improvements to services where these were identified. Patients generally said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day. The practice had adequate facilities and made adaptations to appointment locations to treat patients and meet their needs. The practice had involved patients in the development of plans for new premises and we saw that the move was on schedule for 2016. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group (PPG) was active. Staff had received inductions, regular performance reviews and attended staff meetings and events.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. For example the practice QOF scores for atrial fibrillation, heart failure and stroke and transient ischaemic attack were all at 100%. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in dementia and end of life care. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs. The practice supported two nursing homes and a designated named partner GP had responsibility for the homes. A community navigator supported patients to access social and community care, including those patients who were housebound.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. All these patients had a 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

Good

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. Immunisation rates were relatively high for all standard childhood immunisations. 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, health visitors and school nurses.

Summary of findings

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. For example the practice offered early morning and late evening appointments on certain days during the week. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability. It had carried out annual health checks for people with a learning disability and these patients had received a follow-up. It offered longer appointments for people with a learning disability.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. It had told vulnerable patients about how to access various support groups and voluntary organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). 87% of 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 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.

Summary of findings

What people who use the service say

Patients mostly 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 31 comment cards which contained mostly positive comments about the practice. We also spoke with six patients on the day of the inspection and met with three members of the patient participation group (PPG).

We reviewed the results of the national patient survey which contained the views of 100 patients registered with the practice. The national patient survey showed patients were generally pleased with the care and treatment they received from the GPs and nurses at the practice. The survey indicated that 87% of respondents said the last GP they saw or spoke to was good at explaining tests and treatments and 97% had confidence and trust in the last nurse they saw or spoke to and 97% had confidence and trust in the last GP they saw or spoke to. The practice performance was similar to the CCG and national average across a number of points of the GP patient survey.

We spoke with six patients on the day of the inspection, reviewed 31 comment cards completed by patients in the two weeks before the inspection and spoke with three members of the PPG. The patients we spoke with and the comments we received were mostly positive. Comments included those stating that the service was caring and that staff were good at listening, thorough and supportive. There were five comments that while complementary about the staff expressed some difficulty in booking appointments or the length of time they would have to wait before being seen.

Areas for improvement

Action the service MUST take to improve

- Ensure medicines are stored securely at all times.
- Ensure there is a cleaning schedule and documented record for all clinical equipment and toys kept in treatment rooms.
- Ensure risk assessments are undertaken for the risk of legionella and the use of a mercury sphygmomanometer.
- Ensure the audit process for prescription pads is monitored and effective.

Action the service SHOULD take to improve

- Ensure GP training records are held centrally and incorporated into the practice training management system.
- Ensure all GPs are trained to level 3 safeguarding and that the practice maintains a record of all GP mandatory training.
- Maintain regular infection control audits so that improvements over time are recorded.

Sackville Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a Care Quality Commission (CQC) Lead Inspector and included a GP specialist advisor and a practice manager specialist advisor.

Background to Sackville Medical Centre

Sackville Medical Centre offers general medical services to people living in the Hove area of Brighton and Hove. It is a practice with five GP partners, two salaried GPs and one retainer doctor (a GP who works sessions to keep up to date with general practice). In addition, the practice had one advanced nurse prescriber, two practice nurses, two healthcare assistants and GP registrar students. There are approximately 11500 registered patients.

The practice was supported by management functions in the form of a practice manager and office manager, IT administrator, medical secretary and a team of receptionists.

The practice runs a number of services for its patients including asthma clinics, minor surgery, child immunisation clinics, diabetes clinics, new patient checks, and weight management support.

Services are provided from:

Sackville Medical Centre

20 Sackville Road

Hove

East Sussex

BN3 3FF

The practice has opted out of providing Out of Hours services to their patients. There are arrangements for patients to access care from an Out of Hours provider.

The practice population has a higher number of patients in paid work or full time education, compared with the England average. The practice population also has a higher than average number of patients to the national average being cared for in nursing homes.

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 Brighton and Hove Clinical Commissioning Group (CCG). We carried out an announced visit on 17 June 2015. During our visit we spoke with a range of staff, including GPs, practice nurses, an advanced nurse prescriber and administration staff.

Detailed findings

We observed staff and patients interaction and talked with nine patients. We reviewed policies, procedures and operational records such as risk assessments and audits. We reviewed 31 comment cards completed by patients, who shared their views and experiences of the service, in the two weeks prior to our visit.

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

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

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

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

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

Requires improvement

Are services safe?

Our findings

Safe track record

The practice prioritised safety and used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. For example we saw that incident reports included a range of issues including a patient fall and a delayed referral to secondary care and all staff told us they felt confident in using the reporting system.

We reviewed safety records, incident reports and minutes of meetings where these were discussed for the last 12 months. This showed the practice had managed these consistently over time and so could show evidence of a safe track record.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. We reviewed records of five significant events that had occurred during the last 12 months and saw this system was followed appropriately. Significant events was a standing item on the practice meeting agenda and the practice manager had an overview of the process. There was evidence that the practice had learned from these and that the findings were shared with relevant staff. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

Staff used incident forms on the practice intranet and sent completed forms to the practice manager. She showed us the system used to manage and monitor incidents. We tracked five incidents and saw records were completed in a comprehensive and timely manner. We saw evidence of action taken as a result and that the learning had been shared. For example we saw that an incident where a two week referral had been cancelled by mistake, the practice took immediate action and implemented additional checks by administrative staff to prevent reoccurrence.

Where patients had been affected by something that had gone wrong they were given an apology and informed of the actions taken to prevent the same thing happening again.

National patient safety alerts were disseminated by the practice manager via email 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. They also told us alerts were discussed at partner and clinical meetings to ensure all staff were aware of any that were relevant to the practice and where they needed to take action.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed that most staff had received relevant role specific training on safeguarding, however one of the GPs had not attended Level Three training. We asked members of medical, nursing and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details were easily accessible and we saw that information was visible on notice boards in clinical and staffing areas within the practice.

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

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments; for example children subject to child protection plans had an alert on their electronic

record so that all staff would be aware. There was active engagement in local safeguarding procedures and effective working with other relevant organisations including health visitors and the local authority.

There was a chaperone policy, which was visible on the waiting room noticeboard and in consulting rooms and on the practice web site. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). All nursing staff, including health care assistants, had been trained to be a chaperone. Reception staff would act as a chaperone if nursing staff were not available. There was a risk assessment in place that identified only those reception staff who had been trained and who had up to date DBS checks in place could chaperone. These receptionists had undertaken training and understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination. All staff undertaking chaperone duties had received Disclosure and Barring Service (DBS) checks. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).

GPs were appropriately using the required codes on their electronic case management system to ensure risks to children and young people who were looked after or on child protection plans were clearly flagged and reviewed. The lead safeguarding GP was aware of vulnerable children and adults and records demonstrated good liaison with partner agencies such as the police and social services. Staff were proactive in monitoring if children or vulnerable adults attended accident and emergency or missed appointments frequently. These were brought to the GPs attention, who then worked with other health and social care professionals. We saw minutes of meetings where vulnerable patients were discussed.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were not stored securely and only accessible to authorised staff at the time of our inspection. The door to the treatment room was unlocked although the practice nurse told us this was locked at the end of the day. There was also an unlocked cupboard in the treatment room and we saw that some contraceptive medicines were stored there. There was a policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. Records showed room temperature and fridge temperature checks were carried out which ensured medication was stored at the appropriate temperature.

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.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Both blank prescription forms for use in printers and those for hand written prescriptions were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times. However, we saw that a prescription pad was stored in one of the doctor's bags that was not subject to an audit trail.

There was a system in place for the management of high risk medicines such as warfarin, methotrexate and other disease modifying drugs, which included regular monitoring in accordance with national guidance. Appropriate action was taken based on the results and we saw electronic flags were used to alert GPs as to when blood tests and reviews were due.

The practice had clear systems in place to monitor the prescribing of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse). Staff were aware of how to raise concerns around controlled drugs with the controlled drugs accountable officer in their area.

The practice nurse used Patient Group Directions (PGDs) to administer vaccines and other medicines that had been produced in line with legal requirements and national guidance. We saw sets of PGDs that had been updated within the preceding 12 months. We saw evidence that nurses had received appropriate training and been assessed as competent to administer the medicines referred to under a PGD. A member of the nursing staff was qualified as an independent prescriber and she received regular supervision and support in her role as well as updates in the specific clinical areas of expertise for which she prescribed.

Requires improvement

Are services safe?

We saw a positive culture in the practice for reporting and learning from medicines incidents and errors. Incidents were logged efficiently and then reviewed promptly. This helped make sure appropriate actions were taken to minimise the chance of similar errors occurring again.

Cleanliness and infection control

We observed the premises to be clean and tidy. We saw there were general cleaning schedules in place and cleaning records were kept. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

An infection control policy and supporting procedures were available for staff to refer to (August 2014), which enabled them to plan and implement measures to control infection. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these to comply with the practice's infection control policy. In addition we saw that hand washing facilities were available, including notices alerting staff and visitors to good hand washing practice. There was also a policy for needle stick injury and staff knew the procedure to follow in the event of an injury.

The practice nurse was the lead for infection control and had undertaken further training via the local CCG to enable them to provide advice on the practice infection control policy and carry out staff training. All staff received induction training about infection control specific to their role and received annual updates. We did not see evidence of infection control audits being carried out on an annual basis historically, however the infection control lead had implemented infection control audits in line with their lead responsibilities in the weeks preceding our inspection. Minutes of practice meetings showed that the findings of the audits were discussed and we viewed a detailed action plan in response to the audit.

There was a cleaning schedule in place for cleaning both domestic and clinical fridges but there was no cleaning schedule for equipment within the treatment rooms e.g. blood pressure monitors and nebuliser machines. Staff told us this was because clinical equipment was cleaned after each use and was the responsibility of the staff member using it. We also saw that toys were available for children in some clinical areas and that cleaning of these items was the responsibility of the clinician. However, we did not see cleaning schedule or a process for monitoring cleanliness in place for these items.

The practice did not have a policy for the management, testing and investigation of legionella (a bacterium which can contaminate water systems in buildings). The practice had not undertaken a risk assessment for legionella.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date was in the preceding 12 months. A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example weighing scales, spirometers, blood pressure measuring devices and the fridge thermometer.

We saw there was a mercury sphygmomanometer (for manually recording blood pressure) on a wall in one of the treatment rooms. There were no mercury spill kits available within the practice. The senior partner and practice manager told us they would take immediate action to remove this piece of equipment.

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 prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service (These checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).

We saw there was a rota system in place for all the different staffing groups to ensure that enough staff were on duty.

Requires improvement

Are services safe?

There was also an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual leave. Newly appointed staff had this expectation written in their contracts.

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. The practice manager showed us records to demonstrate that actual staffing levels and skill mix met planned staffing requirements.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included regular checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy. Health and safety information was displayed for staff to see and there was an identified health and safety representative.

Identified risks were included on a risk log. Each risk was assessed and rated and mitigating actions recorded to reduce and manage the risk. The meeting minutes we reviewed showed risks were discussed at GP partners' meetings and within team meetings. For example risks associated with the building had been identified following a patient fall, including the risk for frail or elderly patients in accessing the upstairs consulting rooms. As a result, the practice had issued information for patients to request they be seen in a downstairs consulting room if needed and staff had added alerts to patient records when this had been identified.

We saw that staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies. Staff had attended basic life support training and all staff we spoke with were aware of the location of emergency equipment. Staff gave us examples of how they responded to patients experiencing a mental health crisis, including supporting them to access emergency care and treatment. For example we saw that specialist staff including CPNs had been involved in assessing and supporting a patient in this situation.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (used in cardiac emergencies). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly. We checked that the pads for the automated external defibrillator were within their expiry date. The notes of the practice's clinical meetings showed that staff had discussed an emergency concerning a patient who had fallen, requiring emergency treatment as a result and that the practice had learned from this appropriately.

Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Risks identified included power failure, adverse weather, unplanned sickness, failure of the telephone system and access to the building. The document also contained relevant contact details for staff to refer to.

The practice had carried out an internal fire risk assessment that included actions required to maintain fire safety. Staff told us the practice carried out regular fire drills.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We saw that guidance from local commissioners was readily accessible in all the clinical and consulting rooms.

We discussed with the practice manager, GP and nurse how NICE guidance was received into the practice. They told us this was downloaded from the website and disseminated to staff. We saw minutes of clinical meetings which showed this was then discussed and implications for the practice's performance and patients were identified and required actions agreed. Staff we spoke with all demonstrated a good level of understanding and knowledge of NICE guidance and local guidelines.

Staff described how they carried out comprehensive assessments which covered all health needs and was in line with these national and local guidelines. They explained how care was planned to meet identified needs and how patients were reviewed at required intervals to ensure their treatment remained effective. For example, patients with diabetes were having regular health checks and were being referred to other services when required. Feedback from patients confirmed they were referred to other services or hospital when required.

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

The practice used computerised tools to identify patients who were at high risk of admission to hospital. These patients were reviewed regularly to ensure multidisciplinary care plans were documented in their records and that their needs were being met to assist in reducing the need for them to go into hospital. We saw that after patients were discharged from hospital they were followed up to ensure that all their needs were continuing to be met.

Discrimination was avoided when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were cared for and treated based on need and the practice took account of patient's age, gender, race and culture as appropriate.

Management, monitoring and improving outcomes for people

Information about people's care and treatment, and their outcomes, was routinely collected and monitored and this information used to improve care. Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, and managing child protection alerts and medicines management. The information staff collected was then collated by the practice manager to support the practice to carry out clinical audits.

The practice had a system in place for completing clinical audit cycles. The practice showed us two clinical audits that had been undertaken in the last 12 months. Both of these were completed audits where the practice was able to demonstrate the changes resulting since the initial audit. Following each clinical audit, changes to treatment or care were made where needed and the audit repeated to ensure outcomes for patients had improved. For example, an audit of testing and treatment of vitamin deficiency had identified issues with testing against guidelines issued by the CCG. Practice against the guidelines was audited, followed by a clinical meeting where the guidelines were discussed. A re-audit of vitamin D testing showed a reduction in the number of vitamin D blood tests being undertaken and an adherence to the guidelines issues.

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).

Good

Are services effective?

(for example, treatment is effective)

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. This practice was not an outlier for any QOF (or other national) clinical targets, It achieved 97% of the total QOF target in 2014, which was above the national average of 4%. Specific examples to demonstrate this included:

- Performance for diabetes related indicators was similar to the national average.
- The percentage of patients with hypertension having regular blood pressure tests was similar to the national average
- Performance for mental health related and hypertension QOF indicators was better than the national average.
- The dementia diagnosis rate was comparable to the national average

The team was making use of clinical audit tools, clinical supervision and staff meetings to assess the performance of clinical staff. The staff we spoke with discussed how, as a group, they reflected on the outcomes being achieved and areas where this could be improved. Staff spoke positively about the culture in the practice around audit and quality improvement.

The practice's prescribing rates were also similar to national figures. There was a protocol for repeat prescribing which followed national guidance. This required staff to regularly check patients receiving repeat prescriptions had been reviewed by the GP. They also checked all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines. We saw evidence that after receiving an alert, the GPs had reviewed the use of the medicine in question and, where they continued to prescribe it, outlined the reason why they decided this was necessary.

The practice had made use of the gold standards framework for end of life care. It had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss the care and support needs of patients and their families. We viewed minutes of palliative care meetings where GP partners, salaried GPs and specialist palliative care staff had attended.

The practice also kept a register of patients identified as being at high risk of admission to hospital and of those in various vulnerable groups for example, those with learning disabilities and those experiencing mental ill health. Structured annual reviews were also undertaken for people with long term conditions (e.g. Diabetes, COPD, Heart failure). We were shown examples of reviews and saw these had been undertaken comprehensively.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that most staff were up to date with attending mandatory courses such as annual basic life support. However, there was no central record of GP mandatory training and we were told that GPs were responsible for their own training updates. We noted a good skill mix among the doctors with one having recently certified as a trainer and additional diplomas having been attained e.g. diploma in palliative care. All GPs were up to date with their yearly continuing professional development requirements and all either have been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

All staff undertook annual appraisals that identified learning needs from which action plans were documented. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses, for example one of the practice nurses was training as an independent prescriber. As the practice was a training practice, doctors who were training to be qualified as GPs were offered extended appointments and had access to a senior GP throughout the day for support. We received positive feedback from the trainees we spoke with.

Practice nurses and health care assistants had job descriptions outlining their roles and responsibilities and provided evidence that they were trained appropriately to fulfil these duties. For example, on administration of vaccines, cervical cytology and assisting with surgical procedures. Those with extended roles, for example seeing

Good

Are services effective?

(for example, treatment is effective)

patients with long-term conditions such as asthma, COPD, diabetes and coronary heart disease were also able to demonstrate that they had appropriate training to fulfil these roles.

We did not see evidence of poor performance having been identified, however the practice manager was able to demonstrate the appropriate action that would be been taken to manage this.

Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and manage those of patients with complex needs. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from these communications. Out-of Hours reports, 111 reports and pathology results were all seen and actioned by a GP on the day they were received. Discharge summaries and letters from outpatients were usually seen and actioned on the day of receipt and all within five days of receipt. The GP who saw these documents and results was responsible for the action required, for example patients who were considered to be high risk would be contacted on discharge from hospital. All staff we spoke with understood their roles and felt the system in place worked well. There were no instances identified within the last year of any results or discharge summaries that were not followed up.

Emergency hospital admission rates for the practice were relatively low at 1.4% compared to the national average of 1.4%. The practice held multidisciplinary team meetings monthly to discuss patients with complex needs. For example, those with multiple long terms conditions, mental health problems, those with end of life care needs or children on the at risk register. Palliative care meetings were attended by palliative care nurses and decisions about care planning were documented in a shared care record. Staff felt this system worked well. Care plans were in place for patients with complex needs and shared with other health and social care workers as appropriate.

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. We saw evidence there was a system for sharing appropriate information for patients with complex needs with the ambulance and Out-of-Hours services.

For patients who were referred to hospital in an emergency there was a policy of providing a printed copy of a summary record for the patient to take with them to Accident and Emergency. The practice had also signed up to the electronic Summary Care Record and planned to have this fully operational by 2015. (Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours).

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record to coordinate, document and manage patients' care. All staff were fully trained on the system. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference. We saw evidence that audits had been carried out to assess the completeness of these records and that action had been taken to address any shortcomings identified.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it. The practice policy highlighted how patients should be supported to make their own decisions and how these should be documented in the medical notes.

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) and had a section stating the patient's preferences for treatment and decisions. We saw an example of a care plan for a patient with a learning disability and saw that this had been reviewed and a template was in place to highlight when further reviews were required. When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision. For example, we saw that a patient with dementia

Good

Are services effective?

(for example, treatment is effective)

had a care plan in place and a best interest meeting had been held with involvement of external specialist staff. All clinical staff demonstrated a clear understanding of the Gillick competency test. (These are used to help assess whether a child under the age of 16 has the maturity to make their own decisions and to understand the implications of those decisions).

There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures, a patient's verbal consent was documented in the electronic patient notes with a record of the discussion about the relevant risks, benefits and possible complications of the procedure. In addition, the practice obtained written consent for significant minor procedures and all staff were clear about when to obtain written consent.

Health promotion and prevention

It was practice policy to offer a health check to all new patients registering with the practice. The GP was informed of all health concerns detected and these were followed up in a timely way. We noted a culture among the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing. We saw a good amount of health promotion material in the practice waiting area and there was a section of the waiting room where patients could check their weight or blood pressure and access further information about health promotion.

The practice also offered NHS Health Checks to all its patients aged 40 to 75 years. We were told that patients would be followed up within a relevant timeframe if they had risk factors for disease identified at the health check and further investigations would be scheduled.

The practice had many ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice had identified the smoking status of 84% of patients over the age of 16 and actively offered nurse-led smoking cessation clinics to 100% of these patients. Similar mechanisms of identifying 'at risk' groups were used for patients who were obese and those receiving end of life care. These groups were offered further support in line with their needs.

The practice's performance for the cervical screening programme was 77%, which was similar to the national average of 81%. There was a policy to offer telephone reminders for patients who did not attend for their cervical screening test. A practice nurse had responsibility for following up patients who did not attend. The practice also encouraged its patients to attend national screening programmes for bowel cancer and breast cancer screening.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance was above average for the majority of immunisations where comparative data was available. For example:

- Flu vaccination rates for the over 65s were 69%, and at risk groups 44%. These were similar to national averages.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey (July 2015), feedback from NHS Choices, results of the Friends and Family Test survey, in-house feedback forms and both verbal and written feedback between April 2014 and March 2015. The data we reviewed had been reviewed by the Patient Participation Group (PPG). (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 evidence from all these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the national patient survey showed the practice was rated slightly higher than the CCG and national average for patients who rated the practice as good. The practice was rated similar to or slightly above the CCG and national average for its satisfaction scores on consultations with doctors and nurses. For example:

- 89% said the GP was good at listening to them compared to the CCG average of 87% and national average of 89%.
- 87% said the GP gave them enough time compared to the CCG average of 84% and national average of 87%.
- 97% said they had confidence and trust in the last GP they saw compared to the CCG average of 95% and national average of 95%
- 94% said the nurse gave them enough time compared to the CCG average of 92% and the national average of 92%.
- 92% said the nurse was good at listening to them compared to the DDG average of 92% and the national average of 91%.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 31 completed cards and the majority were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. Three comments were less positive regarding difficulties getting an appointment or the length of time they waited to be seen, however all comments included positive feedback about the staff. We also spoke with nine patients on the day of our inspection. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

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

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. The practice switchboard was located away from the reception desk and staff were able to take patients away from the reception area to hold confidential conversations. Additionally, 88% said they found the receptionists at the practice helpful compared to the CCG average of 89% and national average of 87%.

Staff told us that if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected, they would raise these with the practice manager. The practice manager told us she would investigate these and any learning identified would be shared with staff.

There was a clearly visible notice in the patient reception area stating the practice's zero tolerance for abusive behaviour. Receptionists told us that referring to this had helped them diffuse potentially difficult situations.

We saw that people whose circumstances may make them vulnerable and those experiencing poor mental health were able to access the practice without fear of stigma or prejudice and we observed staff treating people in a sensitive manner.

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:

Good

Are services caring?

- 87% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 85% and national average of 86%.
- 81% said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 80% and national average of 81%.
- 93% said the last nurse they saw or spoke to was good at explaining tests and treatments compared to the CCG average of 90% and the national average of 90%.
- 87% said the nurse they saw was good at involving them in decision about their care compared to the CCG average of 84% and the national average of 85%.

Patients we spoke with on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. Patient feedback on the comment cards we received was also positive and aligned with these views.

Staff told us that translation services were available via telephone or face to face for patients who did not have English as a first language.

Care plans were developed for those patients who needed them and patients were involved in agreeing these. We saw examples of comprehensive care plans that had been developed with the involvement of patients, including those for patients with a learning disability and older people.

Patient/carer support to cope emotionally with care and treatment

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

- 84% said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 84% and national average of 85%.
- 92% said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 91% and national average of 90%.

The patients we spoke with on the day of our inspection and the comment cards we received were also consistent with this survey information. For example, these highlighted that staff responded compassionately when they needed help and provided support when required.

Notices in the patient waiting room, on the TV screen and patient website also told patients how to access a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer. There was written information available for carers to ensure they understood the various avenues of support available to them.

Staff told us that if families had suffered a bereavement, their usual GP or a member of the reception team contacted them, depending on their circumstances. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service. One patient we spoke with who had had a bereavement confirmed they had received follow up support from the practice and said they had found it helpful.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patient's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered. For example, the practice had developed an online consultation process where patients could request treatment and advice from their GP online. The GPs also held weekly ward rounds at local care homes for their patients in residential care.

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. For example we saw that the practice participated in a local proactive care project with other practices in the area and attended regular meetings.

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG). For example, members of the PPG told us they had been involved in developing an action plan for the practice to improve patient access to appointments in advance, this included the development of an electronic booking system.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example, longer appointment times were available for patients with learning disabilities, those requiring interpreting support and those experiencing poor mental health. In addition the practice had developed more online services that were particularly useful for the working patient population and held weekly ward rounds at the larger care homes they supported. The majority of the practice population were English speaking patients but access to online, telephone and face to face translation services were available if they were needed. Staff were aware of when a patient may require an advocate to support them and there was information on advocacy services available for patients.

The premises and services were located in a converted house in a residential area and had not been designed to meet the needs of people with disabilities. Some services were held on the second level and there was no lift access. The practice had received funding for new premises and at the time of our inspection were awaiting planning approval to begin their relocation. In the meantime, the practice had implemented a policy where all patients with mobility issues could access services on one level of the practice. This was achieved by administrative staff adding an alert to a patient's electronic record so that staff were able to plan to see them in the ground floor consulting rooms. We viewed notices in the waiting area informing patients that they could access services on one level if they had mobility issues. The consulting rooms were also accessible for patients with mobility difficulties and there were access enabled toilets and baby changing facilities. There was a large waiting area with plenty of space for wheelchairs and prams. This made movement around the practice easier and helped to maintain patients' independence.

Staff told us that they did not have any patients who were of "no fixed abode" as there was a dedicated homeless GP service in the area but would see someone if they came to the practice asking to be seen and would register the patient so they could access services. There was a system for flagging vulnerability in individual patient records. For example, if a patient had a learning disability or experienced mental ill health this would be flagged on the electronic patient record system so that all staff were aware. The practice had a register for patients who may be living in vulnerable circumstances.

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

Access to the service

The surgery was open from 8am to 6.30 pm Monday to Friday. GP appointments were available from 8.30 am to 11.30 am and 3pm to 5.30 pm on weekdays. Early morning appointments were available on a Wednesday and Thursday morning for blood-tests and extended hours surgeries were available on a Monday evening and Wednesday and Thursday mornings. The practice also participated in a local extended hours service (EPIC) which included them acting as a host site on a rotational basis. This meant that pre-booked appointments were available

Good

Are services responsive to people's needs?

(for example, to feedback?)

for patients between 6.30pm and 8pm Monday to Friday and for six hours on a Saturday and Sunday. The surgery premises was closed between 1pm and 1.30 pm and the phone lines closed between 1pm and 2pm.

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits and how to book appointments through the website. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Information on the Out-of-Hours service was provided to patients.

Longer appointments were also available for older patients, those experiencing poor mental health, patients with learning disabilities and those with long-term conditions. This also included appointments with a named GP or nurse. Home visits were made to two local care homes on a specific day each week, by a named GP and to those patients who needed one.

The patient survey information we reviewed showed patients responded positively to questions about access to appointments and generally rated the practice well in these areas. For example:

- 81% were satisfied with the practice's opening hours compared to the CCG average of 73% and national average of 75%.
- 93% described their experience of making an appointment as good compared to the CCG average of 88% and national average of 85%.
- 69% said they usually waited 15 minutes or less after their appointment time compared to the CCG average of 66% and national average of 65%.
- 72% said they could get through easily to the surgery by phone compared to the CCG average of 76% and national average of 73%.

Patients we spoke with were satisfied with the appointments system and said it was easy to use. They confirmed that they could see a doctor on the same day if they felt their need was urgent although this might not be their GP of choice. . They also said they could see another doctor if there was a wait to see the GP of their choice. Routine appointments were available for booking four weeks in advance. Comments received from patients also showed that patients in urgent need of treatment had often been able to make appointments on the same day of contacting the practice. For example, one patient we spoke with had called the surgery in the morning and had attended for an appointment a few hours later.

Home visits and longer appointments were available for older people and people with long-term conditions. We were told that elderly patients who had complex issues would be discussed at multidisciplinary meetings that involved the specialist palliative care team if appropriate.

The practice had a good understanding of the issues facing the working age population of the practice and we saw that ways to address these included health promotion input and accessibility outside of normal practice hours, including online advice and access to medical records.

Listening and learning from concerns and complaints

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

We saw that information was available to help patients understand the complaints system, including information displayed in the waiting area and as part of the new patient pack that was given to patients at the time of registering with the practice. Patients we spoke with were aware of the process to follow if they wished to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice.

We looked at four complaints received in the last 12 months and found that these were dealt with in a timely way and that communication was seen as a priority, that clinical review meetings were held to review the complaint and identify action and learning, and that external advice and input was sought as required.

The practice reviewed complaints annually to detect themes or trends alongside other methods of feedback and planned action to address any themes identified. For example, in response to concerns raised by patients about difficulties accessing appointments the practice worked with the PPG to nominate a PPG member as an 'appointment champion' to work with the practice staff on improving access to appointments. As a result, action was taken to implement a method for online advice, extending

Good

Are services responsive to people's needs?

(for example, to feedback?)

telephone consultations, nominating a senior administrator with responsibility for patient access and initiating training for a second nurse practitioner. Lessons learned from individual complaints had been acted on and improvements made to the quality of care as a result.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality, evidence based care and promote good outcomes for patients. We found details of the vision and practice values were part of the practice's statement of purpose and three year business plan. We saw evidence the strategy and business plan were regularly reviewed by the practice and also saw the practice values were clearly displayed in the waiting areas and in the staff room. The practice vision and values included work in a positive, friendly and professional manner while ensuring that services were timely and up to date.

We spoke with fifteen members of staff and they all knew and understood the vision and values and knew what their responsibilities were in relation to these and had been involved in developing them.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the practice. We looked at a number of these policies and procedures including health and safety, whistleblowing and complaints. Staff had signed to state that they had read the policies and a summary of these was included in a staff handbook that was given to all staff on commencement in post. All policies and procedures we looked at had been reviewed annually and were up to date.

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead nurse for infection control and a GP partner was the lead for safeguarding. We spoke with fifteen members of staff and they were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

The GP and practice manager took an active leadership role for overseeing that the systems in place to monitor the quality of the service were consistently being used and were effective. The included using the Quality and Outcomes Framework to measure its performance (QOF is a voluntary incentive scheme which financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). The QOF data for this practice showed it was performing in line with national standards at five percentage points above the CCG average and four percentage points above the national average. We were told that QOF data was regularly discussed at monthly team meetings and action plans were produced to maintain or improve outcomes.

The practice also had an on-going programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. For example, we viewed a two week wait process audit which was a full cycle audit and undertaken in response to a significant event. The initial audit showed there was a lack of a consistent approach so the practice redesigned the process so that it included immediate action by the GP plus administrative input. Results of the re-audit demonstrated immediate improvements and we viewed a plan for a further re-audit six months later. Evidence from other data from sources, including incidents and complaints was used to identify areas where improvements could be made. Additionally, there were processes in place to review patient satisfaction and that action had been taken, when appropriate, in response to feedback from patients or staff. The practice regularly submitted governance and performance data to the CCG.

The practice identified, recorded and managed risks. It had carried out risk assessments where risks had been identified and action plans had been produced and implemented, for example a risk assessment for administrative staff undertaking administrative duties identified that those staff must have had training and must be DBS checked.

The practice held monthly staff meetings where governance issues were discussed, including significant event analysis. We looked at minutes from these meetings and found that performance, quality and risks had been discussed.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example disciplinary procedures, induction and complaints/adverse incidents which were in place to support staff. We were shown the staff handbook that was available to all staff, which included sections on equality and harassment and bullying at work. Staff we spoke with

Are services well-led?

Good

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

knew where to find these policies if required. The practice had a whistleblowing policy which was also available to all staff in the staff handbook and electronically on any computer within the practice.

Leadership, openness and transparency

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

We saw from minutes that team meetings were held every month. Staff told us that there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and confident in doing so and felt supported if they did. Staff said they felt respected, valued and supported, particularly by the manager and partners in the practice.

Seeking and acting on feedback from patients, public and staff

The practice encouraged and valued feedback from patients. It had gathered feedback from patients through the patient participation group (PPG), surveys and complaints received. It had an active PPG which included representatives from various population groups, including those with long term conditions, people of working age and older people. The PPG had identified the need to expand the membership of the group to include representatives from other population groups, including younger patients. The PPG had been extended to include a virtual group and plans were in place to use social media to further develop interest in the group. The PPG had carried out quarterly surveys and met every quarter. The practice manager showed us the analysis of the last patient feedback report, which was considered in conjunction with the PPG. The results and actions agreed from these surveys are available on the practice website. We spoke with three members of the PPG and they were very positive about the role they played and told us they felt engaged with the practice. (A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care).

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 also gathered feedback from staff through staff meetings, appraisals and discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at staff files and saw that regular appraisals took place which included a personal development plan. Staff told us that the practice was very supportive of training and that they had attended staff training sessions where guest speakers had attended.

The practice was a new GP training practice and one of the GP partners was an educational supervisors. At the time of our inspection there was one GP registrar present and they provided very positive feedback in respect of their learning experience within the practice.

The practice had completed reviews of significant events and other incidents and shared with staff at meetings to ensure the practice improved outcomes for patients.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment 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 due to not assessing the risk from legionella bacteria. This was in breach of regulation 12(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 The provider had failed to comply with the proper and safe management of medicines. Medicines were not always stored securely within locked treatment rooms. This was a breach of regulation 12(1)/ 12(2)(g) 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 an effective audit trail of prescription pads was in place within the practice. This was in breach of regulation 12(2)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment The provider had failed to ensure that equipment and other items in treatment rooms were cleaned in line with current legislation and guidance. The provider had failed to operate a cleaning schedule for the cleaning of equipment and other items in treatment rooms and was therefore unable to monitor the levels of cleanliness. This was a breach of regulation 15(1)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014